332-025-0021

Risk Assessment Practice Standards

(1) Recognizing the importance of collaborative maternal health care, when determining the appropriateness of community birth, an LDM must assess risks, including ongoing and cumulative risks, by using clinical skills and expertise, relevant state rules and laws, principles of informed choice, midwifery core competencies, the setting of practice and access to higher levels of care, and careful consideration of selection criteria.

(2) When an indication to transfer presents the LDM must transfer care. If the mother or newborn present with any of the following indications the LDM must:

(a) During the antepartum period, plan for transfer of care and an in-hospital birth;

(b) During the intrapartum period, arrange transportation to the hospital and transfer of care unless the birth is imminent;

(c) When the birth is imminent, take the health and condition of the mother and baby and conditions for transport into consideration in determining whether to proceed with out-of-hospital birth or to arrange for transportation to a hospital and transfer of care;

(d) During the postpartum period arrange for transfer of care.

(3) The timing for when arranging transportation and transfer of care in subsection (2) of this rule must occur is tied to the degree of risk of the indication to transfer.

(4) If a client refuses transfer of care, the midwife must terminate midwifery care. The timing for when termination of care must occur is tied to the degree of risk of the indication to transfer. The LDM may immediately terminate midwifery care orally and then provide written notice to the client or relinquish care to a licensee under ORS 682.

Proposed Rule

(5) After transferring care, an LDM may continue to provide supportive care to the client including, but not limited to, nutritional advice, education, emotional, and psychosocial support.

(6) Upon documented resolution of an indication to transfer, an LDM may resume primary care and responsibility for the client or newborn, or both, and proceed with midwifery care.

(7) Indication to transfer - Pre-existing and historical conditions:

(a) Active cancer.

(b) Active or chronic renal disease.

(c) Acquired immune deficiency syndrome (AIDS).

(d) Four (4) or more cesarean sections.

(e) Diabetes currently requiring oral medication or insulin.

(f) Mother presenting with a previous classical uterine incision, T-incision, prior uterine rupture or extensive transfundal surgery.

(g) Three (3) cesarean sections without previous successful vaginal birth.

(8) Indication to transfer - Antepartum:

(a) Hypertension at or above 140 systolic or at or above 90 diastolic on two (2) separate occasions that are more than four (4) hours apart, or hypertension at or above 160 systolic or at or above 110 diastolic on one (1) occasion.

(b) Deep venous or any treated thromboembolic disease.

(c) Active substance abuse.

(d) Ectopic pregnancy.

Proposed Rule

(e) Any pregnancy with abnormal fetal surveillance testing including, but not limited to, biophysical profile, non-stress test and auscultated acceleration testing.

(f) Acquired Immune Deficiency Syndrome (AIDS).

(g) Multiples.

(h) Hemoglobin under nine (9) unresponsive to treatment at term.

(i) Evident or suspected placenta accreta.

(j) Pregnancy lasting longer than 43 weeks 0 days gestation (21 days past the due date).

(k) Placenta less than 2.0 centimeters from internal os not resolved by onset of labor and as determined by ultrasound evidence.

(9) Indication to transfer - Intrapartum:

(a) Hypertension at or above 140 systolic or at or above 90 diastolic on two (2) separate occasions that are more than four (4) hours apart or hypertension at or above 160 systolic at or above 110 diastolic on one (1) occasion.

(b) Two (2) temperatures at 100.4 degrees Fahrenheit or 38 degrees Celsius or greater at two (2) intervals within one (1) hour or one (1) temperature at 102.2 degrees Fahrenheit or 39 degrees Celsius or greater.

(c) Signs and symptoms of complete or partial placental abruption.

(d) Vital sign instability or altered level of consciousness unresponsive to treatment.

(e) Persistent inability to auscultate fetal heart tones.

(f) Excessive vomiting, dehydration, acidosis or exhaustion unresponsive to treatment.

(g) Signs and symptoms of uterine rupture.

Proposed Rule

(h) Prolapsed cord or cord presentation.

(i) Retained placenta.

(j) Signs and symptoms of placenta previa or suspected placenta previa.

(k) Evident or suspected footling or kneeling breech and birth is not imminent.

(l) Active genital herpes in the vaginal, perineal, or vulva areas when the mother is in labor or has ruptured membranes.

(m) Signs and symptoms of shock.

(n) Signs and symptoms of chorioamnionitis or suspected chorioamnionitis.

(o) Labor or premature rupture of membrane less than 36 and 0 weeks gestation.

(p) Thick meconium stained amniotic fluid and birth is not imminent.

(q) Persistent non-reassuring fetal status.

(r) Lack of adequate progress in second stage in breech presentation, which means no progress in descent after a maximum of one (1) hour of active pushing in cases where the mother is fully dilated and has ruptured membranes.

(s) Lack of adequate progress in second stage with cephalic presentation, which means no descent after a maximum of three (3) hours of active pushing in cases where the mother is fully dilated and has ruptured membranes.

(t) Transverse or oblique lie at onset of labor.

(u) Significant hemorrhage unresponsive to treatment with or without sustained vital sign instability or shock.

(10) Indication to transfer - Postpartum:

Proposed Rule

(a) Signs and symptoms of uterine infection.

(b) Pre-eclampsia or eclampsia.

(c) Laceration requiring transfer of care for repair including but not limited, to 3rd and 4th degree lacerations.

(d) Increasingly painful or enlarging hematoma.

(e) Significant hemorrhage unresponsive to treatment with or without sustained vital sign instability or shock.

(f) Postpartum depression or mood disorder with suspicion of possible endangerment of self or others.

(11) Indication to transfer - Newborn Care:

(a) Apgar less than seven (7) at 10 minutes of age.

(b) Persistent nasal flaring, grunting or retraction after one (1) hour of life without improvement.

(c) Seizures.

(d) Apnea.

(e) Central cyanosis.

(f) Persistent inability to maintain temperature between 97 to 100 degrees Fahrenheit or 36 to 37 degrees Celsius.

(g) Persistent projectile or bilious vomiting or emesis of fresh blood.

(h) Evident or suspected infection.

(i) Significant distended abdomen.

Proposed Rule

(j) Weight less than 2,270 grams (five pounds.)

(k) Jaundice at birth or in the first 24 hours.

(l) Unresolved pallor at birth.

(12) "Indication for Consult" means a condition or clinical situation that places a mother or newborn at increased obstetric or neonatal risk but does not automatically exclude a mother and newborn from a community birth.

(13) When a mother or newborn present with one (1) or more indications for consult the LDM must:

(a) Arrange for transfer of care; or

(b) Comply with all the following:

(A) Consult with an Oregon licensed health care provider, as defined in OAR 332-025-0021(16) and (17), who is experienced and knowledgeable about the indication for consult unless a different Oregon licensed health care provider is otherwise stated specifically within this rule;

(B) Communicate to the mother the recommendations given by the consulting Oregon licensed health care provider if the mother was not present at the consultation;

(C) Obtain informed consent in accordance with OAR 332-025-0120;

(D) Make a plan with the mother about the indication; and

(E) Document the recommendations, consultation, discussion, informed consent and plan.

(14) Indication for Consult - Preexisting or historical medical conditions:

Proposed Rule

(a) Current treatment with prescription medication for any ongoing or chronic medical conditions.

(b) Cardiac condition.

(c) Active or chronic liver disease.

(d) Hyperthyroidism.

(e) Pulmonary disease being currently treated or is symptomatic.

(f) Hypertension at or above 140 systolic or at or above 90 diastolic outside of pregnancy.

(g) Deep venous thrombosis or any treated thromboembolic event.

(h) Previous myomectomy.

(i) Family history of thrombophilia.

(j) Placental abruption with adverse outcomes.

(k) One (1) or two (2) cesarean sections without previous successful vaginal birth.

(l) Three (3) cesarean sections with a previous successful vaginal birth.

(m) Psychiatric disorders with concern for maternal and fetal safety.

(n) Thrombophlebitis.

(o) Hemoglobinopathies.

(p) Preterm pre-eclampsia.

(q) Isoimmunization to blood factors.

(r) Syphilis.

Proposed Rule

(s) Human Immunodeficiency Virus (HIV) positive mother.

(t) Previous myomectomy.

(u) Fetal demise.

(v) Bleeding disorder.

(w) Preterm delivery less than 34 weeks.

(x) Obstetric hemorrhage requiring transfusion.

(15) Indication for consult - Antepartum:

(a) Incomplete spontaneous abortion.

(b) Hemoglobin under 10 unresponsive to treatment.

(c) Oligohydramnios or polyhydramnios.

(d) Primary genital herpes.

(e) Second or third trimester bleeding.

(f) Abnormal fetal cardiac rate or rhythm.

(g) Abnormally decreased fetal movement.

(h) Uterine anomaly.

(i) Substance use disorder.

(j) Platelet count of less than 115,000.

(k) Isoimmunization to blood factors.

(l) Known fetal anomalies that may require medical attention.

Proposed Rule

(m) Psychiatric disorders with concern for maternal and fetal safety.

(n) Thromboembolic event.

(o) Gestational diabetes or blood glucose dysregulation well-controlled with diet and exercise.

(p) Syphilis.

(q) Human Immunodeficiency Virus (HIV) positive mother.

(r) Hemoglobinopathies.

(s) Confirmed or suspected cholestasis.

(t) Breech presentation after 36 weeks. Consult for breech presentation after 36 weeks must be with a physician who provides cesarean delivery.

(u) Thrombophilia.

(16) Indication for consult - Intrapartum:

(a) A mother presenting with hypertension at or above 140 systolic or at or above 90 diastolic during labor or birth.

(b) Frank or complete breech identified in labor and without previous consult unless birth in imminent.

(17) Indication for consult - Postpartum:

(a) Hypertension at or above 150 systolic or at or above 100 diastolic on two (2) separate occasions which are more than four (4) hours apart or hypertension at or above 160 systolic or at or above 110 diastolic on one (1) occasion.

(b) Evident or suspected infection unresponsive to treatment.

Proposed Rule

(c) Ongoing or unresolved urinary retention.

(18) Indication for consult - Newborn:

(a) Failure to urinate within 24 hours after birth or pass stool within 48 hours after birth.

(b) Excessive ruddiness at birth.

(c) Any generalized rash at birth.

(d) Birth injury such as facial or brachial palsy, suspected fracture or severe bruising.

(e) Weight loss greater than 10 percent of birth weight that does not respond to treatment.

(f) Direct Coomb's positive. Consultation for Direct Coomb's positive newborns must be with a pediatric care provider.

(g) Newborn with Human Immunodeficiency Virus (HIV)-positive mother. Consultation for a newborn with Human Immunodeficiency Virus (HIV)-positive mother must be with a pediatric care provider.

(h) Evident or suspected major congenital anomaly.

(i) Evident or suspected neonatal opioid withdrawal syndrome.

(j) Pulse oximeter reading of less than 90 percent on right hand at greater than 24 hours.

(k) Heart rate less than 80 or greater than 160 (at rest) without improvement.

(l) Persistent cardiac murmur.

(m) Persistent poor feeding.

(n) Persistent hypotonia.

Proposed Rule

(o) Gestational age assessment of less than 36 weeks and 0 days.

(p) Respiration rate greater than 100 within the first two (2) hours postpartum, and greater than 80 thereafter, lasting more than one (1) hour without improvement.

(q) Evident or suspected abnormally elevated bilirubin.

(19) For the purpose of this rule “consultation” means a dialogue for the purpose of obtaining information or advice, with an Oregon licensed health care provider who has direct experience handling complications of the risk(s) present, as well as the ability to confirm the indication for consult, which may include, but is not limited to confirmation of a diagnosis and recommendation(s) regarding management of medical, obstetric, or fetal problems or conditions. Consultation may be by phone, in person, or in writing.

(20) For the purpose of this rule “Oregon licensed health care provider” means a physician or physician assistant licensed under ORS 677, a certified nurse midwife or nurse practitioner licensed under ORS 678, a naturopath licensed under ORS 685, or a licensed direct entry midwife licensed under ORS 687.

332-025-0130

Practice Standards for Terminating Midwifery Care

(1) The procedure for terminating midwifery care in a non-emergent situation is as follows:

(a) Provide written notice no fewer than three business days as postmarked, unless the mother is in labor or during an emergency, at which time the LDM must continue to provide midwifery care until another provider assumes care;

(b) Notice must be sent to the last known address of the mother by certified mail, return receipt requested, as well as by regular mail.

(c) Document the termination of care in the mother’s records.

Proposed Rule

(2) To terminate midwifery care in an emergency, the LDM must activate the 911 emergency system and transfer care to a licensee under ORS Chapter 682.

(3) An LDM may leave after transferring care to a licensee under ORS Chapter 682.

(4) If the mother refuses assistance from licensees under ORS Chapter 682 the LDM must continually urge the mother to transfer care to a licensee under ORS Chapter 682 and may:

(a) Continue care to save a life; and

(b) Only perform actions within the technical ability of the LDM.

Proposed Rule