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DIVISION 1

PROCEDURAL RULES

332-001-0000
Notice of Proposed Rule

Prior to the adoption, amendment, or repeal of any rule, the State Board of Direct Entry Midwifery shall:

(1) Publish notice of the adoption, amendment, or repeal in the Secretary of State's Bulletin referred to in ORS 183.360 at least twenty-one (21) days before the effective date.

(2) Mail such notice to persons on the State Health Division's mailing list established pursuant to ORS 183.335(7) at least 28 days before the effective date of the rule.

(3) Mail or deliver such notice to the Associated Press.

(4) Mail such notice to the following persons, organizations, or publications listed according to Board programs, where the Board determines that such persons, organizations, or publications would have an interest in the subject matter of the proposal:

(a) Oregon Midwifery Council;

(b) Oregon Association of Naturopathic Physicians;

(c) Chiropractic Association of Oregon;

(d) Oregon Pediatric Society;

(e) Oregon Medical Association;

(f) Oregon Chapter of the American College of Nurse-Midwives;

(g) Oregon Chapter of the American College of Obstetrics and Gynecologists;

(h) Oregon Public Health Association;

(i) Oregon Academy of Family Physicians;

(j) Oregon Nurses Association;

(k) Oregon Association of Hospitals and Health Systems;

(l) Oregon Primary Care Association; and

(m) Health Services Commission.

Stat. Auth.: OL 1993, Ch. 362 & ORS 183.341

Stats. Implemented:

Hist.: DEM 1-1993, f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94

332-001-0005
Model Rules of Procedure

Pursuant to ORS 183.341, the State Board of Direct Entry Midwifery adopts the Model Rules of Procedures as promulgated by the Attorney General of the State of Oregon under the Administrative Procedures Act as amended and effective September 17, 1997.

Stat. Auth.: OL Ch. 362 & ORS 183

Stats. Implemented: OL Ch. 362 Section 7

Hist.: DEM 1-1994, f. & cert. ef. 6-15-94; DEM 1-1998, f. 2-27-98, cert. ef. 3-1-98

332-001-0010
Delegation to Administrator

(1) To ensure continuity in the administration and daily operations of the Board of Direct Entry Midwifery, the Board Administrator, appointed and delegated authority by the Assistant Director of Health in addition to authority delegated by the Board to act on behalf of the Board as its agent, pursuant to carrying out the duties and functions of the Board as mandated in Oregon Laws 1993, Chapter 362, shall:

(a) Direct the administration and daily operations;

(b) Develop and carry out short and long term agency objectives;

(c) Direct and assure fiscal control over the use of human, equipment and budgetary resources. Hire employees to assist the Administrator in carrying out duties of the Board. Appoint, motivate and provide training, evaluate performance, resolve grievances, initiate promotions and disciplinary actions;

(d) Sign notifications, proposed rules and other documents pertaining to administrative rule adoption, amendment and/or appeal;

(e) Direct and oversee enforcement and regulatory programs of the Board;

(f) Direct and determine budget requests projecting resource needs and implement biennial budget;

(g) Enter into contracts with any state agency, personal professional service, organization or business as deemed appropriate; and

(h) Generate Board Financial Statement. Provide Board at regularly scheduled meetings with financial statements and reports.

(2) The Board Administrator's authority delegated by the assistant Director for Health and Board in no way diminishes the Board's policy-making authority in the coordination, review and approval of these activities.

Stat. Auth.:OL 1993, Ch. 362, Sections 7 & 8

Stats. Implemented:

Hist.: DEM 1-1993, f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94

332-001-0020
Agency Representation

(1) When the Board proposes to refuse to issue or renew a license, or proposes to revoke or suspend a license or place a license on probation, opportunity for hearing shall be accorded as provided in ORS 183.413 to 183.502.

(2) Promulgation of rules, conduct of hearings, issuance of orders and judicial review of rules and orders shall be as provided by ORS 183.310 to 183.480.

(3) Subject to the approval of the Attorney General, an offi-

cer or employee of the Health Division Licensing Office is authorized to appear on behalf of the Board when the Board proposes to deny, suspend or revoke a license or impose a civil penalty.

(4) The agency representative may not make legal argument on behalf of the Board:

(a) "Legal argument" includes arguments on:

(A) The jurisdiction of the Board to hear the contested case;

(B) The constitutionality of a statute or rule or the application of a constitutional requirement to an agency or Board; and

(C) The application of court precedent to the facts of the particular contested case proceeding.

(b) "Legal argument" does not include presentation of evidence, examination and cross-examination of witnesses or presentation of factual arguments or arguments on:

(A) The application of the facts to the statutes or rules directly applicable to the issues in the contested case;

(B) Comparison of prior actions of the agency in handling similar situations;

(C) The literal meaning of the statutes or rules directly applicable to the issues in the contested case; and

(D) The admissibility of evidence or the correctness of procedures being followed.

(5) When an agency officer or employee represents the Board, the presiding officer shall advise such representative of the manner in which objections may be made and matters preserved for appeal. Such advice is of a procedural nature and does not change the application of the law on waiver or the duty to make timely objections. Where such objections involve legal argument, the presiding officer shall provide reasonable opportunity for the agency officer or employee to consult legal counsel and permit such counsel to file written legal argument within a reasonable time after conclusion of the hearing.

Stat. Auth.: OL 1993, Ch. 362 & ORS 183

Stats. Implemented: ORS 183.450(7)

Hist.: DEM 1-1998, f. 2-27-98, cert. ef. 3-1-98

DIVISION 15

GENERAL ADMINISTRATION

332-015-0000
Definitions

(1) "*Antepartum*" means the period of time before the onset of labor with reference to the mother.

(2) "*Birth assistant*" means anyone who provides support or hands on aid to the primary birth attendant, or who functions under the supervision of a primary birth attendant, and has been trained in intrapartum emergency skills of direct entry midwifery.

(3) "*Board*" means the policy-making body known as the State Board of Direct Entry Midwifery.

(4) "*Board Administrator*" means the individual appointed by the Health Division who directs the daily functions of the Board as defined in Oregon Laws 1993, Chapter 362, Section 18.

(5) "*Board office*" means the unit within the Health Division which administers the State Board of Direct Entry Midwifery.

(6) "*Continuing education*" means ongoing training or instruction by which midwives shall keep current regarding issues relevant to the provision of maternal, newborn and well women care.

(7) "*Emergency skills of midwifery*" means the provision of vital sign assessment, CPR, infant resuscitation, maternal hemorrhage control, charting, fetal monitoring, treatment of shock, essentials of maternal and infant transport procedures, and the setup of necessary equipment.

(8) "*Emergency transport*" means the mechanism by which a mother or newborn would be moved to a location where appropriate care could be provided. Such means may include ambulance or private vehicle.

(9) "*Employed by*" means other than independent contractor relationship and does not require remuneration.

(10) "*Equivalent*" means substantially comparable but not identical, covering the same subject matter.

(11) "*Family planning*" means advice, counseling and provision of various contraceptive methods.

(12) "*Informed choice*" means the process of educating health care consumers about all aspects of their care, including risks, benefits, and alternatives, for any procedures, tests, or other care under consideration, in order to enable consumers to make an active choice in shaping their care.

(13) "*Intrapartum*" means the period of time from the onset of labor through the birth of the baby.

(14) "*License*" means the document authorizing the holder to use the title Licensed Direct Entry Midwifery.

(15) "*Licensed Direct Entry Midwife*" means a person who meets the minimum qualifications for licensure under Oregon Laws 1993, Chapter 362, Section 3 and is authorized by the Board to supervise the conduct of labor and childbirth; advise the parent as to the progress of the childbirth; render prenatal, intrapartum and postpartum care, and who meets the qualifications for reimbursement under medical assistance programs according to Oregon Laws 1993, Chapter 362, Section 11.

(16) "*MANA*" means the Midwives Alliance of North America.

(17) "*MEAC*" means the Midwifery Education and Accrediting Council.

(18) "*NARM*" means the North American Registry of Midwives.

(19) "*Newborn examination*" means the assessment of newborn well-being during the first hours of life.

(20) "*Official transcript*" means an original document certified by a school or educational institution, on a form approved by the Department of Education or regulating authority, delivered from the school to the Board office by mail or courier, which includes:

(a) School and location;

(b) Student's name, address and date of birth;

(c) Enrollment and completion or termination dates;

(d) Hours and types of course work;

(e) Final examination scores;

(f) School seal or stamp;

(g) Signature of authorized school representative or registrar.

(21) "*Pathology in childbirth*" means the variations which significantly compromise the well-being of mother, fetus, or newborn.

(22) "Client disclosure forms" means the written provision of information to clients which shall include but not be limited to: philosophy of care, practice style, educational background, clinical experience, financial arrangements, malpractice insurance coverage, documentation of informed choice process, and the address of the State Board of Direct Entry Midwifery.

(23) "*Peer review*" means the discussion of cases with other care providers and students for the purpose of obtaining and providing suggestions regarding care.

(24) "*Postpartum*" means the period of time after the birth of the baby.

(25) "*Practice*" means the clinical procedures used in the conduct of direct entry midwifery.

(26) "*Prenatal*" means the encompassing period of time from conception to the onset of labor.

(27) "Primary birth attendant" means the midwife who assumes direct responsibility for the direct entry midwife/client relationship.

(28) "*Re-Activated license*" means a previously licensed person, who has not made application for renewal prior to the expiration of the previous license and only if the license holder meets other qualifications for re-licensure as prescribed by the Board.

(29) "*Risk assessment*" means the analysis of health compromising conditions relevant to pregnancy, birth and the postpartum period based on information gathered through interview, clinical examination and historical data. Risk categories are identified as follows:

(a) "*Absolute Risk*" means the conditions or clinical situations whereby a client is evaluated to determine obstetrical or

neonatal risk which would preclude being a acceptable candidate for an out of hospital birth.

(b) "*Non-Absolute risk*" means situations which sometimes place a client at increased obstetric or neonatal risk but does not automatically exclude a client from out-of-hospital birth.

(c) "*Consultation*" means discussion with another health care provider.

(d) "*Non-Absolute risk factor consultation*" means situations which require a medical consultation. This consultation shall be with a licensed health care provider with hospital privileges.

(29) "*Sharps*" means items which includes needles, IV tubing with needles attached, scalpel blades, lancets, glass tubes that could be broken during handling and syringes that have been removed from their original sterile containers.

(30) "*Valid license*" means a license that has not expired or been suspended or revoked.

Stat. Auth.: OL 1993, Ch. 362, Sections 1 & 7

Stats. Implemented: ORS 183.450(7)

Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94; DEM 1-1998, f. 2-27-98, cert. ef. 3-1-98

332-015-0010
Standards for Qualifications for Licensure of Direct Entry Midwives

The State Board of Direct Entry Midwifery shall review each applicant's qualifications for licensure according to Oregon Laws 1993, Chapter 362, Section 3 to determine whether sufficient knowledge in the practice of direct entry midwifery has been attained. Applicants must meet the following criteria:

(1) Training and/or education as determined by the Board in accordance with OAR 332-015-0040.

(2) Pursuant to Oregon Laws 1993, Chapter 362, Section 3, participation in 25 assisted deliveries, 25 deliveries for which the midwife was the primary birth attendant, 100 prenatal care visits, 25 newborn examinations, and 40 postnatal examinations. Of these births at least 25 assisted deliveries must have taken place in an out-of-hospital setting. The applicant must have provided primary care for at least ten of these deliveries, including four prenatal visits, one newborn examination and one postpartum exam (continuity of care).

(3) Current certification in cardiopulmonary resuscitation for adults and newborns, which includes newborn bag and mask ventilation;

(4) A written plan for emergency transport; and

(5) Successful passage of Board approved examination(s) as set forth in OAR 332-015-0050.

Stat. Auth.: OL 1993, Ch. 362, Sections 3 & 4

Stats. Implemented: OL 1993, Ch. 362, Sections 3 & 4

Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94; DEM 1-1998, f. 2-27-98, cert. ef. 3-1-98

332-015-0030
Application for Licensure

Requirements for licensure consists of the following:

(1) Specific experience and/or training.

(2) Documentation of minimum clinical experiences as outlined in OAR 332-015-0010(2).

(3) Current certification in cardiopulmonary resuscitation for adults and newborns, which includes newborn bag and mask ventilation.

(4) Written plan for emergency transport for mother and/or newborn.

(5) Submission of completed and signed application form and other required documentation, which includes the following information:

(a) Applicant's name, address and telephone number;

(b) Applicant's date of birth;

(c) Affidavit of licensure information from all states licensed, if applicable;

(d) Applicant's signature and date of application;

(e) Applicant's Social Security Number;

(f) Any and all previous license and examination information; and

(g) Disclosure of all information pertaining to conviction of any crime.

(6) Satisfactory evidence of passage of the NARM examination, which may include official documentation of a passing score of the Certified Professional Midwife (CPM) examination, or copy of the applicant's CPM credential issued by the North American Registry of Midwives (NARM). Copies of examination results or other documentation provided by the applicant are subject to NARM verification.

(7) Completion of mandatory Oregon Laws and Rules Questionnaire.

(8) Payment of the application and original license fees.

Stat. Auth.: OL 1993, Ch. 362, Section 3

Stats. Implemented: OL 1993, Chapter 362, Section 3

Hist.: DEM 1-1994, f. & cert. ef. 6-15-94; DEM 1-1998, f. 2-27-98, cert. ef. 3-1-98

332-015-0040
Documentation of Experience and/or Training

(1) All applicants must have completed the following minimum core competencies adapted from the 1997 Edition of the Midwives of North America (MANA) and approved by the Board:

(a) **General Knowledge and Skills**: The midwife provides care incorporating certain concepts, skills and knowledge from a variety of health and social sciences, including but not limited to:

(A) Communication, counseling and teaching skills.

(B) Human anatomy and physiology relevant to childbearing.

(C) Community standards of care for women and their developing infants during the childbearing cycle, including midwifery and bio-technical medical standards and the rationale for and limitations of such standards.

(D) Health and social resources in her community.

(E) Significance of and methods for documentation of care through the childbearing cycle.

(F) Informed decision making.

(G) The principles and appropriate application of clean and aseptic technique and universal precautions.

(H) The selection, use and care of the tools and other equipment employed in the provision of midwifery care.

(I) Human sexuality, including indications of common problems and indications for counseling.

(J) Ethical considerations relevant to reproductive health.

(K) The grieving process.

(L) Knowledge of cultural variations.

(M) Knowledge of common medical terms.

(N) The ability to develop, implement and evaluate an individualized plan for midwifery care.

(O) Woman-centered care, including the relationship between the mother, infant and their larger support community.

(P) Knowledge of various health care modalities as they apply to the childbearing cycle.

(b) **Care During Pregnancy (Antepartum)**: The midwife provides health care, support and information to women throughout pregnancy. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:

(A) Identification, evaluation and support of maternal and fetal well-being throughout the process of pregnancy.

(B) Education and counseling for the childbearing cycle.

(C) Preexisting conditions in a woman's health history which are likely to influence her well-being when she becomes pregnant.

(D) Nutritional requirements of pregnant women and methods of nutritional assessment and counseling.

(E) Changes in emotional, psycho-social and sexual variations that may occur during pregnancy.

(F) Environmental and occupational hazards for pregnant women.

(G) Methods of diagnosing pregnancy.

(H) Basic understanding of genetic factors which may indicate the need for counseling, testing or referral.

(I) Basic understanding of the growth and development of the

unborn baby.

(J) Indications for, risks and benefits of bio-technical screening methods and diagnostic tests used during pregnancy.

(K) Anatomy, physiology and evaluation of the soft and bony structures of the pelvis.

(L) Palpation skills for evaluation of the fetus and uterus.

(M) The causes, assessment and treatment of the common discomforts of pregnancy.

(N) Identification of, implications of and appropriate treatment for various infections, disease conditions and other problems which may affect pregnancy.

(O) Special needs of the Rh(D)-negative woman.

(c) **Care During Labor, Birth and Immediately Thereafter (Intrapartum)**: The midwife provides health care, support and information to women throughout labor, birth and the hours immediately thereafter. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:

(A) The normal processes of labor and birth.

(B) Parameters and methods for evaluating maternal and fetal well-being during labor, birth and immediately thereafter, including relevant historical data.

(C) Assessment of the birthing environment, assuring that it is clean, safe and supportive, and that appropriate equipment and supplies are on hand.

(D) Emotional responses and their impact during labor, birth and immediately thereafter.

(E) Comfort and support measures during labor, birth and immediately thereafter.

(F) Fetal and maternal anatomy and their interactions as relevant to assessing fetal position and the progress of labor.

(G) Techniques to assist and support the spontaneous vaginal birth of the baby and placenta.

(H) Fluid and nutritional requirements during labor, birth and immediately thereafter.

(I) Assessment of and support for maternal rest and sleep as appropriate during the process of labor, birth and immediately thereafter.

(J) Causes of, evaluation of and appropriate treatment for variations which occur during the course of labor, birth and immediately thereafter.

(K) Emergency measures and transport procedures for critical problems arising during labor, birth or immediately thereafter.

(L) Understanding of and appropriate support for the newborn's transition during the first minutes and hours following birth.

(M) Familiarity with current bio-technical interventions and technologies which may be commonly used in a medical setting.

(N) Evaluation and care of the perineum and surrounding tissues.

(d) **Postpartum Care**: The midwife provides health care, support and information to women throughout the postpartum period. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes but is not limited to the following:

(A) Anatomy and physiology of the mother during the postpartum period.

(B) Lactation support and appropriate breast care including evaluation of, identification of and treatments for problems with nursing.

(C) Parameters and methods for evaluating and promoting maternal well-being during the postpartum period.

(D) Causes of, evaluation of and treatment for maternal discomforts during the postpartum period.

(E) Emotional, psycho-social and sexual variations during the postpartum period.

(F) Maternal nutritional requirements during the postpartum period including methods of nutritional evaluation and counseling.

(G) Causes of, evaluation of and treatments for problems arising during the postpartum period.

(H) Support, information and referral for family planning methods as the individual woman desires.

(e) **Newborn Care**: The entry-level midwife provides health care to the newborn during the postpartum period and support and information to parents regarding newborn care. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:

(A) Anatomy, physiology and support of the newborn's adjustment during the first days and weeks of life.

(B) Parameters and methods for evaluating newborn wellness including relevant historical data and gestational age.

(C) Nutritional needs of the newborn.

(D) Community standards and state laws regarding indications for, administration of and the risks and benefits of prophylactic bio-technical treatments and screening tests commonly used during the neonatal period.

(E) Causes of, assessment of, appropriate treatment and emergency measures for newborn problems and abnormalities.

(f) **Professional, Legal and Other Aspects**: The entry-level midwife assumes responsibility for practicing in accord with the principles outlined in this document. The midwife uses a foundation of knowledge and/or skill which includes the following:

(A) Oregon's documents concerning the art and practice of Midwifery.

(B) The principles and practice of data collection as relevant to midwifery care.

(C) Laws governing the practice of midwifery in her local jurisdiction.

(D) Various sites, styles and modes of practice within the larger midwifery community.

(E) A basic understanding of maternal/child health care delivery systems in her local jurisdiction.

(F) Awareness of the need for midwives to share their knowledge and experience.

(g) **Well-woman Care and Family Planning**: Depending upon education and training, the entry-level midwife may provide family planning and well-woman care. The practicing midwife may also choose to meet the following core competencies with additional training. In either case, the midwife provides care, support and information to women regarding their overall reproductive health, using a foundation of knowledge and/or skill which includes the following:

(A) Understanding of the normal life cycle of women.

(B) Evaluation of the woman's well-being including relevant historical data.

(C) Causes of, evaluation of and treatments for problems associated with the female reproductive system and breasts.

(D) Information on, provision of or referral for various methods of contraception.

(E) Issues involved in decision-making regarding unwanted pregnancies and resources for counseling and referral.

(2) The training requirements may be satisfied by a combination of the following:

(a) Self study, including attending workshops, studying textbooks, reviewing video and audio tapes;

(b) Completion of training programs, including seminars, lectures, or classes;

(c) Participation in birth experiences as evidenced by letters from primary birth attendant and supported by delivery summaries, statistical data forms and/or prenatal summaries, and/or client provided documentation of such participation. If a client provides information a client consent for disclosure of medical records should be included. In the alternative, client identifying information should be removed from the records.

(3) In the alternative to (2) above, training requirements may be met by satisfactory completion of certain midwifery training programs plus additional clinical experience, or by programs which include clinical experience. Those applicants who have been awarded a NARM CPM credential or a certificate of completion or diploma from a MEAC accredited program will satisfy Board training requirements as long as they meet the standards of OAR 332-015-0010(2).

NOTE: A list of approved training programs is on file and available for

review at the board office.

Stat. Auth.: OL 1993, Ch. 362, Section 7

Stats. Implemented: OL 1993, Ch. 362, Sections 3, 7 & 8

Hist.: DEM 1-1994, f. & cert. ef. 6-15-94; DEM 1-1998, f. 2-27-98, cert. ef. 3-1-98; DEM 2-1998, f. 4-14-98, cert. ef. 4-15-98

TABLE 1

CORE COMPETENCIES*

I. General Knowledge and Skills

I. — The midwife provides care incorporating certain concepts, skills and knowledge from a variety of health and social science disciplines, including but not limited to:
A. — Basic communication, counseling and teaching skills.
B. — Human anatomy and physiology relevant to childbearing.
C. — Community standards of care for women and their developing infants during the childbearing cycle, including midwifery and allopathic** medical standards and the rationale for and limitations of such standards.
D. — Health and social resources in her community.
E. — Significance of and methods for documentation of care through the childbearing cycle.
F. — Informed decision making.
G. — The principles and appropriate application of clean and aseptic technique and universal precautions.
H. — Human sexuality, including indication of common problems and indications for counseling.
I. — Ethical considerations relevant to reproductive health.
J. — The grieving process.
K. — Knowledge of cultural variations.
L. — Knowledge of common medical terms.
M. — The ability to develop, implement and evaluate an individualized plan for midwifery care.
N. — Woman-centered care, including the relationship between the mother, infant and their larger support community.
O. — Knowledge of various health care modalities as they apply to the childbearing cycle.

II. Antepartum Care

II. — The midwife provides health care, support and information to women throughout pregnancy. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:
A. — Education and counseling for the childbearing cycle.
B. — Preexisting conditions in a woman's health history which are likely to influence her well-being when she becomes pregnant.
C. — Nutritional requirements of pregnant women and methods of nutritional assessment and counseling.
D. — Environmental and occupational hazards for pregnant women.
E. — Methods of diagnosing pregnancy.
F. — Basic understanding of genetic factors which may indicate the need for counseling, testing or referral.
G. — Basic understanding of the growth and development of the unborn baby.
H. — Indications for, risks and benefits of allopathic screening methods and diagnostic tests used during pregnancy.
I. — Identification and evaluation of maternal and fetal well-being throughout the process of pregnancy.
J. — Anatomy, physiology and evaluation of the soft and bony structures of the pelvis.
K. — Palpation skills for evaluation of the fetus and uterus.
L. — The causes, assessment and treatment of the common discomforts of pregnancy.
M. — Identification of, implications of and appropriate treatment for various infections, disease conditions and other problems which may affect pregnancy.
N. — Special needs of the Rh - woman.
O. — Issues involved in decision-making regarding unwanted pregnancies and resources for counseling and referral.

III. Intrapartum Care

III. — The midwife provides health care, support and information to women throughout labor, birth and the immediate postpartum period. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:
A. — The normal processes of labor and birth.
B. — Parameters and methods for evaluating maternal and fetal well-being during labor, birth and the immediate postpartum period, including relevant historical data.
C. — Assessment of the birthing environment, assuring that is clean, safe and supportive, and that appropriate equipment and supplies are on hand.
D. — Emotional responses and their impact during labor, birth and immediate postpartum period.
E. — Comfort and support measures during labor, birth and the immediate postpartum period.
F. — Fetal and maternal anatomy and their interactions as relevant to assessing fetal position and the progress of labor.
G. — Techniques to assist and support the spontaneous vaginal birth of the baby and placenta.
H. — Fluid and nutritional requirements during labor, birth and the immediate postpartum period.
I. — Assessment of and support for maternal rest and sleep as appropriate during the process of labor, birth and the immediate postpartum.
J. — Causes of, evaluation of and appropriate treatment for variations which occur during the course of labor, birth and the immediate postpartum.
K. — Emergency measures and transport procedures for critical problems arising during labor, birth or immediately postpartum.
L. — Understanding of and appropriate support for the newborn's transition during the first minutes and hours following birth.
M. — Familiarity with current allopathic medical interventions and technologies which may be commonly used in a medical setting.
N. — Evaluation and care of the perineum and surrounding tissues.

IV. Postpartum Care of the Mother and Family Planning

IV. — The midwife provides health care, support and information to women throughout the postpartum period. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes but is not limited to the following:
A. — Anatomy and physiology of the mother during the postpartum period.
B. — Lactation support and appropriate breast care including evaluation of, identification of and treatments for problems with nursing.
C. — Parameters and methods for evaluating and promoting maternal well-being during the postpartum peri-

od.
D. — Causes of, evaluation of and treatment for maternal discomforts during the postpartum period.
E. — Emotional, psycho-social and sexual changes of the postpartum period.
F. — Maternal nutritional requirements during the postpartum period including methods of nutritional evaluation and counseling.
G. — Causes of, evaluation of and treatments for problems arising during the postpartum period.
H. — Support, information, provision of, or referral for family planning methods as the individual woman desires.

V. Neonatal Care

V. — The entry-level midwife provides health care to the newborn during the postpartum period and support and information to parents regarding newborn care. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:
A. — Anatomy, physiology and support of the newborn's adjustment during the first days and weeks of life.
B. — Parameters and methods for evaluating newborn wellness including relevant historical data and gestational age.
C. — Nutritional needs of the newborn.
D. — Community standards and state laws regarding indications for, administration of and the risks and benefits of prophylactic allopathic treatments and screening tests commonly used during the neonatal period.
F. — Causes of, assessment of, appropriate treatment and emergency measures for neonatal problems and abnormalities.

VI. Professional, Legal and Other Aspects

VI. — The entry-level midwife assumes responsibility for practicing in accord with the principles outlined in this document. The midwife uses a foundation of knowledge and/or skill which includes the following:
A. — Oregon's documents concerning the art and practice of Midwifery.
B. — The principles of data collection and reporting as relevant to midwifery practice.
C. — Laws governing the practice of midwifery in her local jurisdiction.
D. — A basic understanding of midwifery and other maternal/child health care delivery systems in her local jurisdiction.

*Core Competencies were adapted by the Board from Midwives Alliance of North America (MANA) 1994 edition.
**The term "allopathic medicine" is used as an abbreviated term to refer to Modern Western application of medical principles which uses synthesized pharmaceudical agents, surgery and laboratory diagnosis as the basis of care provision.
Stat. Auth.:OL 1993, Ch. 362
Stats. Implemented:
Hist.: DEM 1-1994, f. & cert. ef. 6-15-94

332-015-0050
NARM Midwifery Examination

The Board has selected the Certified Professional Midwifery examination administered by the North American Registry of Midwives (NARM) as its qualifying examination. Individual applicants are responsible for payment of all NARM application, examination, national certification or other fees directly to NARM.

(1) Applicants who meet the education and/or training requirements and achieve a passing score on the examination must request certification of the passing score be sent from the North American Registry of Midwives to the Board office as a prerequisite to application.

(2) Testing schedules and other information about the examination may be obtained from the Board office.

Stat. Auth.: OL 1993, Ch. 362, Section 7
Stats. Implemented: OL 1993, Ch. 362, Section 7
Hist.: DEM 1-1994, f. & cert. ef. 6-15-94; DEM 1-1998, f. 2-27-98, cert. ef. 3-1-98

332-015-0060
Application for Licensure Based on Equivalency

(1) An applicant who is currently licensed to practice direct entry midwifery in another state or who has been licensed within the past three years and who has not had a license suspended or revoked is eligible for licensure by equivalency.

(2) The requirements for licensure by equivalency are as follows:

(a) A completed application form and required documentation listed in OAR 331-015-0040(2), (5)(a) through (g), and (6);

(b) In lieu of documentation listed in OAR 331-015-0040(6), evidence satisfactory to the Board that applicant has passed another state sponsored exam which the Board finds to be the equivalent of the NARM exam;

(c) Affidavit of Licensure from another state. An original signed and sealed or stamped form issued upon the request of an applicant licensed in another state and mailed directly to the Board office by the state;

(d) Current certification in cardiopulmonary resuscitation for adults and newborns, which includes newborn bag and mask ventilation;

(e) A written plan for emergency transport;

(f) Completion of mandatory Oregon Laws and Rules Questionnaire; and

(g) Payment of the application and original license fees.

Stat. Auth.: OL 1993, Ch. 362, Sections 4 & 7
Stats. Implemented: OL 1993, Ch. 362, Sections 4 & 7
Hist.: DEM 1-1998, f. 2-27-98, cert. ef. 3-1-98

DIVISION 20

LICENSURE

332-020-0000
Licenses

(1) Licenses shall be issued when all qualifications have been met.

(2) Licenses shall be issued for no more than one year and shall expire on December 31.

(3) Sixty (60) calendar days prior to the end of the calendar year, the Board office shall mail a notice of renewal to the last known address of the license holder.

(4) Application for renewal shall be made in advance of the license expiration date and shall be accompanied by payment of license fee, proof of continuing education and peer review as required in OAR 332-020-0010 and OAR 332-025-0020(2), and proof of current certification in cardiopulmonary resuscitation for adults and newborns, which includes newborn bag and mask ventilation. The renewed license is effective as of the expiration date of the prior license. Any license that is not renewed at the end of the calendar year shall automatically revert to inactive status.

(5) Direct entry midwives who renew within three years from date of expiration may be granted a reactivated license upon reapplication, payment of license fee for each year inactive, submission of continuing education and peer review as required in OAR 332-020-0010 and 332-025-0020(2), and proof of current certification in cardiopulmonary resuscitation for adults and newborns, which includes newborn bag and mask ventilation.

(6) Direct entry midwives who fail to renew within three years following the date of expiration, may be granted a reactivated license upon:

(a) Reapplication and payment of examination and license fees;

(b) Submission of proof of having obtained continuing education and peer review as required per OAR 332-020-0010 and 332-025-0050(2);

(c) Successful passage of a written examination prescribed by the Board; and

(d) Submission of proof of current certification in cardiopulmonary resuscitation for adults and newborns, which includes newborn bag and mask ventilation.

(7) An applicant who was previously licensed in Oregon and who has been engaged in the active practice of direct entry midwifery in another state or territory during the last three years preceding reapplication for Oregon licensure will not be required to pass the written examination for reactivation according to Oregon Laws 1993, Chapter 362, Section 9, provided the following documentation and fee is submitted:

(a) Application form;

(b) License fee;

(c) Verification of work experience and copies of statistical reporting forms in accordance with OAR 332-015-0040;

(d) Submission of proof of having obtained continuing education and peer review as required in OAR 332-020-0010 and 332-025-0020(2); and

(e) Proof of current certification in cardiopulmonary resuscitation for adults and newborns, which includes newborn bag and mask ventilation.

(8) Up to one year from the date of the denial of issuance or renewal, or the date of the order of suspension a direct entry midwife may be restored to active license status upon:

(a) Application and payment of license fee if expired during suspended status and not reactivated following cessation of suspended status;

(b) Submission of proof of having obtained continuing education and peer review as required by OAR 332-020-0010 and 332-025-0020(2);

(c) Proof of current certification in cardiopulmonary resuscitation for adults and newborns, which includes newborn bag and mask ventilation;

(d) Has met corrective action as prescribed by the Board; and

(e) If applicable, paid all fines assessed by the Board.

(9) A direct entry midwife whose license has been revoked may be relicensed upon;

(a) Application and payment of examination and license fees;

(b) Successful passage of a Board prescribed written examination;

(c) Submission of proof of having obtained continuing education and peer review as required per OAR 332-020-0010 and 332-025-0020(2);

(d) Proof of current certification in cardiopulmonary resuscitation for adults and newborns, which includes newborn bag and mask ventilation;

(e) Has met corrective action as prescribed by the Board; and

(f) If applicable, paid all fines assessed by the Board.

Stat. Auth.: OL 1993, Ch. 362, Sect. 3, 7, 9 & 10

Stats. Implemented:

Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94

332-020-0010
Continuing Education

(1) Each direct entry midwife must complete thirty clock hours of continuing education every two years from date of licensure to qualify for renewal of license. A midwife who has attended fewer than five births in the previous year shall be required to take an additional 10 hours of continuing education.

(2) Continuing education is required for renewal, every two years, even if the direct entry midwife license has been inactive during that period.

(3) Licenses will not be renewed without receipt of the required continuing education report.

(4) Licensees failing to obtain thirty clock hours of continuing education every two years must reapply and qualify according to the requirements of OAR 332-015-0030 and successfully pass a written examination.

(5) Continuing education includes attendance or participation at an instructional program presented, recognized, or under the auspices of any permanently organized institution, agency, or professional organization or association. For example, lectures, postsecondary school or postgraduate courses, scientific sessions at conventions, teaching (provided that no more than half the required hours be in teaching), or research, or correspondence courses, or video tapes, or similar self-study.

(6) Subject matter shall be related to direct entry midwifery practice as set forth in Oregon Laws 1993, Chapter 362, Sections 3 and 8, the law and rules regulating licensed direct entry midwives, science, health care professional concerns such as infection control or medical emergencies, ethics, and business practices.

(7) Documentation shall include the name of the sponsoring institution/association or organization, title of presentation description of content, name of instructor or presenter, date duration in hours, and license or statement of attendance or completion provided by the sponsor.

(8) Submission to the Board of proof of participation in continuing education is the responsibility of the direct entry midwife.

(9) Proof of thirty clock hours of continuing education shall be accumulated and held by the direct entry midwife until submitted to the Board biannually at the time of renewal.

(10) Hours obtained in excess of the thirty required each two year period will not be carried forward as credit for the subsequent two year continuing education requirement.

Stat. Auth.:OL 1993. Ch. 362, Sect 7 & 9

Stats. Implemented:

Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94

332-020-0020
Fees; Refunds

(1) Fees established by the Board and approved by the Department of Administrative Services are as follows:

(a) $250 — Initial license and renewal.

(b) $250 — Examination.

(2) Examination and/or initial licensure fee will be refunded if the applicant does not meet the qualifications for examination or licensure.

Stat. Auth.:OL 1993, Ch. 362, Sect 3

Stats. Implemented:

Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94; DEM 1-1997(Temp), f. 7-22-97, cert. ef. 7-23-97

332-020-0030
Absolute and Non-Absolute Risk Criteria

(1) Antepartum:

(a) Absolute Risk Criteria:

(A) Active cancer;

(B) Cardiac disease;

(C) Severe Renal disease - active or chronic;

(D) Severe Liver disease - active or chronic;

(E) Active hyperthyroidism;

(F) Chronic obstructive pulmonary disease;

(G) Essential chronic hypertension;

(H) Pre-eclampsia/eclampsia;

(I) Acute or chronic thrombophlebitis;

(J) Current ITP;

(K) Current substance abuse;

(L) Hemoglobin under 10;

(M) Labor or PROM prior to 36 weeks;

(N) Abruption placenta;

(O) Placenta previa;

(P) Persistent severe abnormal quantity of amniotic fluid;

(Q) Blood coagulation defect;

(R) Documented IUGR;

(S) Amnionitis;

(T) Seizure disorder requiring prescriptive medication;

(U) History of previous uterine inversion;
(V) Ectopic pregnancy;
(W) Incomplete spontaneous abortion;
(X) Pregnancy lasting longer than 43 weeks gestation;
(Y) Multiple gestation;
(aa) Malpresentation at the onset of labor;
(bb) Previous uterine wall surgery excluding low transverse caesarian section and myomectomy;
(cc) Pregnancy lasting longer than 42 weeks with an abnormal non-stress test;
(dd) Rupture of membranes for greater than 72 hours before the onset of labor;
(ee) Primary herpes infection at the onset of labor and secondary herpes that cannot be covered at the onset of labor;
(b) Non-Absolute Risk.
(A) Serious infectious disease requiring medical supervision;
(B) Significant glucose intolerance;
(C) Deep conization of cervix;
(D) Inappropriate fetal size for gestation;
(E) Significant 2nd or 3rd trimester bleeding;
(F) Abnormal fetal cardiac rate or rhythm, or decrease of movement;
(G) History of significant postpartum hemorrhage;
(H) Ongoing use of prescriptive drugs;
(I) Uterine anomaly;
(J) Anemia (hematocrit less than 30 or hemoglobin less than 10) at term;
(K) Asthma requiring medical supervision (medication, prescription);
(L) Platelet count less than 100,000;
(M) Estimated weight greater than 10.5 pounds;
(N) Myomectomy with review of surgical records;
(O) Psychotic disorders;
(P) History of thrombophlebitis;
(Q) Hemoglobinopathies;
(R) Previous Rh sensitization.
(2) Intrapartum:
(a) Absolute Risk Criteria:
(A) Suspected uterine rupture;
(B) Active herpes lesion in an unprotectable area;
(C) No prenatal care of unavailable records;
(D) Prolapsed cord or cords presentation;
(E) Abnormal bleeding;
(F) Persistent fever of 101 degrees fahrenheit or above, taken orally;
(G) Pre-eclampsia/eclampsia;
(H) Amniotic fluid with thick or moderate/thick meconium and birth not imminent;
(I) Evidence of fetal distress or abnormal fetal heart rate pattern unresponsive to treatment or inability to auscultate fetal heart tones;
(J) Excessive vomiting, dehydration, acidosis or exhaustion unresponsive to treatment;
(K) Blood pressure greater than or equal to 150/100 which persist or rises, and birth is not imminent;
(L) Failure to progress in active phase of labor with presence of strong contractions;
(M) Failure to descend within the expected time during active pushing, generally two hours for primip and one hour for multip.
(3) Postpartum:
(a) Absolute Risk Criteria:
(A) Retain placenta with no bleeding greater than one hour;
(B) Retained placenta with bleeding;
(C) Laceration requiring hospital repair;
(D) Uncontrolled postpartum bleeding;
(E) Increasingly painful or enlarging hematoma;
(F) Development of pre-eclampsia;
(G) Signs of shock unresponsive to treatment
(b) Non-Absolute Risk Criteria:
(A) Infectious process;
(B) Any condition requiring more than 12 hours of postpartum observation;
(C) 36-37 week gestation.
(4) Infant:
(a) Absolute Risk Criteria:
(A) Apgar less than 7 at 10 minutes of age;
(B) Respiration rate greater than 60 accompanied by any of the following lasting more than one hour: nasal flaring, grunting, or retraction;
(C) Cardiac irregularities, heart rate less than 80 or greater than 160 (at rest), or any other abnormal or questionable cardiac findings;
(D) Seizures;
(E) Temperature less than 97 degrees Fahrenheit or greater than 100 degrees Fahrenheit when taken rectally or any other evidence of infectious process;
(F) Apnea;
(G) Central cyanosis;
(H) Large or distended abdomen;
(I) Any infant that has required intubation
(J) Any infant where meconium has been visualized at the level of the cords;
(K) Any condition requiring more than 12 hours of observation postbirth;
(L) Gestational age under 36 weeks;
(M) Persistent poor suck, hypotonia or a weak or high pitched cry;
(N) Persistent projectile vomiting or emesis of fresh blood;
(O) Signs and symptoms of infection in the newborn;
(b) Non-Absolute Risk Criteria:
(A) Apgar less than 7 at 5 minutes;
(B) Weight less than 2270 grams (5 lbs.);
(C) Jitteriness;
(D) Failure to void within 24 hours or stool within 48 hours from birth;
(E) Maternal substance abuse identified intrapartum or postpartum;
(F) Excessive pallor, ruddiness, or jaundice at birth;
(G) Any generalized rash at birth;
(H) Birth injury such as facial or brachial palsy, suspected fracture or severe bruising;
(I) Blood glucose less than 40;
(J) Weight decrease in excess of 10% of birth weight;
(K) Maternal-infant interaction problems;
(L) Direct Coomb's positive cord blood;
(M) Major congenital anomaly;

Stat. Auth.:OL 1993, Ch. 362, Sec 3, 7 & 8
Stats. Implemented:
Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94

DIVISION 25

PRACTICE

332-025-0000
Filing Changes in Business Related Information

Licensed Direct Entry Midwives shall notify the Board office within 30 calendar days, in writing, of any changes as follows:
(1) Business name, address, or location.
(2) Mailing address.
(3) Business telephone number and business hours.
(4) Licensure status, whether from active to inactive practice or from inactive to active practice.

Stat. Auth.:OL 1993. Ch. 362. Sec. 7
Stats. Implemented:
Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94

332-025-0010
Information Request

(1) The Board will provide the following information in

response to telephone requests:

(a) The name and license number of a midwife and an indication as to whether the midwife's license is active or expired; or

(b) Any information as to the assumed business name, the location, and the telephone number of a midwife.

(2) A request for any information other than that listed in section (1) of this rule must be in writing.

(3) The Board shall charge a fee for copies of its records. Fees charged shall not exceed the actual costs of locating, compiling, making available for inspection, preparing copy in paper, audio, microfilm or machine readable format, and delivering public records. All fees assessed shall be paid before public records are made available. Estimates for processing requests for public records will be given when requested.

(4) Persons wishing to obtain copies of the following records may learn the charge for them by contacting the Board office:

(a) A list of names, addressees, and place of business for all midwives and licenses currently held with the Board;

(b) A list of all active midwives;

(c) One or more photocopies of any Board document or portion thereof;

(d) Copies of examination packets and materials;

(e) Informational packets and/or materials;

(f) Copies of the administrative rules and/or statute.

Stat. Auth.:OL 1993, Ch. 362, Sec. 7

Stats. Implemented:

Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94

332-025-0020
Practice Standards

Pursuant to Oregon Laws 1993, Chapter 362, Section 8, licensed direct entry midwives shall be guided by the following practice standards when supervising the conduct of labor and childbirth; advising the parent; and, in rendering prenatal, intrapartum and postpartum care.

(1) To facilitate the cooperation of collection and reporting data on births in accordance with Oregon Laws 1993, Chapter 362, Section 8 and 15, a licensed direct entry midwife shall include the designation L.D.M. after their name when completing birth certificates.

(2) As a condition of license renewal, licensed direct entry midwives shall participate in peer review meetings in their regions or in conjunction with professional organization meeting(s) which shall include, but not be limited to the discussion of cases, and obtaining feedback and suggestions regarding care. Documentation shall be made on forms approved by the Board. Licensees shall participate in peer review with licensed direct entry midwives according to the following schedule:

(a) Once per year if the licensee performed as the primary birth attendant at less than 40 births during the license year; or

(b) Twice per year if the licensee performed as the primary birth attendant at more than 40 births during the license year.

(3) A general explanation of the midwife's emergency transport plan shall be included in the client disclosure form to be given to the client. It shall include but not be limited to destination of transport; mode of transport; and provision for delivery equipment to be carried in the vehicle.

(4) Licensed direct entry midwives shall maintain equipment necessary to assess maternal, fetal and newborn well-being; to maintain aseptic technique; to respond to emergencies requiring immediate attention; and to resuscitate mother and newborn when attending an out-of-hospital birth. In accordance with Oregon Laws 1993, Chapter 362, Section 8, Subsection (4), the Board recommends the following equipment as a guideline for licensed direct entry midwives;

(a) Anti-hemorrhagic agents;

(b) Antiseptic scrub;

(c) Birth certificates;

(d) Blood pressure cuff;

(e) Bulb syringe;

(f) Equipment for amniotomy;

(g) Eye prophylaxis;

(h) Flashlight or lantern and batteries;

(i) Heat source for newborn resuscitation;

(j) Infant and adult resuscitation equipment;

(k) Infant suction catheter with mucus trap;

(l) Labor, delivery postpartal and statistics records forms.

(m) Nitrazine paper;

(n) Scales and measuring tape;

(o) Sealable plastic containers for bodily fluids as per Oregon Health Division; and

(p) Sharps and sealable plastic containers;

(q) Sterile and non-sterile exam gloves;

(r) Stethoscope and fetascope;

(s) Thermometer;

(t) Three hemostats;

(u) Umbilical cord occlusion devices;

(v) Urine dipsticks;

(w) Venipuncture equipment.

(5) Licensed direct entry midwives shall ensure that medications and newborn metabolic screening are provided in accordance with the provisions of OAR 333-019-0265, 333-019-0390, 333-021-0800 and 333-024-0205 through 0235 relating to mandatory services for newborns. The State Health Officer shall assist with access to the mandated prescriptive medications if a licensed direct entry midwife is unable to locate an appropriate state licensed health care provider who may prescribe medications.

(6) Licensed direct entry midwives who satisfactorily complete a Board approved course in prescriptive medications and the use of medical oxygen equipment may administer in an emergency requiring immediate attention medications at the direction of a state licensed health care provider who is licensed to administer prescriptive medications.

(7) In an emergency requiring immediate attention, licensed direct entry midwives may perform perineal repair, use amnihooks, dopplers, and infant suction catheter with mucus trap in the performance of services in accordance with Oregon Laws 1993, Chapter 362, Section 1, Subsection (3).

(8) Licensed direct entry midwives who satisfactorily complete a Board approved course in prescriptive medications may, in an emergency requiring immediate attention, administer local anesthetic as indicated at the direction of a state licensed health care provider who is authorized to administer local anesthetic.

(9) Licensed direct entry midwives shall dispose of pathological waste resulting from the birth process in accordance with Oregon State Health Division provisions:

(a) Incineration, provided the waste is properly containerized at the point of generation and transported without compaction to the site of incineration; or

(b) Burial on private property if burial of human remains on such property is not prohibited or regulated by a local government unit at the designated site. Such burials shall be made in accordance with the provisions of the local government unit; the Oregon State Health Division requirements as set forth in OAR Chapter 333, Division 61; and ORS 432.307.

(10) Licensed direct entry midwives shall dispose of biological waste materials which come into contact with blood and/or body fluids in a sealable plastic bag (separate from sealable trash or garbage liners) or in a manner that protects the licensee and the client and others who may come into contact with the material during disposal. Biological wastes may also be incinerated or autoclaved in equipment dedicated to treatment of infectious wastes.

(11) Licensed direct entry midwives shall dispose of sharps which come into contact with blood or bodily fluids in a sealable rigid (puncture proof) container that is strong enough to protect the licensee and the client and others from accidental cuts or puncture wounds during the disposal process.

(12) Sharps shall be placed into appropriate containers at the point of generation and may be transported without compaction to a landfill having an area designed for sharps burial or transported to an appropriate health care facility equipped to handle sharps disposal, provided the lid of the container is tightly closed or

taped to prevent the loss of content and the container is appropriately labeled.

(13) Licensees shall maintain client disclosure records providing accurate information to prospective clients on services rendered. Documentation shall include but not be limited to:

(a) Clinical experience;

(b) Services provided to clients;

(c) Type of emergency medications used in situations requiring immediate attention;

(d) Responsibilities of the mother and her family;

(e) Fees for services including financial arrangements;

(f) Malpractice coverage; and

(g) Emergency transport plan, which includes:

(A) Place of transport;

(B) Mode of transport;

(C) Provisions for back-up physician and hospital including location and telephone numbers; and

(D) Availability of private vehicle or ambulance including emergency delivery equipment carried in the vehicle.

(14) Licensed direct entry midwives shall assess the appropriateness of an out-of-hospital birth for each client, taking into account the health and condition of the mother and fetus or baby according to the following two categories of risk assessment criteria in determining appropriate care:

(a) "Absolute risk" as defined in OAR 332-015-0000(29)(a) and indicators referenced in the following subsections, means that clients presenting these conditions or clinical situations are felt to be at extreme obstetrical or neonatal risk. These clients are not considered appropriate candidates for out-of-hospital birth. Clients must plan for an in-hospital birth if risk factors are present in the antepartum, intrapartum or postpartum periods. If a risk factor first develops when birth is imminent, the individual midwife must use judgment taking into account the health and condition of the mother and baby to determine which is most safe for mother and baby.

(A) **ANTEPARTUM ABSOLUTE RISK CRITERIA**; active cancer; cardiac disease; severe renal disease - active or chronic; severe liver disease - active or chronic; uncontrolled hyperthyroidism; chronic obstructive pulmonary disease; essential chronic hypertension over 140/90; pre-eclampsia/eclampsia; acute or chronic thrombophlebitis; current ITP; current substance abuse known to cause adverse effects; incomplete spontaneous abortion; hemoglobin under 9 at term; labor or PROM prior to 36 weeks; abruption placenta; placenta previa at onset of labor; persistent severe abnormal quantity of amniotic fluid; blood coagulation defect; documented IUGR; amnionitis; ectopic pregnancy; pregnancy lasting longer than 43 weeks gestation (21 days past the due date); multiple gestation; malpresentation at the onset of labor; pregnancy lasting longer than 42 weeks (14 days past the due date) with an abnormal non-stress test; any pregnancy with abnormal fetal surveillance tests; rupture of membranes for greater than 72 hours before the onset of labor with chorioamnionitis; primary herpes infection at the onset of labor and secondary herpes that cannot be covered at the onset of labor; babies at significant risk for shoulder dystocia; and HIV positive status.

(B) **INTRAPARTUM ABSOLUTE RISK CRITERIA**: suspected uterine rupture; active herpes lesion in an unprotectable area; prolapsed cord or cord presentation; abnormal bleeding; persistent fever of 101 degrees Fahrenheit (38 degrees Centigrade) or above, taken orally; pre-eclampsia/eclampsia; amniotic fluid with thick or moderate/thick meconium and birth not imminent; evidence of fetal distress or abnormal fetal heart rate pattern unresponsive to treatment or inability to auscultate fetal heart tones; excessive vomiting, dehydration, acidosis or exhaustion unresponsive to treatment; blood pressure greater than or equal to 150/100 which persist or rises, and birth is not imminent; failure to progress in active phase of labor with presence of strong contractions; failure to descend within the expected time during active pushing, generally 2 hours for primip and 1 hour for multip; current substance abuse.

(C) **POSTPARTUM ABSOLUTE RISK CRITERIA**: retained placenta with bleeding; retained placenta with suspected placenta accreta; retained placenta greater than 3 hours; retained placenta greater than 30 minutes with abnormal or significant bleeding; laceration requiring hospital repair; uncontrolled postpartum bleeding; increasingly painful or enlarging hematoma; development of pre-eclampsia; and signs or symptoms of shock unresponsive to treatment.

(D) **INFANT ABSOLUTE RISK CRITERIA**: Apgar less than 7 at 10 minutes of age; respiration rate greater than 80 in the first 2 hours postpartum, and greater than 60 thereafter, accompanied by any of the following lasting more than one hour without improvement: nasal flaring, grunting, or retraction; cardiac irregularities, heart rate less than 80 or greater than 160 (at rest), or any other abnormal or questionable cardiac findings; seizures; temperature less than 97 degrees Fahrenheit (36.1 degrees Centigrade) or greater than 100.7 degrees Fahrenheit (38 .2 degrees Centigrade) when taken rectally or any other evidence of infectious process; apnea; central cyanosis; large or distended abdomen; any infant which has required intubation; any infant where meconium has been visualized at the level of the cords; any condition requiring more than 12 hours of observation postbirth; gestational age under 36 weeks; persistent poor suck, hypotonia or a weak or high pitched cry; persistent projectile vomiting or emesis of fresh blood; and signs and symptoms of infection in the newborn.

(b) "Non-absolute" risk as defined in OAR 332-015-0000 (29)(b) and indicators referenced in the following subsections, includes situations that sometimes place a client at increased obstetric or neonatal risk. Some of the factors to consider regarding these non-absolute criteria would include the specific midwife's experience and expertise, the particular birth setting, and the ease and time involved in accessing emergency transport/back-up systems. In order to allow for the individualization of these situations, the non-absolute risk criteria do not automatically exclude a client from out-of-hospital birth. Instead, they require careful consideration and consultation. This consultation shall be with a licensed health care provider with hospital privileges and may be conducted by telephone depending on the clinical and geographical situation. Consultation shall be documented in the client records.

(A) **ANTEPARTUM NON-ABSOLUTE RISK CRITERIA**: conditions requiring on-going medical supervision or ongoing use of medications; significant glucose intolerance; deep conization of cervix; inappropriate fetal size for gestation; significant 2nd or 3rd trimester bleeding; abnormal fetal cardiac rate or rhythm, or decrease of movement; uterine anomaly; anemia (hematocrit less than 30 or hemoglobin less than 10 at term; seizure disorder requiring prescriptive medication; platelet count less than 75,000; previous uterine incision other than low transverse cesarean and/or myomectomy with review of surgical records and/or subsequent birth history; Isoimmunization to blood factors; psychotic disorders; history of thrombophlebitis; and hemoglobinopathies;

(B) **INTRAPARTUM NON-ABSOLUTE RISK CRITERIA**: no prenatal care or unavailable records; maternal exhaustion unresponsive to treatment; history of substance abuse during this pregnancy.

(C) **POSTPARTUM NON-ABSOLUTE RISK CRITERIA**: infectious process; any condition requiring more than 12 hours of postpartum observation; and 36-37 week gestation.

(D) **INFANT NON-ABSOLUTE RISK CRITERIA**: Apgar less than 7 at 5 minutes without improvement; weight less than 2270 grams (5 lbs.); jitteriness; failure to void within 24 hours or stool within 48 hours from birth; maternal substance abuse identified intrapartum or postpartum; excessive pallor, ruddiness, or jaundice at birth; any generalized rash at birth; birth injury such as facial or brachial palsy, suspected fracture or severe bruising; baby with signs and symptoms of hypoglycemia; weight decrease in excess of 10% of birth weight; maternal-infant interaction problems; direct Coomb's positive cord blood; and major congenital anomaly.

(15) Practice standards for the determination of initial visits, laboratory tests, prenatal visits, education/counseling/anticipatory guidance, emergency access, intrapartum care, postpartum care,

and newborn care include:

(a) INITIAL VISITS: In the first prenatal visits, the following history shall include but not be limited to: health, reproductive, family, social and current pregnancy. The primary care giver will evaluate nutritional status, height, weight and blood pressure, uterine size relative to gestational age, urinary analysis, and evaluation of the breast for nursing.

(b) LABORATORY TESTS: Licensed direct entry midwives shall document the following test results in the client's records: CBC; minor blood factor antibody screen; STD and syphilis screening; Hepatitis B surface antigen; blood group and Rh type; rubella titer; and Pap Smear.

(c) PRENATAL VISITS: The following schedule of prenatal visits is recommended: every four weeks for the first 32 weeks, every two to three weeks until 36 weeks, and weekly thereafter. Each visit must include the interval history and physical examination, including blood pressure, weight, fundal height, fetal presentation, fetal heart rate, evaluation of urine for protein and glucose with a dip stick, and the mother's assessment of fetal activity. The midwife must continuously evaluate the pregnancy for risks taking into consideration information derived from: physical examination, laboratory tests, maternal complaints, and the overall physical and emotional well-being of the mother. The family must be kept informed of these risks. The home visit must include assessment of the birthing environment and must be done prior to the labor including access of telephone.

(d) ASSESSMENT OF FETAL WELL-BEING: At 42 weeks, midwives shall conduct one of the following tests:

(A) Amniotic fluid index and a non-stress test followed in 3 or 4 days with a repeat non-stress test;

(B) Bio-physical profile; or

(C) Contraction stress test.

(e) EDUCATION/COUNSELING/ANTICIPATORY GUIDANCE: The midwife must offer information or referral to community resources on childbirth preparation, breast feeding, exercise and nutrition, parenting, and care of the newborn. Using the informed choice process, birth attendants must inform pregnant women and their families about available obstetric and pediatric tests and procedures, such as: triple screening, chorionic villi sampling, amniocentesis, prenatal Rho immune globulin, ultrasound, human immunodeficiency virus (HIV) counseling and testing, newborn metabolic screening, eye prophylaxis, herpes testing and treatment, neonatal vitamin K and circumcision. The midwife shall counsel the parents regarding current Centers for Disease Control (CDC) and American College of Obstetrics and Gynecology (ACOG) protocols regarding Group B Strep testing. Together they will select a protocol and the midwife will follow the chosen guidelines must the membranes rupture prior to the onset of labor.

NOTE: CDC source *Prevention of Perinatal Group B Streptococcal Diseases: A Public Health Perspective*, Morbidity and Mortality Weekly Report, May 31, 1996, Volume 45, Recommendations and Reports 7; ACOG source Volume 80, Number 6, December 1992.

(f) EMERGENCY ACCESS: Each licensed direct entry midwife shall provide a mechanism that ensures twenty-four hour coverage for the practice.

(g) INTRAPARTUM CARE:

(A) Assessment during labor: The following parameters shall be included as part of the initial assessment of a laboring woman and her baby as indicated: maternal temperature, blood pressure, pulse, frequency, duration and intensity of uterine contractions, pelvic exam, and the physical and emotional environment. Fetal well-being shall also be assessed which includes fetal lie, position, and presentation, fundal height, fetal movement, heart rate before, during and after uterine contractions, fetal scalp color as appropriate, and if relevant, the color, odor and clarity of amniotic fluid.

(B) The initial assessments listed in subsection (A) of this section, shall be repeated as indicated by the individual circumstances of the laboring woman and her baby throughout labor. Fetal heart tones shall be evaluated as soon as possible following rupture of membranes. For clients without signs of risk factors, during the active phase of the first stage of labor, the fetal heart rate shall be evaluated at least every 30 minutes. For those clients with risk factors, fetal heart tones shall be auscultated at least every 15 minutes in active stage of labor. Fetal heart tones shall be auscultated approximately every 5 to 10 minutes or after every contraction as indicated in the second stage of labor for all clients.

(C) Premature rupture of membranes at term: When a client reports suspected rupture of membranes before the onset of labor at 37 weeks gestation or greater, timely evaluation must include obtaining a careful history, documentation of ruptured membranes, and evaluation for the presence of infection and/or fetal distress. Clients must be instructed in measures to prevent and identify infection. No vaginal examination shall be performed until the client is in active labor, unless cord prolapse is suspected.

(D) Physiologic care during labor: The primary care giver must make certain that the mother is receiving nourishing, easily digestible foods and adequate fluid throughout labor. The woman must be encouraged to urinate every one to two hours.

(h) POSTPARTUM CARE:

(A) Postpartum assessment and care: The pulse, uterine fundus, and lochia must be checked within the first 15 minutes. The uterine fundus and lochia discharge shall be checked for the first hour after birth and thereafter until the woman's condition is stable. The perineum and vagina shall be inspected for lacerations. If the required emergency repair does not fall within the expertise of the primary care giver, arrangements must immediately be made for transfer or proper attendance. Before the primary care giver leaves or the family is discharged, the mother's general condition, blood pressure, pulse, temperature, fundus, lochia, and ability to ambulate and urinate must be assessed and found to be within normal limits. The primary care giver or other qualified persons must stay with the mother and infant until both are stable and secure and at least two hours have passed since the birth. The family must be instructed to make certain that someone is with the mother at all times during the first twenty four hours and that she receives support and care for at least the first few days.

(B) Postpartum instructions: The family must be provided with instructions that include: self and baby care and hygiene, signs of infection and methods for prevention (mother and infant), signs of illness in the newborn, normal infant feeding patterns, uterine massage and normal parameters of lochial flow, and safety in the home and car. Emotional needs, the changes in family dynamics, and the importance of rest, fluids, and good nutrition must be reviewed. Further follow-up must be arranged and instructions for the reporting of problems or deviation from normal will be given. Parents will be encouraged to contact the primary care giver with any questions or concerns.

(C) Laboratory studies/medications: Rubella vaccine must be discussed with non-immune women postpartum. An Rho Immune Globulin workup must be done for Rh negative women, including cord blood. Unsensitized Rh negative women who have given birth to an Rh positive infant must be given Rho immune globulin intramuscularly within 72 hours post-birth.

(D) Follow-up: Postpartum follow-up care must minimally include: visits during the first 24 to 36 hours following birth, at 3 to 4 days to assess mother and baby, and a visit or telephone consultation within 1 to 2 weeks post-birth. The primary care giver must continue to monitor appropriate vital signs, and physical and social parameters including adequacy of support systems and signs of infection. Information must be provided regarding lactation, postpartum exercise, and community resources available. Education may be provided on various family planning methods. Those midwives who are certified to fit cervical caps may do so at the six week check up.

(i) NEWBORN CARE:

(A) Newborn assessment and care: Newborn assessment must include the monitoring of temperature, pulse, and respirations each hour for the first two hours post-birth and thereafter until stable. A thorough physical examination must be done shortly after birth including assessment of length, weight, head circumference, fontanels, palate, heart, lungs, abdomen, genitalia, muscular and skeletal system, dislocated hips, back, buttocks, rectum, assessment of neurological status (including assessment for jitteriness or lethargy as well as the presence of normal newborn reflex-

es), and general appearance. A gestational age assessment must be done. The family must be informed of any deviation from normal. The primary care giver or another qualified person must stay with the family until a minimum of two hours post-birth have passed, all parameters of physical assessment are found to be within normal limits, and the infant has demonstrated normal suck and swallow reflexes.

(B) Laboratory studies/medications/birth registrations: Out-of-hospital care providers must adhere to state guidelines for the administration of vitamin K and ophthalmic prophylaxis. Infant metabolic screening shall be performed and/or documented according to the Oregon Health Division recommendations. Additional laboratory studies may be warranted as determined by the infant's condition or pediatric consultation. All births must be registered with the Oregon Health Division Vital Records Section.

(C) Prolonged rupture of membranes: If the birth has taken place more than twenty four hours after rupture of membranes, the baby must be closely observed for twenty-four hours for signs and symptoms of infection.

(D) Follow-up: It is recommended that follow-up care include: a visit within 24 to 36 hours following birth, at 3 to 4 days, visit or telephone consultation within 1 to 2 weeks post-birth, and a visit at 6 weeks of age to monitor appropriate vital signs, weight, length, head circumference, color, infant feeding, and sleep/wake and stool/void patterns. Information must be provided about infant safety and development issues, immunization, circumcision, and available community resources. It is also recommended that the newborn be seen by a physician or licensed pediatric health care provider.

Stat. Auth.: OL 1993, Ch. 362, Sections 7 & 8
Stats. Implemented: OL 1993, Ch. 362, Sections 3, 7 & 8
Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94; DEM 2-1998, f. 4-14-98, cert. ef. 4-15-98

DIVISION 30

DISCIPLINE AND ENFORCEMENT

332-030-0000
Complaints

(1) Any person who wishes to file a complaint with the Board against a midwife may do so on forms issued by the Board. The complaint shall contain:

(a) The name of the person making the complaint;

(b) The name of the person or midwife against whom the complaint is being made;

(c) A concise description of the charge against the person or licensee, giving dates, time, etc. of the alleged violation; and

(d) The signature of the person making the complaint.

(2) Any person is welcome to contact the Board to comment on any service received from a licensee.

(3) After receipt of a written complaint, regarding services performed by a licensed direct entry midwife, the Board shall send a copy of the complaint (including name of complainant) to the licensee and request a reply to the charges within 20 calendar days from the date of the inquiry by the Board.

(4) After receipt of a complaint regarding violations of the licensing laws, the Board will determine if further action is to be taken and may initiate an inspection or investigation.

(5) Following request for a response to the charges, the complaint, the response, and any other pertinent information will be given by the Board to one or more investigators selected by the Board from a list of direct entry midwives approved by the Board and/or other individuals as appropriate.

(6) The investigator(s):

(a) Review the information and as applicable, interviews parties and witnesses, and examines (physical) evidence relating to the complaint;

(b) Advises the Board as to whether the direct entry midwife practiced within the practice standards established by the Board for Direct Entry Midwifery;

(c) May attempt to informally resolve the matter; and

(d) Makes recommendations for Board action.

(7) Following advice from the investigator(s), the Board will determine what action will be taken by the Board.

(8) A report of all investigations and Board actions will be presented to the Board.

Stat. Auth.:OL 1993, Ch. 362, Sec. 10
Stats. Implemented:
Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94

332-030-0010
Disciplinary Action

(1) The Board may refuse to issue, may suspend or may revoke a license or place a licensed person on probation for the causes stated in Oregon Laws 1993, Chapter 362, Section 10.

(2) The Board shall have grounds for a determination of incompetency in the practice of direct entry midwifery pursuant to Oregon Laws 1993, Chapter 362, Section 10, upon evidence of the use of any controlled substance, dangerous or illegal drugs, intoxicating liquor, or any emotional or physical disability of a direct entry midwife, to the extent that such use or condition impairs or prevents the direct entry midwife's ability to perform competently.

(3) The Board shall have grounds for a determination of fraud or misrepresentation in the practice of direct entry midwifery pursuant to Oregon Laws 1993, Chapter 362, Section 10, upon evidence of any advertising statements of a nature that would deceive or mislead the public or that are untruthful, such as:

(a) Incorrect use of a title;

(b) Claiming or implying a qualification, competency or specialty in connection with the practice of direct entry midwifery to which the person is not entitled, or which is untrue.

(4) The specific identification of grounds for disciplinary action stated in sections (2) and (3) of this rule are intended to be descriptive of some, but not all, those causes for which disciplinary action may be taken as stated in Oregon Laws 1993, Chapter 362, Section 10.

(5) When the Board requires correction of deficiencies in lieu of the suspension, revocation or denial of licensure, the correction shall be made within the time frame established by the Board or the suspension, revocation or denial of certification action will proceed.

Stat. Auth.:OL 1993, Ch. 362, Sec. 10
Stats. Implemented:
Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94

332-030-0020
Civil Penalty Considerations

(1) In addition to any other penalty provided by law, a person who violates any provision of Oregon Laws 1993, Chapter 362 or any rule adopted thereunder shall be subject to a civil penalty imposed by the Board. The Board reserves the right to pursue other remedies against alleged violators and may take any other disciplinary action at its discretion that it finds proper, including assessment of penalty not to exceed $1,000.

(2) In establishing the amount of the penalty for each violation, the Board will consider, but not be limited to the following factors:

(a) The gravity and magnitude of the violation;

(b) The person's previous record of complying or of failing to comply with the provision of Oregon Laws 1993, Chapter 362, Section 10 or with the rules adopted under Oregon Laws 1993, Chapter 362, Section 10;

(c) The person's history in taking all feasible steps or in following all procedures necessary or appropriate to correct the violation; and

(d) Such other considerations as the Board may consider appropriate.

(3) The Board may revoke, suspend or refuse to issue the

license of any person, who fails to pay on demand a civil penalty which has become due and payable, provided that it first gives the person an opportunity for a hearing as outlined in ORS 183, and conducted in accordance with Oregon Laws 1993, Chapter 362, Section 10.

Stat. Auth.:OL 1993, Ch. 362, Sec. 10

Stats. Implemented:

Hist.: DEM 1-1993, f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94