MEDICAL BOARD OF CALIFORNIA
Licensing Program

MIDWIFERY ADVISORY COUNCIL AGENDA

MEMBERS OF THE COUNCIL

Carrie Sparrevohn, L.M., Chair
James Byrne, M.D.
Karen Ehrlich, L.M.
Tosi Marceline, L.M.
Barbara Yaroslavsky

Medical Board of California
Hearing Room
2005 Evergreen Street
Sacramento, CA 95815
(916) 263-2382

Action may be taken on any item listed on the agenda.

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources.

Thursday, March 10, 2016
1:00 p.m. – 4:00 p.m.
(or until the conclusion of business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

1. Call to Order/Roll Call

2. Public Comment on Items not on the Agenda
   Note: The Council may not discuss or take action on any matter raised during this public comment section that is not included on this agenda, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125, 11125.7(a)]

3. Approval of the December 3, 2015 Midwifery Advisory Council Meeting Minutes

4. Report from the Midwifery Advisory Council Chairperson – Ms. Sparrevohn

5. Report Regarding the Ability of Licensed Midwives to Consult or Collaborate as Required by AB 1308 – Rosanna Davis, California Association of Midwives

6. Update on Midwife Assistant Regulations – Ms. Lowe/Ms. Webb
   A. Discussion and Approval of the Proposed Midwife Assistant Regulations
   B. Discussion on Utilization of a Midwife Assistant Prior to the Approval of Midwife Assistant Regulations

7. Update on Implementation of Assembly Bill 1308 – Ms. Webb

8. Update on Licensed Midwife Annual Report (LMAR) Taskforce – Ms. Lowe

9. Midwifery Advisory Council Membership – Ms. Lowe
   A. Nomination Recommendations – Process to be used
   B. Nominations to Fill Midwifery Advisory Council Positions
      1. Licensed Midwife – Three Year Term
      2. Licensed Physician and Surgeon – Three Year Term
      3. Public Member – Three Year Term

10. Program Update – Ms. Lowe
    A. Licensing Statistics
    B. Enforcement Statistics

11. Agenda Items for the August 18, 2016 Midwifery Advisory Council Meeting in Sacramento

12. Adjournment

The mission of the Medical Board of California is to protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing and regulatory functions.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meeting Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the Chair may apportion available time among those who wish to speak.

For additional information call (916) 263-2389.

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodation or modification in order to participate in the meeting may make a request by contacting AnnaMarie Sewell at (916) 263-2393 or sending a written request to that person at the Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

MEDICAL BOARD OF CALIFORNIA
Licensing Program

MIDWIFERY ADVISORY COUNCIL

December 3, 2015

Medical Board of California
Hearing Room
2005 Evergreen Street
Sacramento, CA 95815

MEETING MINUTES

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Agenda Item 1 **Call to Order/Roll Call**

The Midwifery Advisory Council (MAC) of the Medical Board of California (Board) was called to order by MAC Chair Carrie Sparrevohn at 1:00 p.m. A quorum was present and notice was sent to interested parties.

Members Present:
Carrie Sparrevohn, L.M., Chair
Karen Ehrlich, L.M.
Tosi Marceline, L.M.
Barbara Yaroslavsky
James Byrne, M.D.

Staff Present:
Diane Dobbs, Department of Consumer Affairs, Legal Counsel
Kimberly Kirchmeyer, Executive Director
Natalie Lowe, Licensing Manager
Elizabeth Rojas, Staff Services Analyst
AnnaMarie Sewell, Associate Governmental Program Analyst
Jennifer Simoes, Chief of Legislation
Kerrie Webb, Legal Counsel
Curtis Worden, Chief of Licensing

Members of the Audience:
Bruce Ackerman, Midwives Alliance of North America
Kayti Buehler, California Association of Midwives
Rosanna Davis, L.M., California Association of Midwives
Andrea Ferroni, L.M.
Rachel Fox-Tierney, L.M.
MacKenzie Hardwick
Diane Holzer, L.M.
Kaleem Joy, L.M.
Rachel Kiene, L.M.
Lesley Nelson, L.M.
Shannon Smith-Crowley, American College of Obstetricians and Gynecologists

Linda Walsh, California Nurse-Midwives Association
Sue Wolcott, L.M., Shasta Midwives

Agenda Item 2 Public Comment on Items not on the Agenda

Ms. Sparrevohn stated that Ms. Monique Webster had resigned from the MAC public member position on November 23, 2015, and the position would be noticed for the March MAC meeting.

Ms. Rosanna Davis commented that El Camino Hospital in Mountain View, CA was unaware of the Transfer of Planned Out-of-Hospital Delivery to Hospital Reporting Form and requested information be provided to the hospital.

Ms. Buehler suggested that a report regarding the consistent lack of collaboration and consultation that is available be placed on the agenda for the next MAC meeting.

Agenda Item 3 Approval of the August 13, 2015 Midwifery Advisory Council Meeting Minutes

Ms. Marceline provided an edit to strike the word "vaginally" on page five, in the second paragraph of the meeting minutes.

Ms. Sparrevohn made a motion to approve the August 13, 2015 meeting minutes with edits; s/Ms. Ehrlich. Motion carried unanimously.

Agenda Item 4 Report from the Midwifery Advisory Council Chairperson

Ms. Sparrevohn requested the support and assistance of the Board to provide resources in order to organize a midwifery college education program.

Ms. Kirchmeyer stated that staff can identify the entities that the MAC could contact for approval, of schools such as the Bureau of Private and Post-Secondary Education.

Ms. Sparrevohn suggested that individuals who are interested in organizing a midwifery college education program contact her.

Agenda Item 5 Implementation of Senate Bill 408 Midwife Assistants

Ms. Simoes stated that Senate Bill (SB) 408 was signed into law by the Governor to ensure midwife assistants meet minimum training requirements. The implementation plan is to hold an Interested Parties meeting and to draft regulations regarding the training requirements by the end of January 2016. The proposed regulations will be presented at the March 2016 MAC meeting for input, and then presented for approval at the May 2016 Board meeting with a possible regulation hearing at the July 2016 Board meeting.

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Agenda Item 6 Update on Implementation of Assembly Bill 1308

Ms. Webb indicated that Assembly Bill (AB) 1308 focuses on regulations that need to be put into place pursuant to Business and Professions Code (B&P) section 2507. Ms. Webb stated that a meeting was held with the California Association of Midwives (CAM) and the American College of Obstetricians and Gynecologists (ACOG), but it was unproductive in moving the issue forward. Ms. Webb stated that CAM suggested a compromise by putting limitations on some types of vaginal births after cesarean (VBAC), but ACOG wanted every woman who is contemplating a VBAC at home to have a physician consult first.

Ms. Sparrevohn questioned if more Interested Parties meetings would be planned for this topic.

Ms. Webb stated that there were no meetings currently planned.

Ms. Sparrevohn questioned if it was mandatory to have consensus before moving forward with regulation.

Ms. Webb indicated that it was not mandatory to have complete consensus prior to moving forward with the regulations; however, the problem is with the science and the language of the statute, specifically with the language "likely to have an impact on the course of the pregnancy and delivery." Ms. Webb stated that both sides see the science very differently.

Ms. Sparrevohn stated that she would be in favor of moving forward in a way that validates the low risk nature of a VBAC with one prior cesarean, and thought CAM was advocating for that as well.

Dr. Byrne stated that when someone seeks a consultation with a physician, they are free to disregard the recommendation.

Ms. Sparrevohn indicated that midwives are not free to disregard the physician recommendation, and the law states the physician must indicate the condition is not likely to impact the pregnancy or birth, or midwives cannot care for the woman.

Dr. Byrne referred to agenda item two and stated there was concern regarding access to care in local communities. Dr. Byrne stated that he had reached out to the Office of Statewide Health Planning and Development (OSHPD) to receive information from the Licensed Midwife Annual Report (LMAR) in order to review the data for VBACs in the prior year and link it to the county data. Dr. Byrne found that the LMAR does not currently show the counties in which VBACs are performed, and requested the LMAR be revised to collect that type of data.

Ms. Ehrlich responded that Dr. Byrne's request was addressed in the recommended revisions to the LMAR that had been previously submitted. In the meantime, it prevents women from receiving the care they want, and preventing midwives from providing care that is within their scope of practice.

Dr. Byrne stated that when assessing risk for prior VBACs it is a low risk for uterine rupture.

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Ms. Ehrlich stated that when speaking of birth and taking care of healthy women in general, with the exception of prior cesareans, there is always a risk factor. Ms. Ehrlich indicated that the risk for VBAC women with one prior cesarean is not higher than women who have never had a birth.

Ms. Yaroslavsky indicated that information should be based on facts, and that by obtaining factual information it allows for a stronger ability to make a good decision.

Ms. Ehrlich stated she was concerned with the barriers that will occur if they do not move forward with allowing licensed midwives to care for women with one prior cesarean.

Dr. Byrne indicated that it would help justify the movement that Ms. Ehrlich was seeking if more data was available to show that it really was beneficial.

Ms. Marceline commented that things change year by year, and when data is captured for a previous year it may not reflect the current situation. Ms. Marceline stated that procedures performed in hospitals and at home for a woman who is having a VBAC will impact whether she is more or less likely to rupture. Ms. Marceline provided an example stating that many hospitals feel that low doses of Pitocin, to either induce or augment a woman's labor if she is having a hospital birth and a VBAC, seem to be in their scope of practice, but it is definitely not in the licensed midwives scope of practice; therefore, there will be a different rate of rupture in home birth cliental than in hospital birth cliental.

Ms. Marceline stated that some women will choose to have a VBAC in a hospital setting, that may not be appropriate for a home birth setting, and that is where the licensed midwife is counseling and selecting her cliental carefully.

Dr. Byrne stated that if the rate was lower with better management, maybe it would cut the risk down four fold so that the risk of uterine rupture is 1 out of 1000, and in the event that it does happen, it is potentially a catastrophic injury. Dr. Byrne stated that it is an issue of what is predictable or what is preventable. Dr. Byrne added that he thought clarity of information and a balanced approached would be the strongest approach.

Ms. Sparrevohn stated that she had analyzed the LMAR data and reviewed every outcome since 2007, that might be attributed to a VBAC gone badly and even when she did that, the outcomes were really good. Ms. Sparrevohn indicated that overall midwife statistics are good, which points to the fact that midwives are not having a lot of problems with VBACs specifically. Ms. Sparrevohn asked how a consult with an obstetrician would change the outcome for any woman that has had one prior cesarean.

Dr. Byrne stated it would not change the outcome. Dr. Byrne indicated that if there is a potential client that is not a mutually assessed good candidate for VBAC, with four prior cesareans, in some ways that information is beneficial coming from a physician, because it is probably not welcomed news, and hearing it from a different voice might help. He thought that from the aspects of informed decision making and clarity, there are a few things that are predictable or preventable for such a catastrophic outcome.

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Dr. Byrne stated that according to the 2014 LMAR data, VBAC is a relatively small number, and instead of throwing in the towel, he asked if it is worth delaying the entire initiative over one issue, or can that one component be parked and agreed upon at a later date since it seems that this is an impasse point.

Ms. Sparrevohn questioned if it would it be possible to place a condition in the regulation allowing changes to the LMAR in order to capture data, and allow for the time being, one prior cesarean with a documented low transverse incision to not require a physician consult, and the regulation be reevaluated at a specific date in order to capture historical data.

Ms. Webb indicated that the suggestion of going forward with regulations with some limitation on VBAC, but not a total limitation without a physician consult, is not something ACOG seems open to at this time.

Ms. Sparrevohn questioned if ACOG could agree to that sort of condition, could it be legally placed in the regulations.

Ms. Webb indicated that it could be done.

Dr. Byrne suggested to include VBAC as a high risk condition and to allow ongoing review and reassessment at a later date.

Ms. Ehrlich questioned if it would still be required that the woman see a physician.

Dr. Byrne confirmed that the woman would still need to see a physician to document if there was an impact on access of care and impact on choice.

Ms. Ehrlich stated that for a couple of decades women have had the right to have their VBACs at home with licensed midwives and stated that what will happen is that right will be taken away and then maybe given back in the future. Ms. Ehrlich felt it should be the other way around since it is historically something that has been the scope of midwifery practice and it needs to be included with further review of being reasonable.

Ms. Ehrlich requested to review the existing information being captured in studies throughout the United States, and take that data into account when trying to eliminate the right of pregnant women.

Ms. Yaroslavsky stated that since there is no data for VBACs being collected for midwives or hospitals, the discussion should not occur until the data is received.

Dr. Byrne commented that OSHPD has the data for hospitals, and added that the clarity would be helpful.

Ms. Ehrlich stated that she objects taking something away from women that they already have, without indication that it is dangerous to the ones making that choice with full and informed consent by midwives.

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Ms. Sparrevohn provided an overview of the regulation that was enacted in 2005 regarding VBAC. Ms. Sparrevohn indicated that when midwives originally adopted the Standard of Care for Licensed Midwives, VBACs were allowed with specific requirements of what had to be in the consent, and one of those things was ACOG's position statement on VBACs. Ms. Sparrevohn stated that the Standard of Care written in 2005 was a way to make sure that women having a home VBAC, or even considering a VBAC, would get consistent information from midwives. Ms. Sparrevohn stated that with the enactment of AB 1308 it went away because the legislation that authorized that regulation got eliminated as part of AB 1308. Ms. Sparrevohn concluded that the MAC was required to create a new regulation, which was currently at an impasse, even though the previous regulation that was in place was working fine and everybody had agreed to it in 2005.

Ms. Smith-Crowley stated that ACOG did not agree to the regulation, and what the Board did was illegal. Ms. Smith-Crowley stated that the Board was not content with ACOG and California Medical Association (CMA) for including physician supervision into the law.

Ms. Smith-Crowley questioned how many times other licensed professionals were allowed to waive the scope of practice. Ms. Smith-Crowley stated a patient cannot agree to have their physician assistant do their appendectomy, or do their open heart surgery, as there are parameters. Ms. Smith-Crowley stated that the only reason the regulation went through is because ACOG decided not to sue. Ms. Smith-Crowley stated that the regulation was extremely problematic for ACOG, and as a concession to ACOG, the Board indicated that the ACOG document would be required to be given to women. ACOG saw the hand writing on the wall that ACOG was not winning. ACOG did not want to sue and thought it would be able to clean it up later.

Ms. Smith-Crowley stated that to set the record straight, ACOG has not supported home VBACs. Ms. Smith-Crowley concluded that the legislation that went through was something that the author decided was important, and ACOG felt they had reached a reasonable compromise by having a physician examination to discuss how physicians expected the course of the pregnancy to go, whether the woman was a good candidate or not, and that it had nothing to do with home births.

Ms. Sparrevohn indicated that she attended the same meeting and recalls that ACOG wrote the regulation. Ms. Sparrevohn felt that everyone understood at the time that ACOG was not endorsing home VBACs; however, the MAC, the Board, and ACOG agreed to the regulation and ACOG authored it.

Ms. Smith-Crowley indicated that the Board did allow ACOG to have input and she can provide the letter that was written to the Office of Administrative Law indicating ACOG thought the regulation exceeded the statute.

Ms. Ehrlich commented that whatever was true or not in 2005, it was currently in the midwives' scope of practice to perform VBACs, and she thought that the regulation should be reinstated and it would meet the approval of the midwives in California.

Dr. Byrne requested clarification regarding a waiver process that allowed the patient to disregard the VBAC counseling.

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Ms. Sparrevohn stated that it was an old process, and it was removed due to AB 1308. Ms. Sparrevohn indicated that the waiver was not specific to VBACs, it was a clause in the Standard of Care that allowed midwives to continue to care for a woman with potentially higher risk conditions as long as the woman was well informed, and she confirmed that she was informed, and then she would continue to birth at home with a midwife.

Ms. Ehrlich indicated that it was moderate risk, and it did not include high risk in the regulation.

Ms. Sparrevohn commented that she understood Ms. Smith-Crowley's statement, that perhaps ACOG agreed to do the specific VBAC regulation because there was a clause in the Standard of Care.

Ms. Smith-Crowley indicated that ACOG was not winning and that was a modification that provided more protection. Ms. Smith-Crowley stated that there is need for statutory changes to indicate a woman will need a physician consult, and the physician provides a discussion about VBAC, and not having a specific sign off. Ms. Smith-Crowley thought a physician consult would ensure there is a medical evaluation of a woman who is potentially at a higher risk.

Ms. Ehrlich suggested changing the statement from "higher risk" to "moderate risk" because if "higher risk" is placed into statute it will remove the right for women in California.

Dr. Byrne questioned what guidance there was from countries where home births are part of their national healthcare and how those countries, such as the Netherlands or the United Kingdom, approach the location of VBACs in counseling.

Ms. Marceline indicated that in the United Kingdom, if a mother is asking for something that the midwife feels is dangerous, and the mother is given informed consent, the mother has the last say. The midwife cannot refuse care because it is more dangerous for a mother to give birth alone.

Ms. Sparrevohn thought that the recommendation in the United Kingdom is to VBAC in a hospital, and in terms of the Netherlands, she was unsure.

Ms. Sparrevohn encouraged groups to find a middle ground.

Ms. Yaroslavsky inquired as to who would be responsible for meeting and agreeing on the terms of the regulations.

Ms. Sparrevohn stated that the agreement will need to happen between CAM and ACOG since the Board has done what it can in terms of Interested Parties meetings. Ms. Sparrevohn concluded that if regulations were going to be drafted for AB 1308 there would have to be movement, and if regulations are not drafted licensed midwives will not be able to provide Medi-Cal services in a birth center.

Agenda Item 7 Licensed Midwife Annual Report Taskforce

Ms. Lowe provided an update on the Interested Parties meeting that was held on October 13, 2015, to discuss possible revisions of the LMAR reporting tool. The meeting provided an open discussion on the requests and needs of licensed midwives and other interested parties on how the future statistics would

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be collected and what data elements would be included. Following the meeting Board staff met with OSHPD staff to discuss the project and what roles and responsibilities each agency would have. It was determined that there were several items that would need additional research and review prior to completing a design document for recommendation to the Board. Ms. Lowe noted that one major area of concern for both Board staff and OSHPD was how data would be reported: whether it would be reported prospectively, or an accumulative report that captures the previous year's data as it is currently being done.

Ms. Lowe stated in addition to the comments provided at the Interested Parties meeting, Board staff felt it would be beneficial to obtain feedback from all licensed midwives in California on the matter, before proceeding with the design of the new system. Ms. Lowe indicated that a survey would be sent to all licensed midwives requesting feedback on the LMAR, and based on the information received; the Board would have a better understanding of the needs of all licensed midwives in California.

Ms. Lowe noted that moving to an online system, where data is reported prospectively, would allow for additional statistics to be captured relatively easy for the midwife. However, if it is agreed to move to a prospective data system, staff would need to take into consideration midwives that would be reporting on paper, and midwives that would be reporting previous years of data that could not utilize the online system.

Ms. Yaroslavsky requested that all the MAC members receive a copy of the questionnaire as some of the members were not midwives.

Ms. Yaroslavsky stated that if access to computers is an issue then staff should inform midwives of free online services that are available, for example, public access to computers at county libraries. Ms. Yaroslavsky suggested adding a question to the survey asking if there is free Wi-Fi service in a nearby public facility for the use of a midwife to complete the LMAR.

Dr. Byrne questioned if there is a precedent with other groups under the Board where one would have both options, and there would be a different fee structure for those who desire to submit a paper format.

Ms. Kirchmeyer responded that the Board must offer the document in paper and online. Ms. Kirchmeyer added that in order for the Board to require midwives to use an online program, the Board would need legislation.

Ms. Sparrevohn hoped that the midwifery organizations and midwifery networks could relay the message that being able to utilize the online prospective data collection system would benefit midwives and maybe midwives could encourage colleagues to utilize computers.

Ms. Marceline asked if midwives would need the consent of the mothers they care for in order to enter their data if the reporting requirements changed.

Ms. Lowe indicated that OSHPD is prohibited from collecting personal identifying information. The new system would automatically assign the patient a random identification number that the midwife could include in the chart, and would use to enter the information into the system. Ms. Lowe stated that the Board hopes there is a strong agreeance that reporting prospectively would be ideal and that an

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online system would be the best way to report the data. However, if the survey indicates that the majority of the midwives decide not to report prospectively then the method to report will be readdressed.

Ms. Ehrlich requested to include the question, "Have you submitted your previous LMARs? If not, why and what would help to trigger you to actually do it?" in the survey.

Mr. Ackerman commented that the paper data forms used with the Midwives Alliance of North America (MANA) statistics system were extremely troublesome. In 2009, MANA found that only three midwives nationwide used the paper version and when staff at MANA spoke to those midwives individually, the midwife indicated that they had not gotten around to completing the reporting. Since then, MANA phased out the paper form.

Mr. Ackerman suggested that an improvement would be to repeal the legislation that is enabling the LMAR, and start collecting data through the MANA statistics.

Ms. Sparrevohn stated that she is aware of discussions relating to the MANA statistics project being moved to an entity that is not associated with MANA so that it would not be part of a professional organization and questioned the status of that process.

Mr. Ackerman indicated that the process will occur through a period of a few years, and the details have not been sorted out.

Ms. Smith-Crowley questioned if the MAC was aware of the new maternal data center with the State and if not, to view the California Maternal Quality Care Collaborative (CMQCC) website at www.cmqcc.org to review the integrated data with the Maternal Data Center. Ms. Smith-Crowley stated that the organization and the data they collect for quality improvement campaigns has reduced the maternal death rate by half in a handful of years. Ms. Smith-Crowley stated that the way the MAC is trying to integrate the care with physicians and midwives, is the way the MAC should look at the Maternal Data Center. Ms. Smith-Crowley stated that if the data goes through OSHPD, to the Maternal Data Center, and the Maternal Data Center could get information from Vital Statistics this would pull the data from everywhere. Part of the issue is that it is easier to figure out the pregnancy related deaths that are within the first 42 days, but it is more difficult to pull the information for the pregnancy associated deaths that are within the year. Ms. Smith-Crowley stated that whoever is completing the birth certificate has no clue that a woman had a birth within the last year, but when the data goes through the Maternal Data Center they are able to pull that data out.

Ms. Smith-Crowley stated that in looking at the data, if one is trying to figure out what is real and what is not, the Maternal Data Center is the one that can do it. Ms. Smith-Crowley stated it was collaborative when the Maternal Data Center worked on the first maternal death review and added that in 2006. The Maternal Data Center went through every maternal death in the state and completed a root cause analysis, and found that 40% of hospitals did not have a hemorrhage protocol in place.

Ms. Smith-Crowley stated that since there was not a protocol in place, the Maternal Data Center stopped the review and collaboratively wrote best practices. Ms. Smith-Crowley concluded that there are benefits of having data go through OSHPD, and the Maternal Data Center.

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Ms. Sparrevohn stated that she thought, as they discussed using the MANA statistics project, that the data would always be funneled through OSHPD.

Mr. Ackerman indicated that was his understanding as well and shared that currently in Washington State all hospitals are using MANA statistics, the statistics go directly from the MANA data set to Obstetrics Clinical Outcomes Assessment Program (OB COAP).

Ms. Ehrlich requested Ms. Smith-Crowley to lobby for a home birth midwife with CMQCC.

Ms. Smith-Crowley agreed with Ms. Ehrlich and confirmed that she would do so.

Ms. Marceline recommended getting rid of the LMAR, and to utilize the new reporting system if it is going to be prospective since it can increase a sense of how well midwives are doing and where midwives need to improve.

Ms. Ferroni stated that she hoped Mr. Ackerman would speak more on the Washington MANA statistics collection that the licensed midwives in Washington use, that goes directly into their version of the CMQCC. Ms. Ferroni commented that she felt it addresses the problems with the data collection and the ability to assess how licensed midwives are doing for the hot topics such as VBAC. Ms. Ferroni concluded that it brings midwives into the big picture of quality improvement as maternity care providers and felt that the MAC should be focusing on that topic.

Agenda Item 8 Program Update

A. Licensing Statistics

Ms. Lowe provided an update on the licensing statistics stating that staff included the breakdown on the status of licenses at the end of the fiscal year which was requested by the MAC. Ms. Lowe noted that the data reflects the total licensing population at the end of each fiscal year, and it is important to recognize that the data is not a cumulative total.

B. Enforcement Statistics

Ms. Lowe provided an update on the enforcement statistics indicating that the data was separated to show licensed midwives and unlicensed midwives per the request of the MAC. Ms. Lowe hoped the data was clear since it shows the respective data for the two different data sets. Ms. Lowe stated that staff also removed the unlicensed midwives hospital reporting forms, and the data will only show hospital reporting forms for licensed midwives.

Ms. Sparrevohn questioned if the Board is receiving hospital reporting forms from unlicensed midwives with their names.

Ms. Lowe indicated the Board is not receiving reporting forms from unlicensed midwives and since staff separated unlicensed enforcement activity at the top from licensed and unlicensed, there will not be two separate reporting areas for the hospital reporting forms.

Ms. Sparrevohn asked if there might be an investigation that is opened as a carry over and how can they view that data.

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Ms. Kirchmeyer indicated that an opened investigation is shown for a specific timeframe, and staff would need to add a line to show what open investigations are still pending.

Ms. Sparrevohn requested to add a line to show the data for pending investigations.

Agenda Item 9 Future Midwifery Advisory Council Meeting Dates

After discussion by the MAC, the proposed dates for the 2016 MAC meetings will be March 10, 2016, August 18, 2016, and December 1, 2016.

Ms. Sparrevohn made a motion to approve the 2016 MAC meeting dates; s/Ms. Yaroslavsky. Motion carried unanimously.

Agenda Item 10 Agenda Items for the Next Midwifery Advisory Council Meeting in Sacramento

- Report from the MAC Chair
- Update on Midwifery Legislation
- Update on LMAR Task Force
- Update on AB 1308 Regulation
- MAC Membership
- Update on Midwife Assistant Regulation
- Discussion of Reporting on Home Birth/VBACs from Other Countries
- Discussion on Consistent Lack of Collaboration and Consultation

Agenda Item 11 Adjournment

Ms. Sparrevohn adjourned the meeting at 2:49 p.m.

The full meeting can be viewed at http://www.mbc.ca.gov/About_Us/Meetings/2015/

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A Survey: Challenges of LM Referrals to Physicians

"If at any point during pregnancy, childbirth, or postpartum care a client's condition deviates from normal, the **licensed midwife shall immediately refer or transfer the client to a physician and surgeon**. The licensed midwife may consult and remain in consultation with the physician and surgeon after the referral or transfer." B&P 2507 (c)(1)

1. Why a survey
2. Survey Questions / Results / Impressions
3. What next?

Survey: Referral Challenges for California Licensed Midwife Clients

- The information collected here will be compiled and reported to the March 2016 MAC Meeting.
- You can complete this survey anonymously, but we hope you provide your name and contact information, which will be kept in strict confidence and will be used only by CAM to assure validity and facilitate any necessary follow up for clarification from the reporting midwife.
- Please only report if you are an LM currently practicing in California.

Frequently Asked Questions:
http://www.californiamidwives.org/resources/Documents/Frequently%20Asked%20Questions%20LM%20Survey%20Jan%202016.pdf

I am reporting

tell us how many midwives you are reporting for

- as an individual licensed midwife
- for a group practice with 2 licensed midwives
- for a group practice with 3 licensed midwives
- Other: _____

In the past two years, since AB1308 took effect, approximately how many times did you have significant difficulty securing timely care, aside from ER or L&D, when a referral to an OB or perinatologist was necessary?

- 0
- 1 - 5
- 5 - 9
- more than 10
- Other: _____

Challenges with Non-Urgent Referral

Note the number of times your referral for a non-urgent obstetrical issue was not accomplished in a timely manner or did not take place because you and the client couldn't find an OB or perinatologist (other than via ER/L&D) willing to take the referral. (Examples: abnormal lab values such as low platelets or positive antibody screen; 2-vessel cord or fluid noted in kidney noted on ultrasound; extreme itchiness suggestive of intrahepatic cholestasis of pregnancy).

_____

Challenges with Time-Sensitive Referral

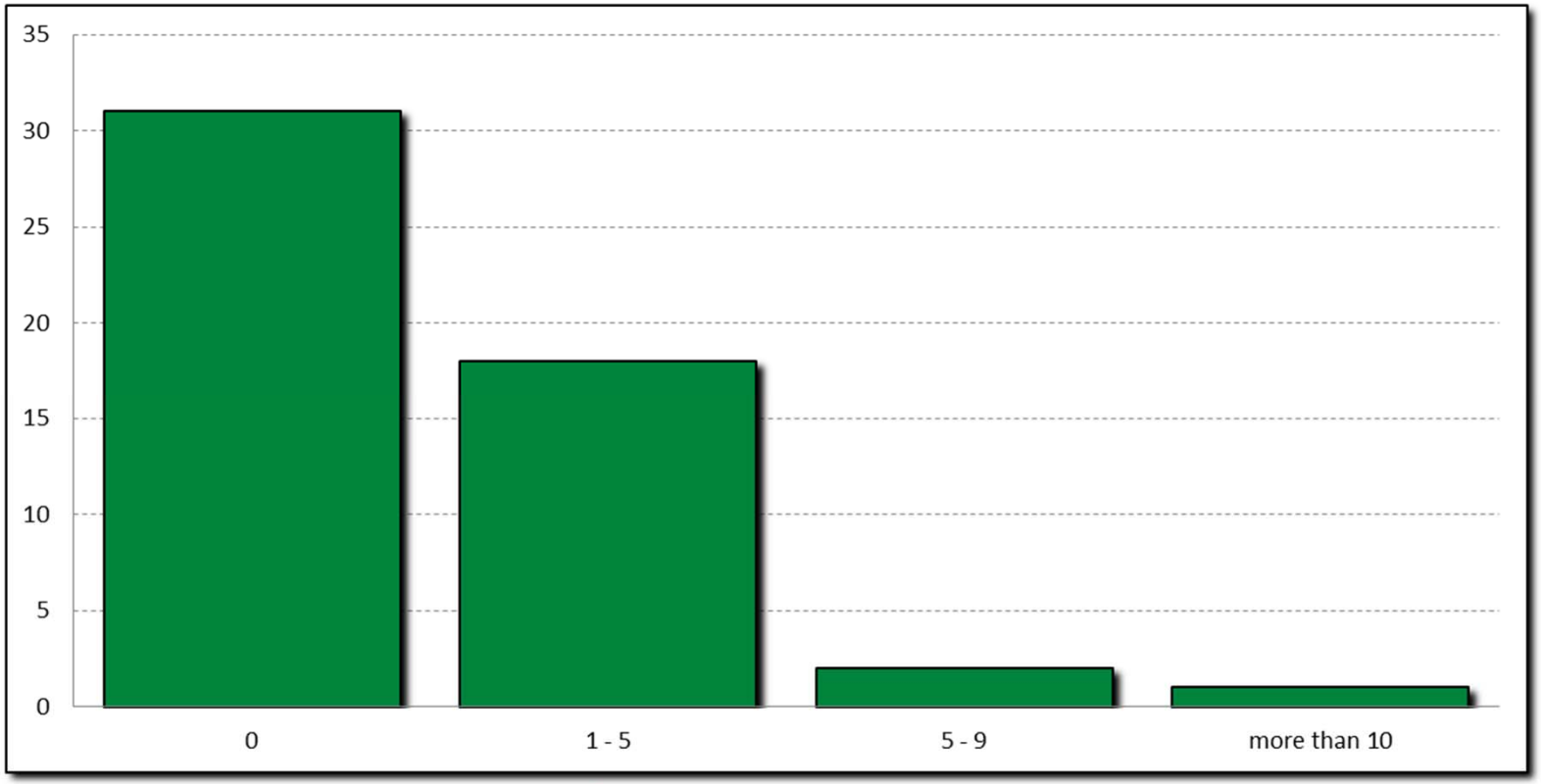
Note the number of times your referral for a time-sensitive obstetrical issue did not occur in a timely manner because you and the client couldn't find an OB/perinatologist (other than via ER/L&D) willing to take the referral. (Examples: occurrence of vaginal bleeding; assessment for external cephalic version at 36 weeks; small for dates; hyperemesis; no FHT when expected; NT ultrasound or other genetic screening).

_____

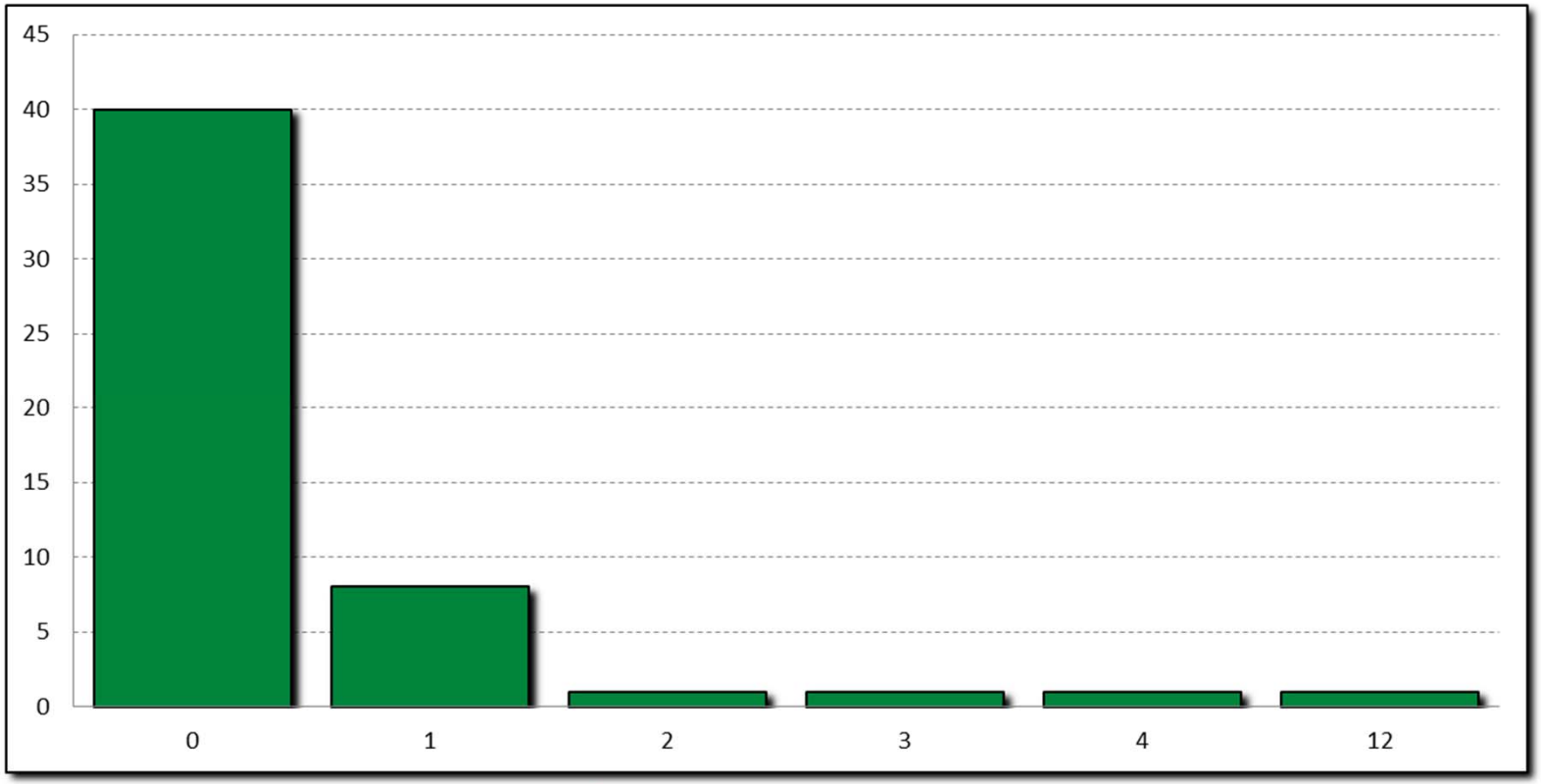
Participation

- 42 responses:
  - 35 from individual LM practices
  - 5 from practices with 2 midwives
  - 1 from a practice with 3 midwives
  - 1 from a practice with 4 midwives
- Representing approximately 52 midwives – all reported being California licensed midwives practicing in CA

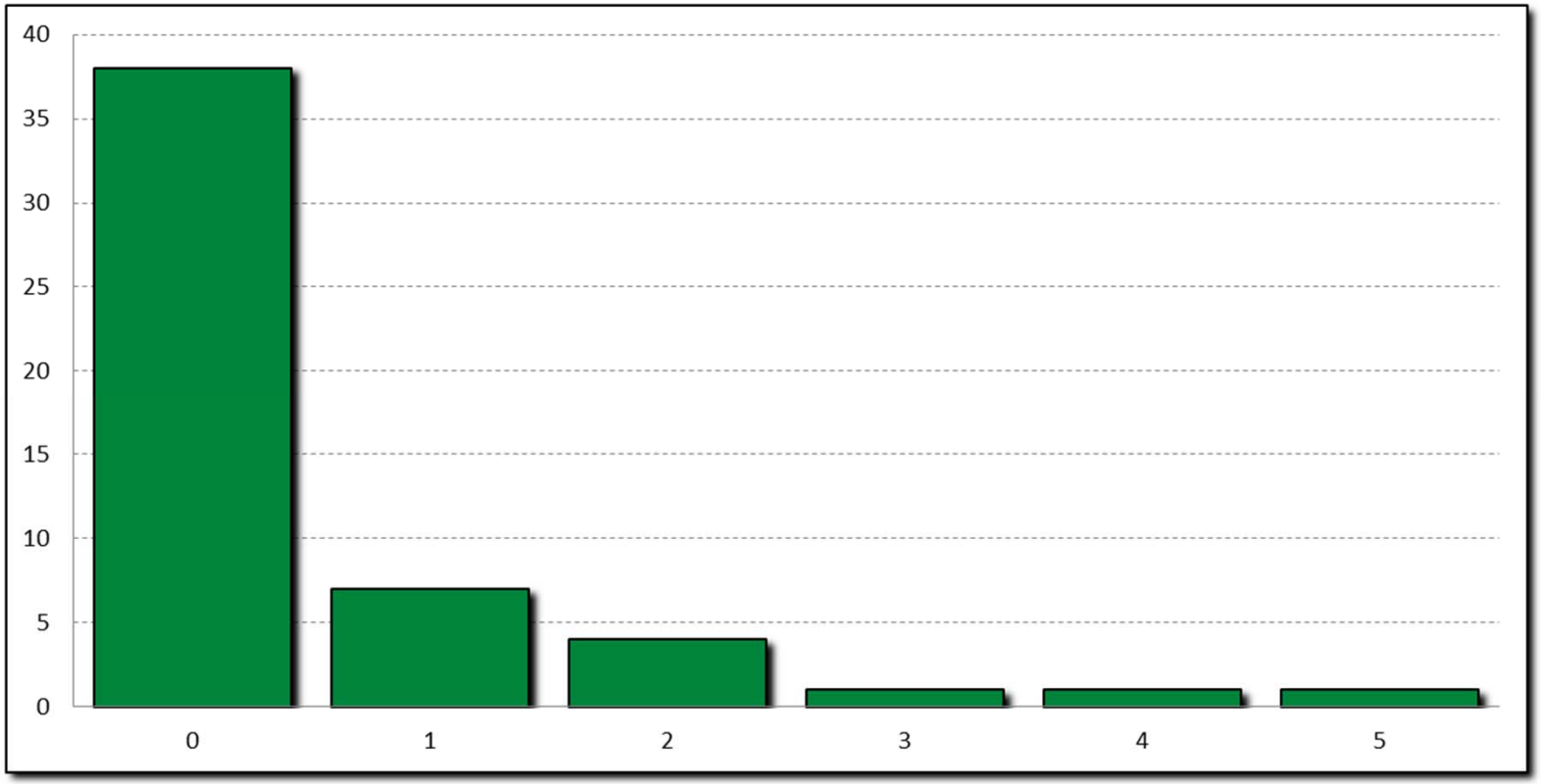
In the past 2 years, approximately how many times did you have significant difficulty securing timely care for clients?



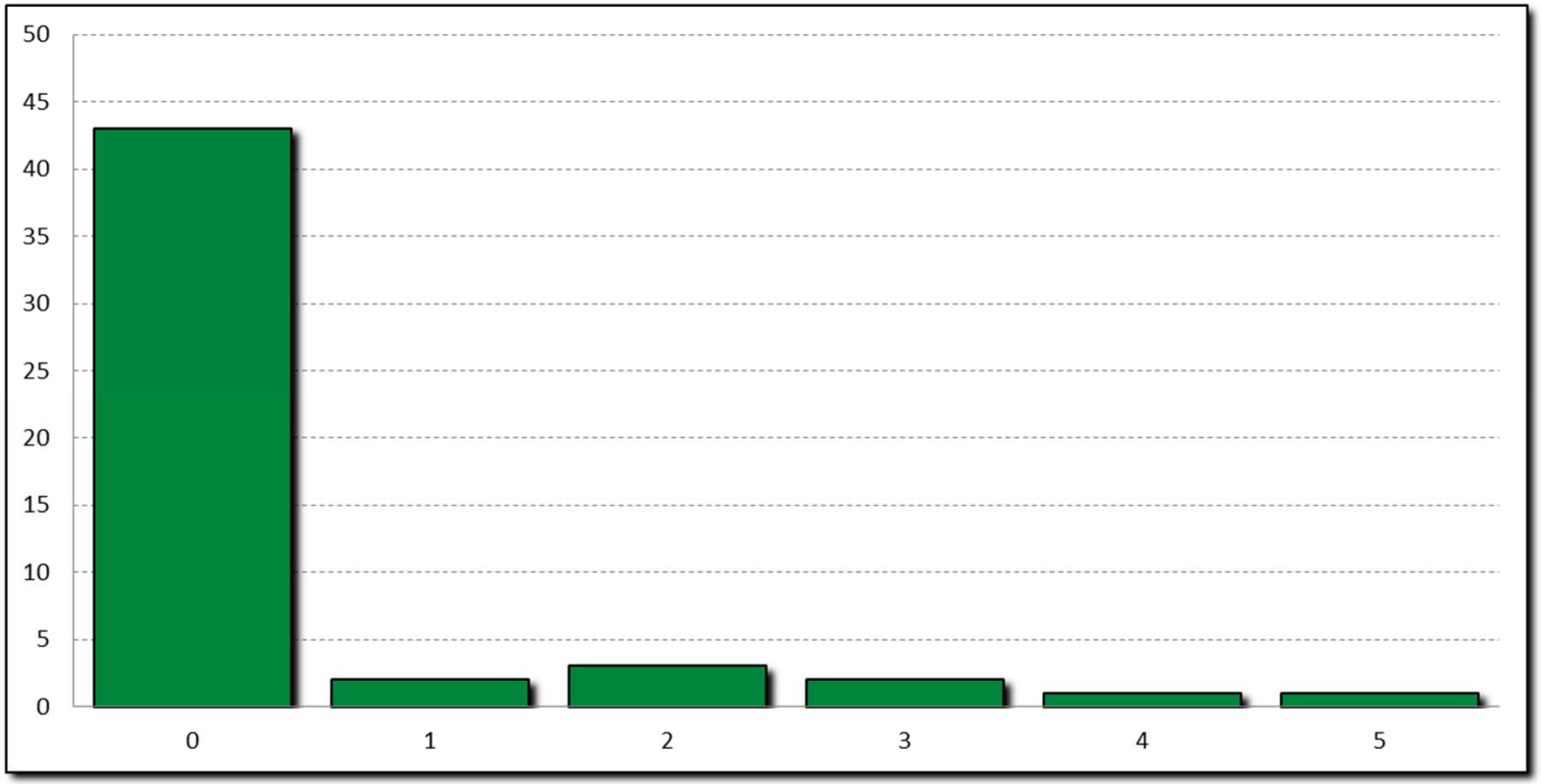
Note the number of times your referral for a non-urgent obstetrical issue was **not accomplished in a timely manner** or did not take place because you and the client couldn't find an OB or perinatologist (other than via ER/L&D) willing to take the referral. (Examples: abnormal lab values such as low platelets or positive antibody screen; 2-vessel cord or fluid noted in kidney noted on ultrasound; extreme itchiness suggestive of intrahepatic cholestasis of pregnancy)



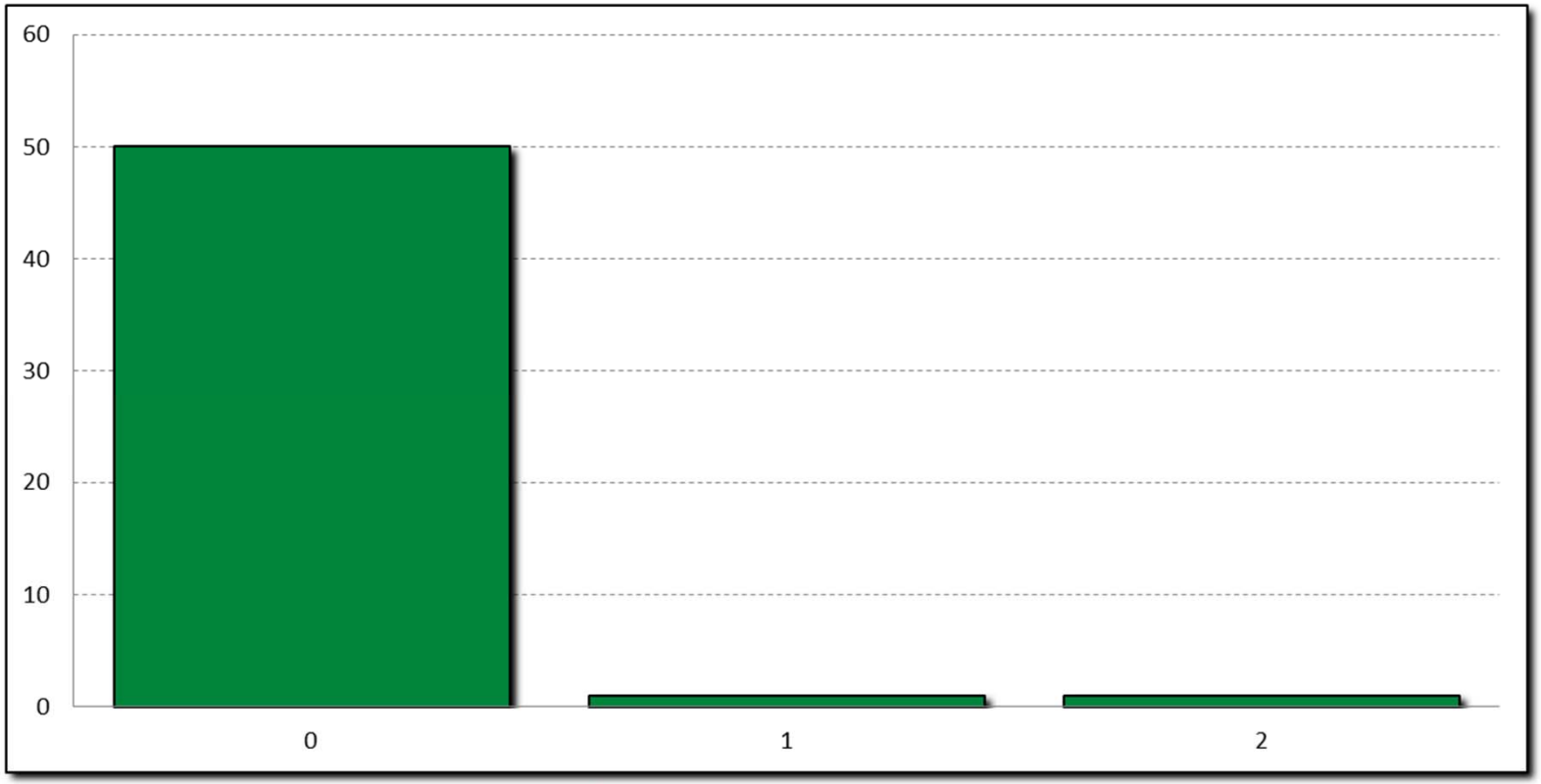
Note the number of times your referral for **a time-sensitive obstetrical issue** did not occur in a timely manner because **you and the client couldn't find an OB/perinatologist (other than via ER/L&D) willing to take the referral**. (Examples: occurrence of vaginal bleeding; assessment for external cephalic version at 36 weeks; small for dates; hyperemesis; no FHT when expected; NT ultrasound or other genetic screening)



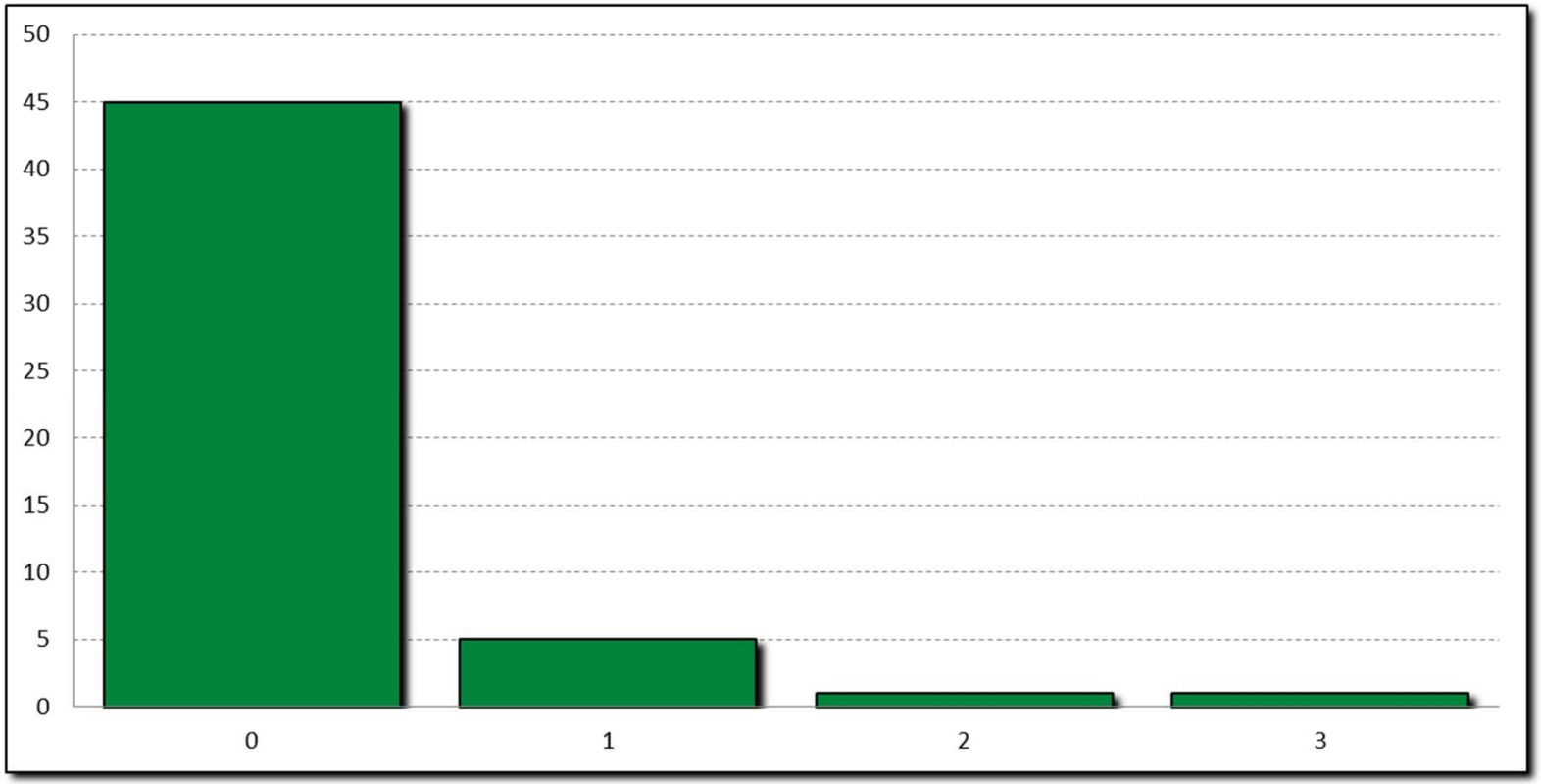
Note the number of times you had **difficulty securing transfer of care for a client who reached 42 weeks**. (Examples: only option was ER or L&D but she was not in labor and only option given was induction, despite normal AFI and NST, and client wanted to wait; and/or elective induction didn't work and resulted in cesarean; or client went home AMA and had an unattended birth after spontaneous labor began)



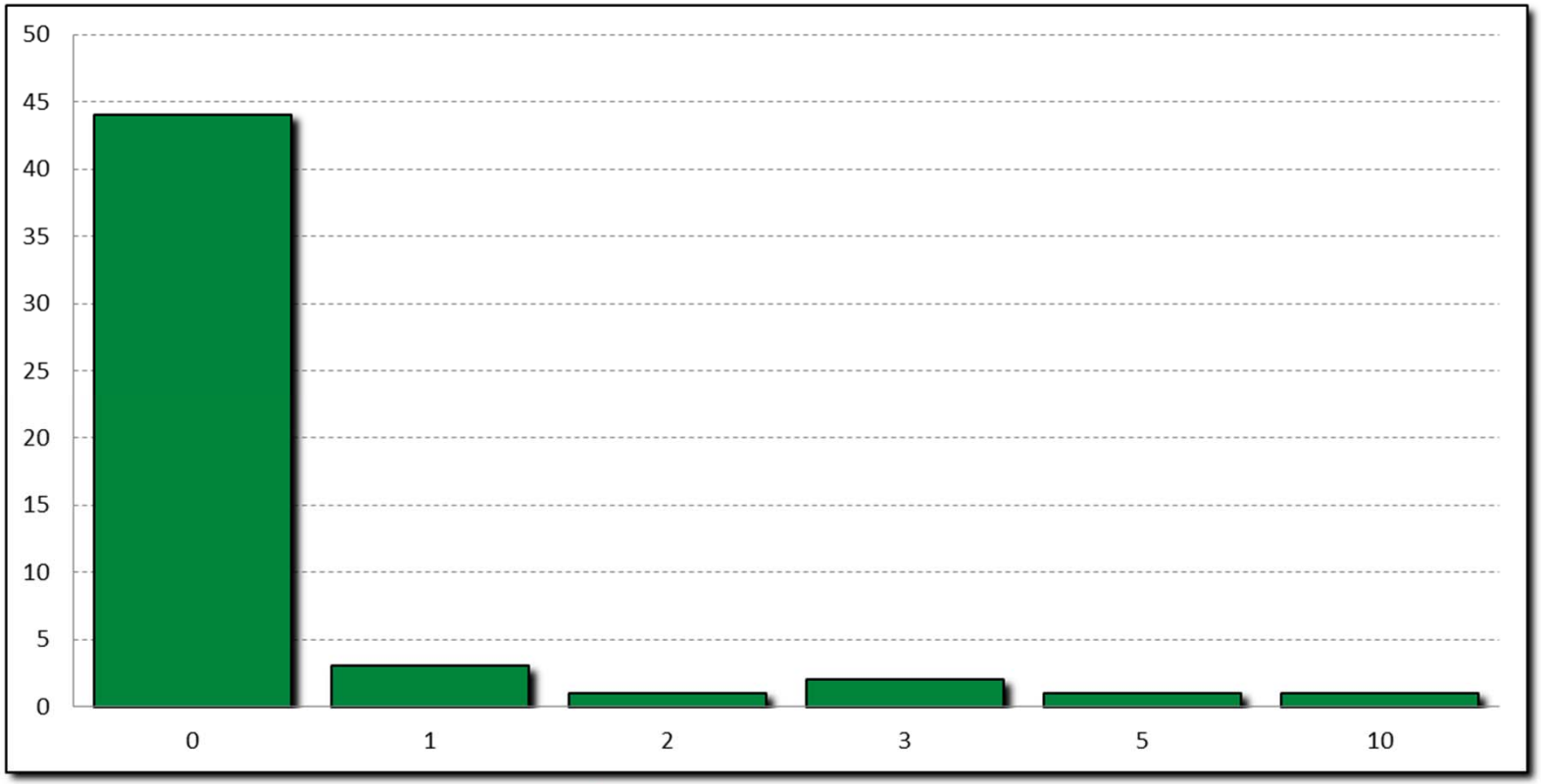
Note the number of times you had a problem securing appropriate care for a client who had **abnormal prenatal screening results**. (Example: prenatal diagnostics service would not take your referral and therefore there was significant delay in getting an OB to take on her care and get in to see a perinatologist)



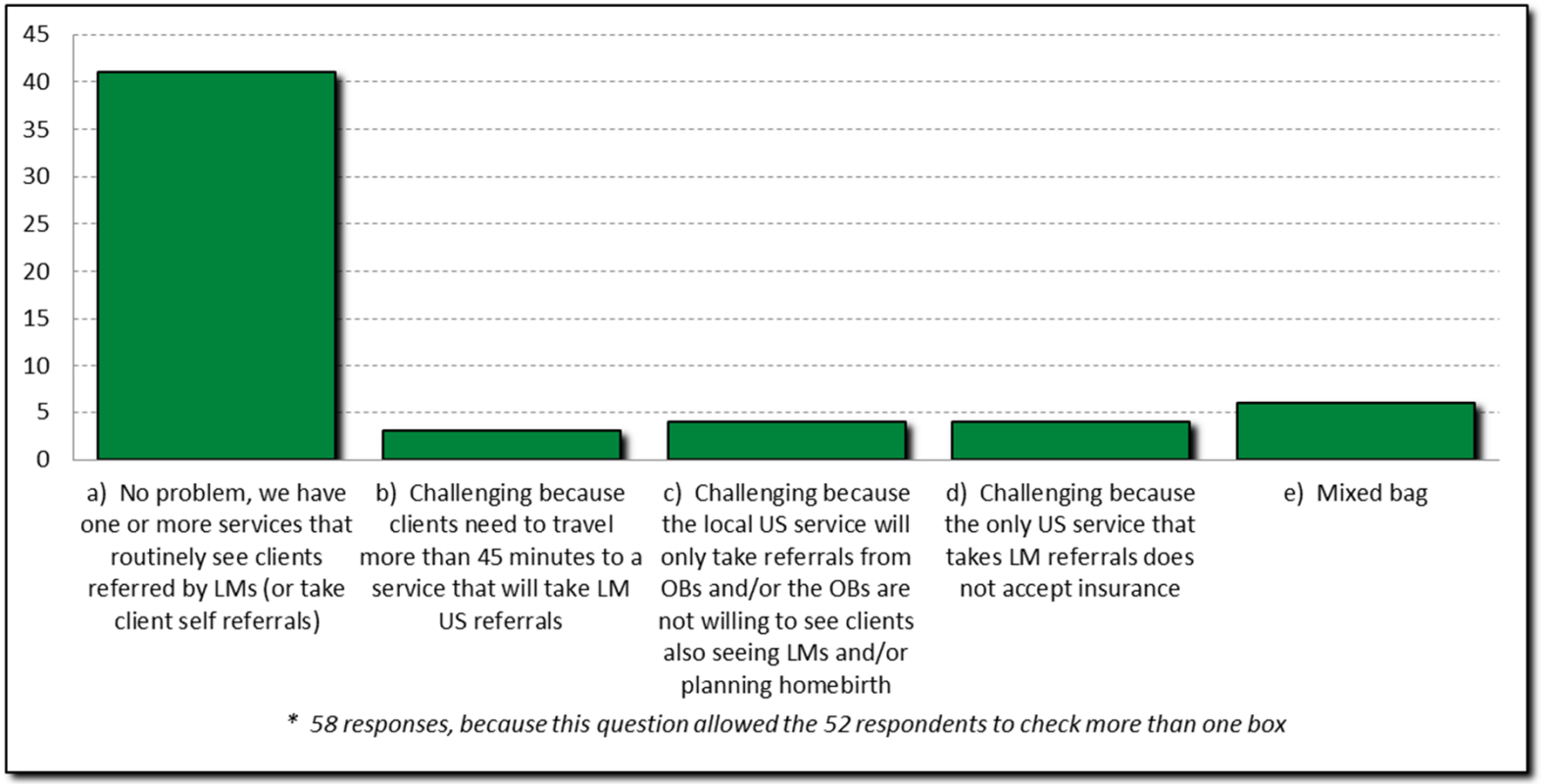
Note the number of times your referral was refused for routine anatomy ultrasound, NT ultrasound and/or biophysical ultrasound.



Note the number of times that care was secured, but it was **expensive because the only option was an (otherwise unnecessary) ER visit**, because the **distance** to accessible care was excessive, and/or **other issues undermined the quality and safety of the care**.



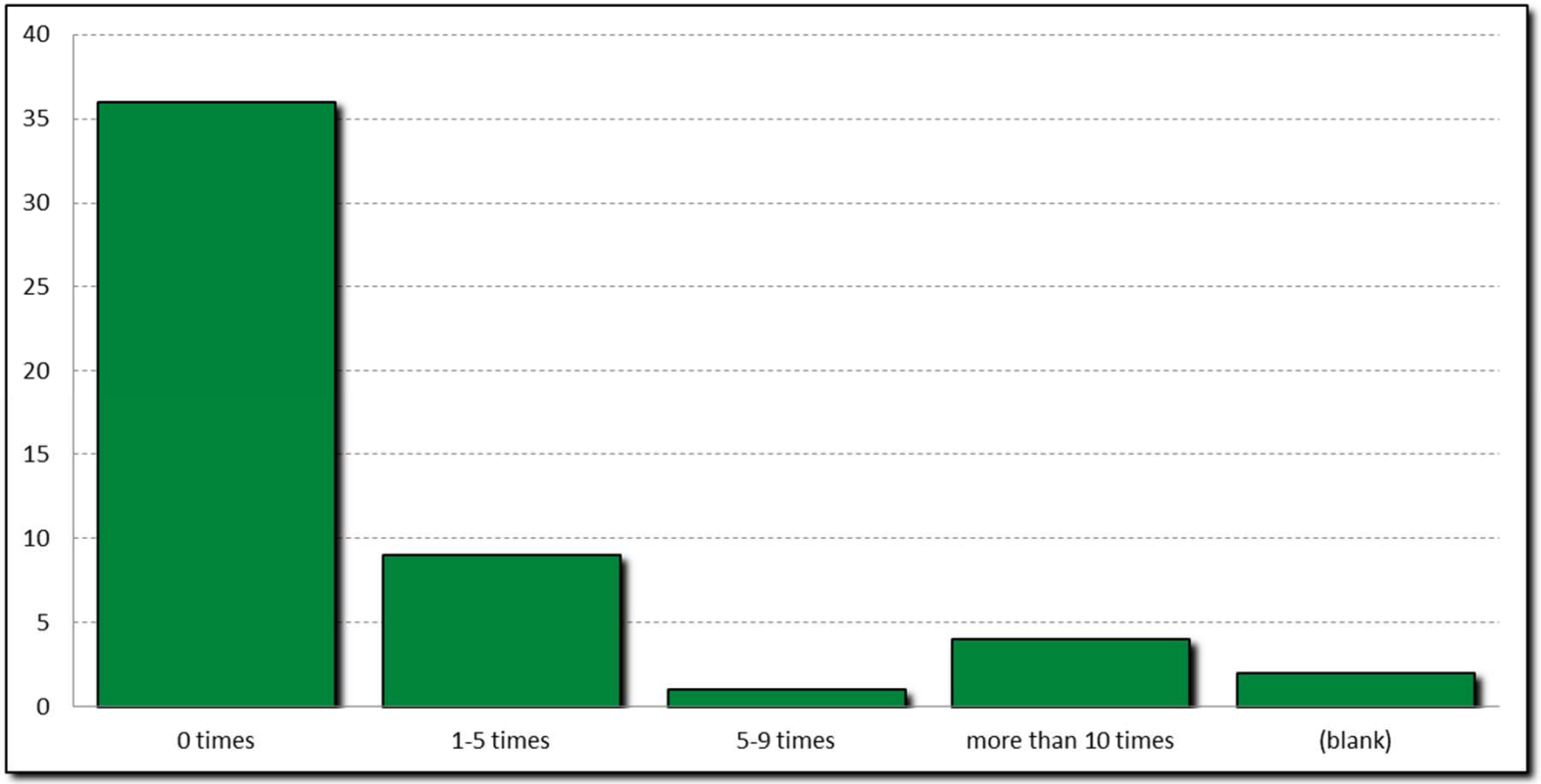
What is the availability in your community for LMs to refer clients for ultrasound?



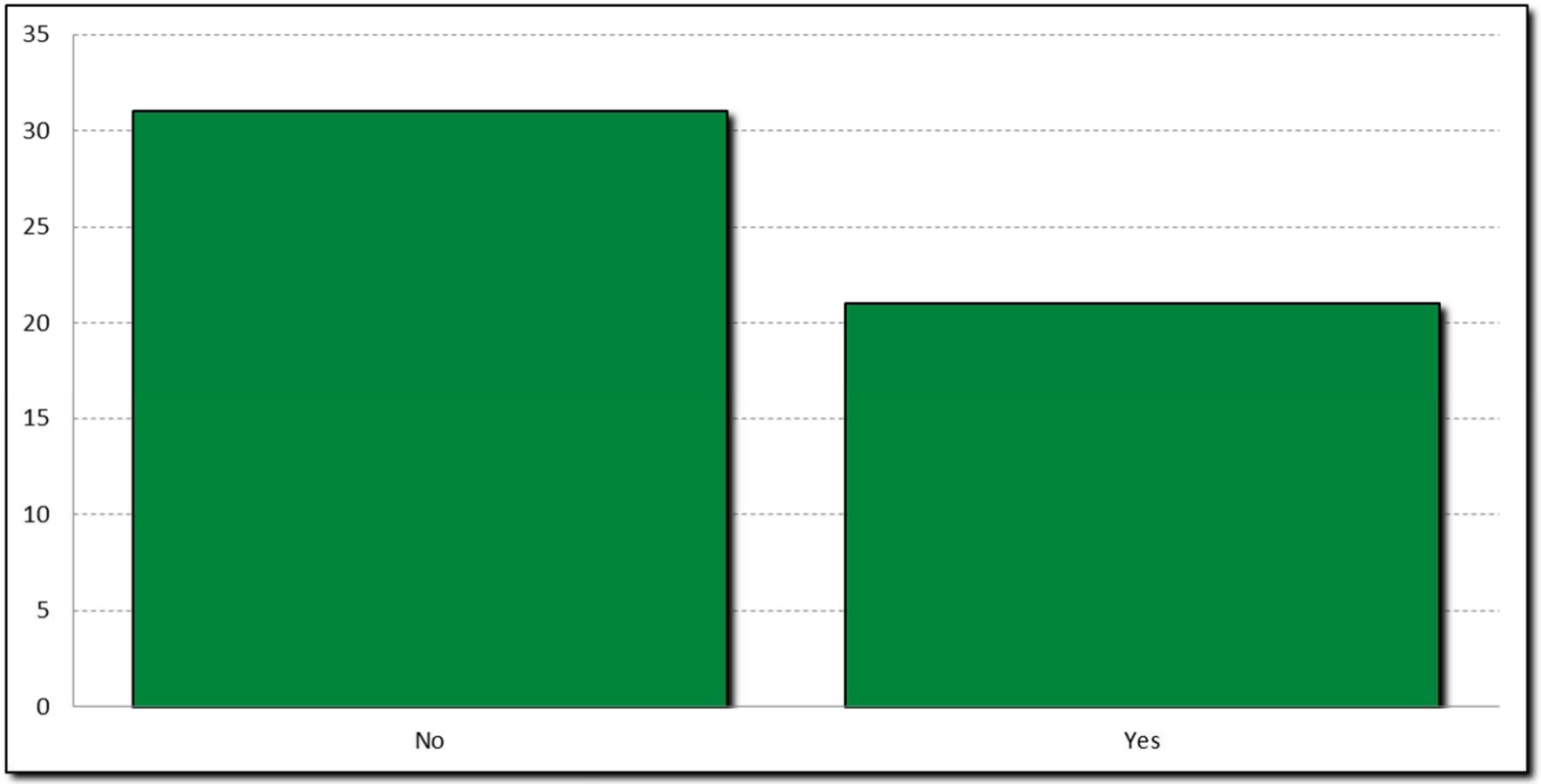
Other referral challenge(s) you would like to report

- ALL of the OB's in my area will only transfer clients into their care if they are NOT past 37 weeks care and in labor.
- I am only able to refer clients to an freestanding US office with insurance if it is a PPO, not HMO. I am able to send clients to a Medi-Cal clinic (cash pay) for routine US because no OB in the areas will see midwifery clients. The US tech is only in the area twice a month and it isn't a great option if I needed an US urgently.
- If the client is on Medi-Cal there can be extra difficulty if their plan is specific instead of general. If they have General Medi-Cal referrals are easier. But with a specific plan, they often won't be covered by the people who accept LM referrals.
- I've had challenges with the general practicing MD (only 1 GP has delivering privileges at our local hsp) in our community regarding concurrent care. He has told my clients that if he doesn't do prenatal visits with them, he won't be their baby's doctor. So they abide.
- My tendency is to use the doc on call at the local hospital, . The attitude is not always pleasant but services are always rendered in a fairly timely manner. My preference would be to be able to contact an OB by phone for a more casual consult when appropriate, before initiating possibly unnecessary testing. A list of friendly OB providers who would be interested in sharing a call line might be something to work towards. This feels like years away but I can see it working well.
- No ability to consult for prior CS
- No non urgent referrals available in my area, Only L&D
- None have State-run hospital with social worker to assist pts with those challenges
- Only one practice has privileges to care for VBAC's at the hospital and that practice refuses to care for clients who have concurrent care with midwives.
- Only option for our one 42 week case was the ER and induction
- Referral to Sweet Success Program. I DO have an OB that I work with but he does not take all forms of insurance. Those with certain Medi-Cal programs cannot see him.
- Stressful to transfer to local hospital because both client and midwife are treated disrespectfully. Client seems to be "punished" for attempting out of hospital birth. Therefore, for non emergent transfers, we drive to hospital 50 mins away.
- The bigger challenge is how women are treated when a transfer of care or consultation happens. It is not uncommon for the homebirth clients to feel like they are being punished for asking for what they want. It's rare that a transfer or referral is a positive, helpful experience.
- The one OB who was fairly willing to consult is in dispute with the local hospital and so is unable to provide consult/care for clients past 20 weeks of pregnancy at this time. No other OBs in my community are willing to see clients outside of the "via L&D through the ER).
- The US service that is happy to get referrals from LMs is a one-person operation, and it's a little nerve-wracking to worry that he might not be available when needed for a time-critical referral.
- We have excellent referral.
- We have one place that will take our referral but they are based in so can go there or only have one day they can be seen in . Only option for 42 weeks is the ER (twice in 2 years)
- We referred a client to local OB's Clinic due to seizure during 2nd trimester of pregnancy, {client} had no prenatal care for 8 weeks! They did send her for ultrasound during that time, but did not have any actual prenatal visit or review of u/s report. Clients with managed Medi-Cal are unable to get ultrasounds unless seen by OB in their plan, in our area the care that they receive in those clinics is generally disrespectful and non-evidenced based at best and many women decline to continue to get the kind of prenatal "care" available through their insurance.

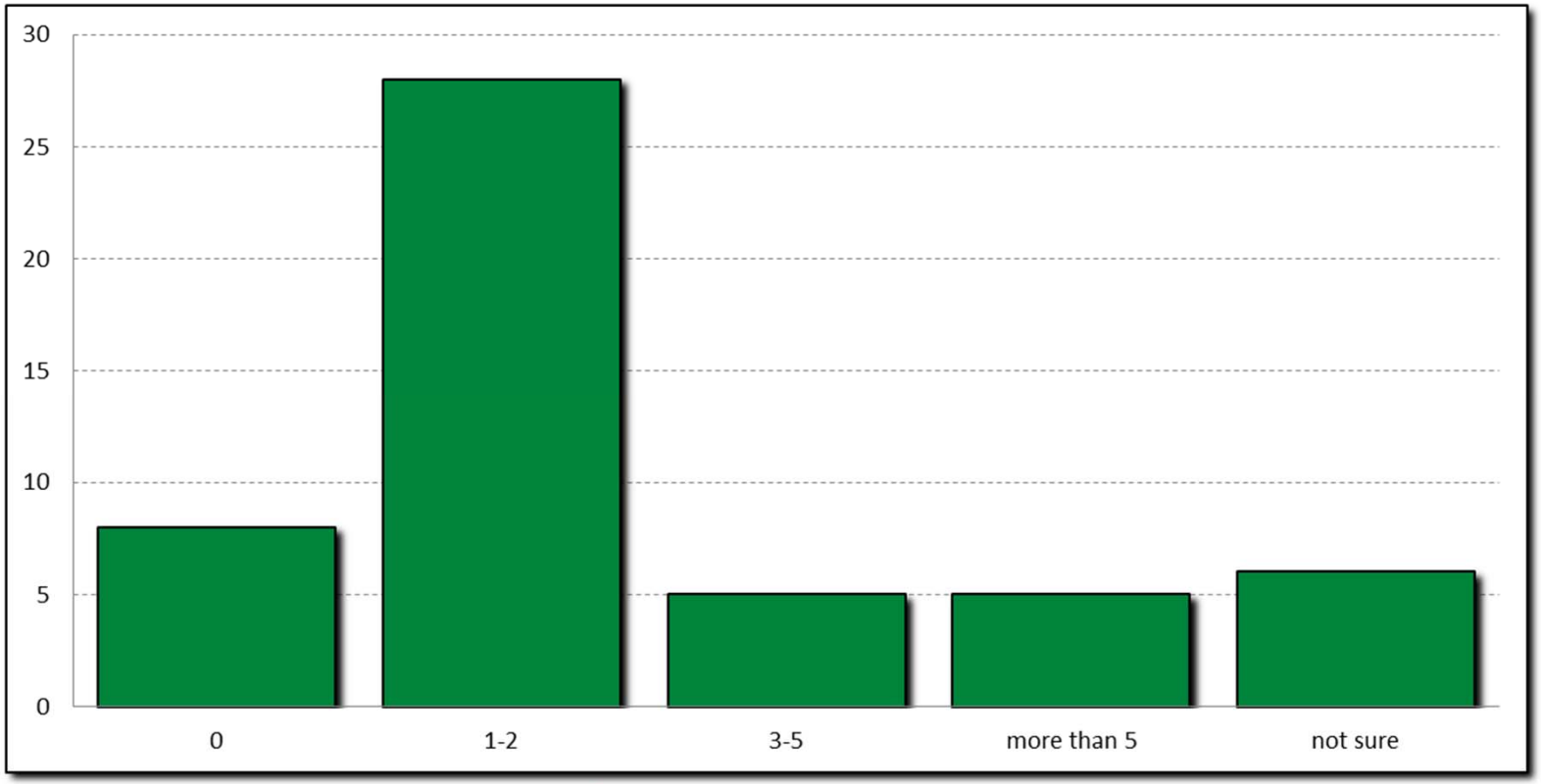
How many times in the past two years did you use alternate methods/locations outside your community to secure needed or desired care because you already knew the client couldn't access care in your community?



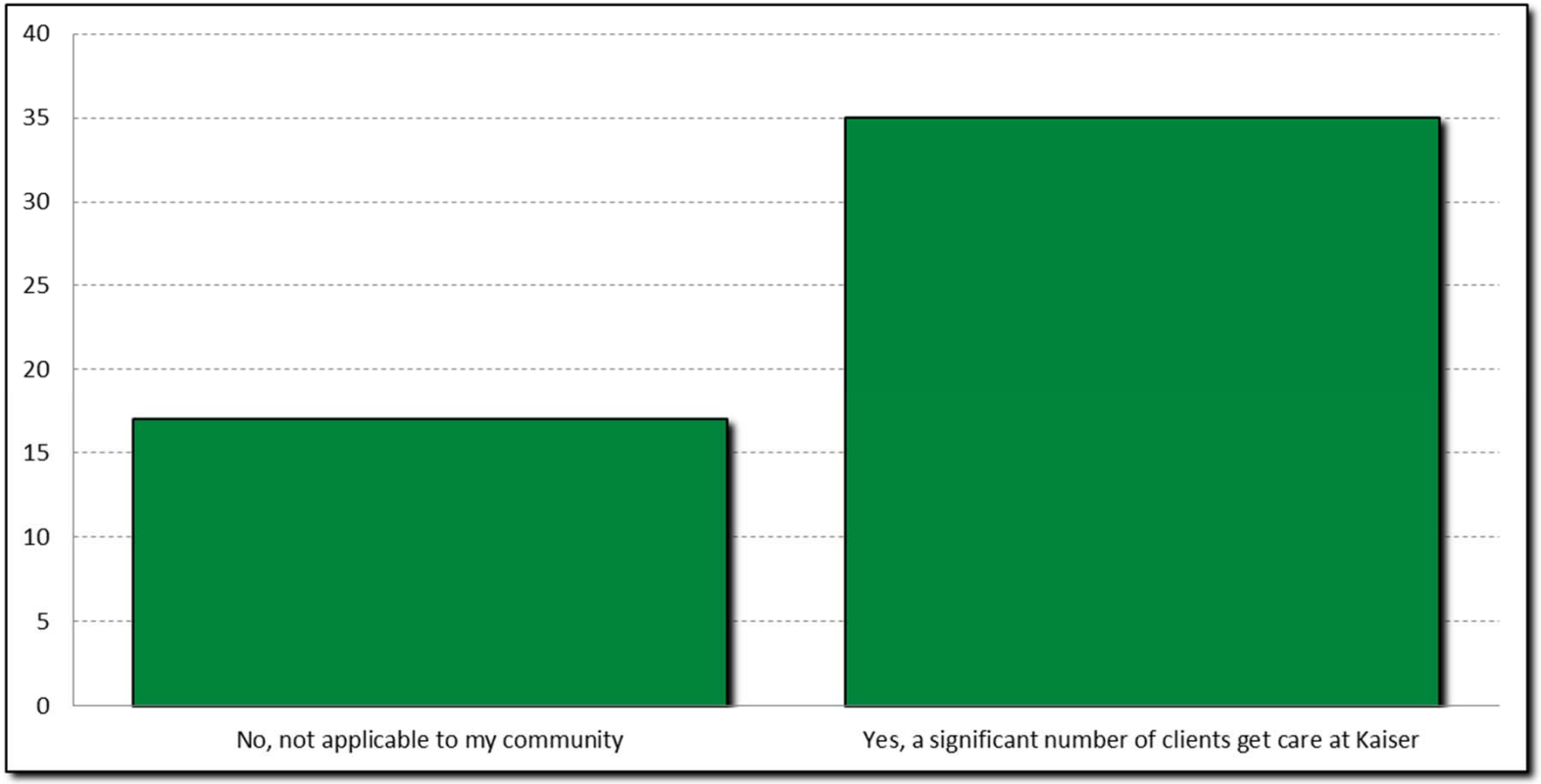
Is it relatively simple in your community to have clients see an OB if the OB knows that the client is planning a homebirth and receiving care with an LM?



How many OBs in your community are willing to accept referrals?

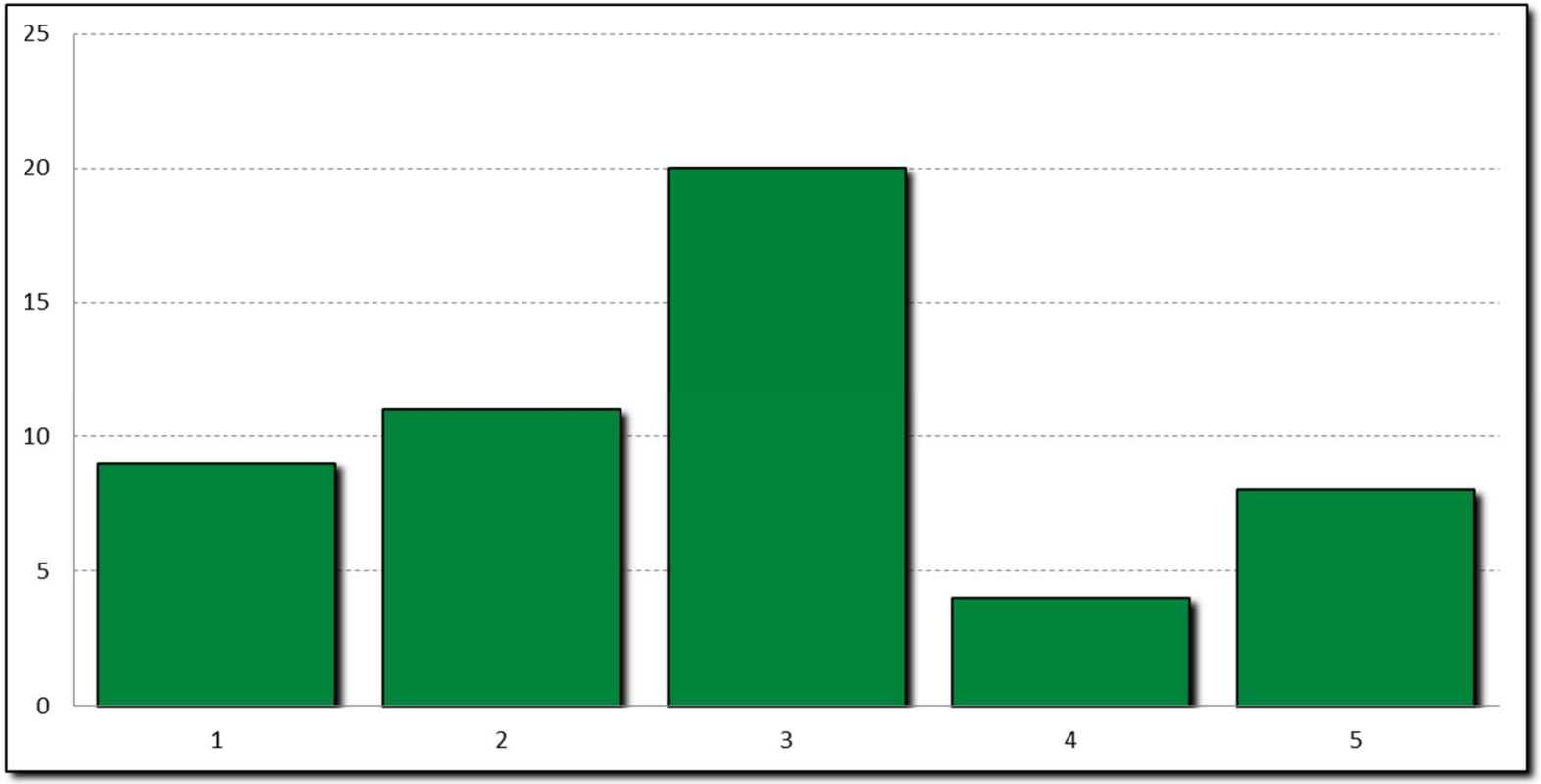


Does having Kaiser in your area take care of many of the referral problems?



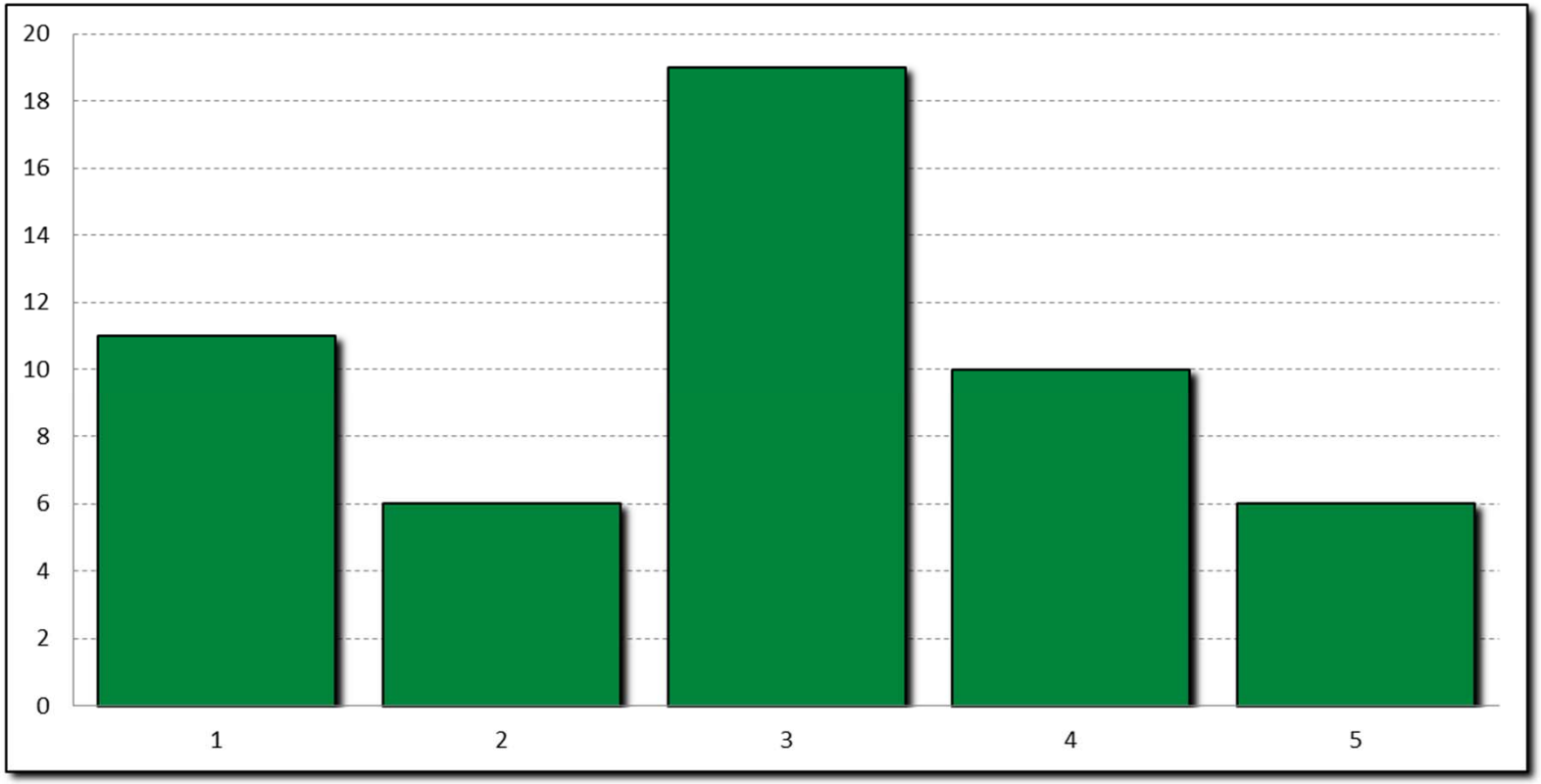
Is it ever a problem that OBs are {uncooperative} (i.e. rude or disrespectful to the client, and/or make undermining remarks about clients choices to see midwife and/or plan homebirth).

1 = major problem, 5 = not a problem



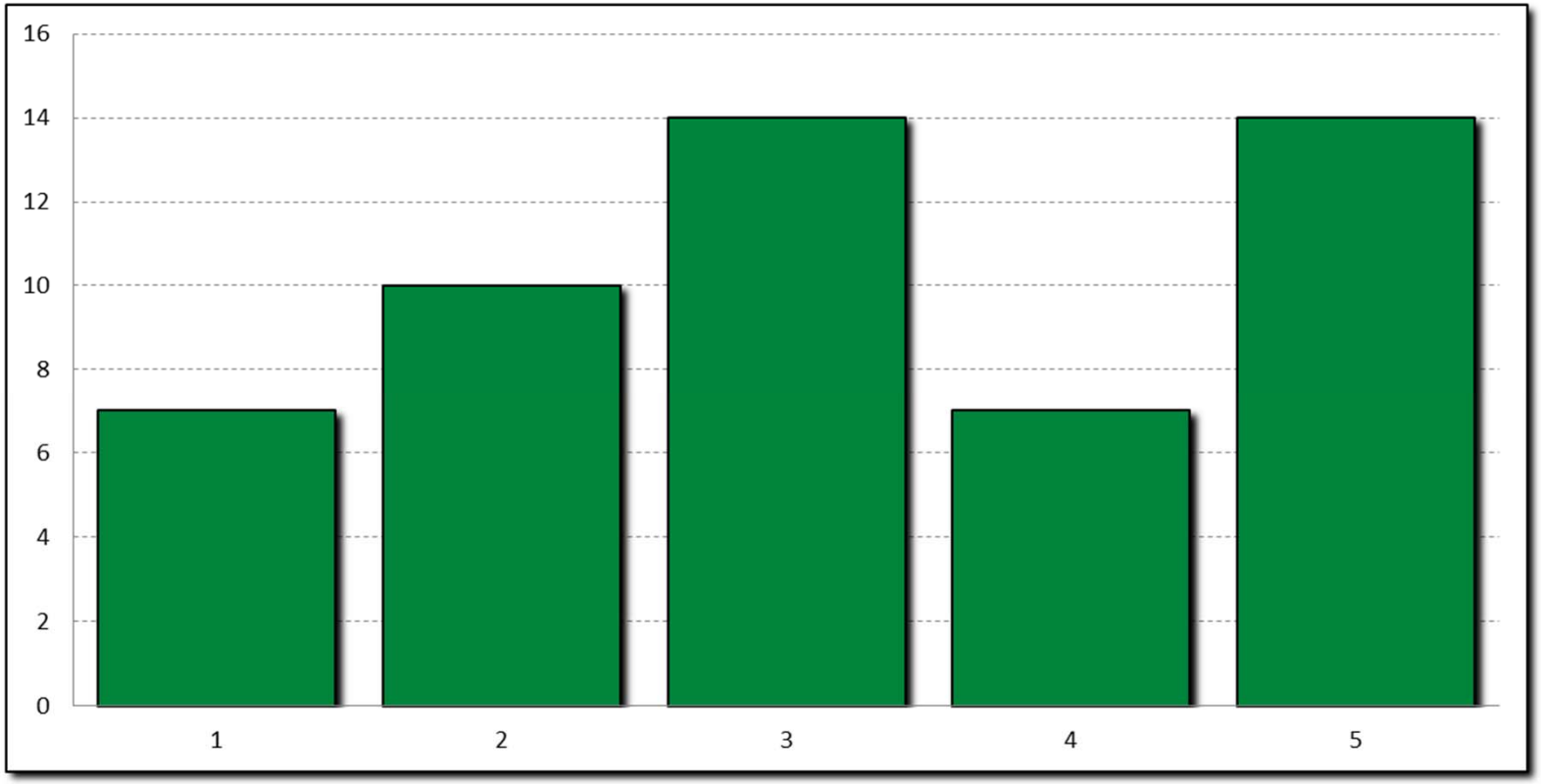
I am unable to secure OB referrals for non-urgent issues (aside from ER care).

1 = major problem, 5 = not a problem



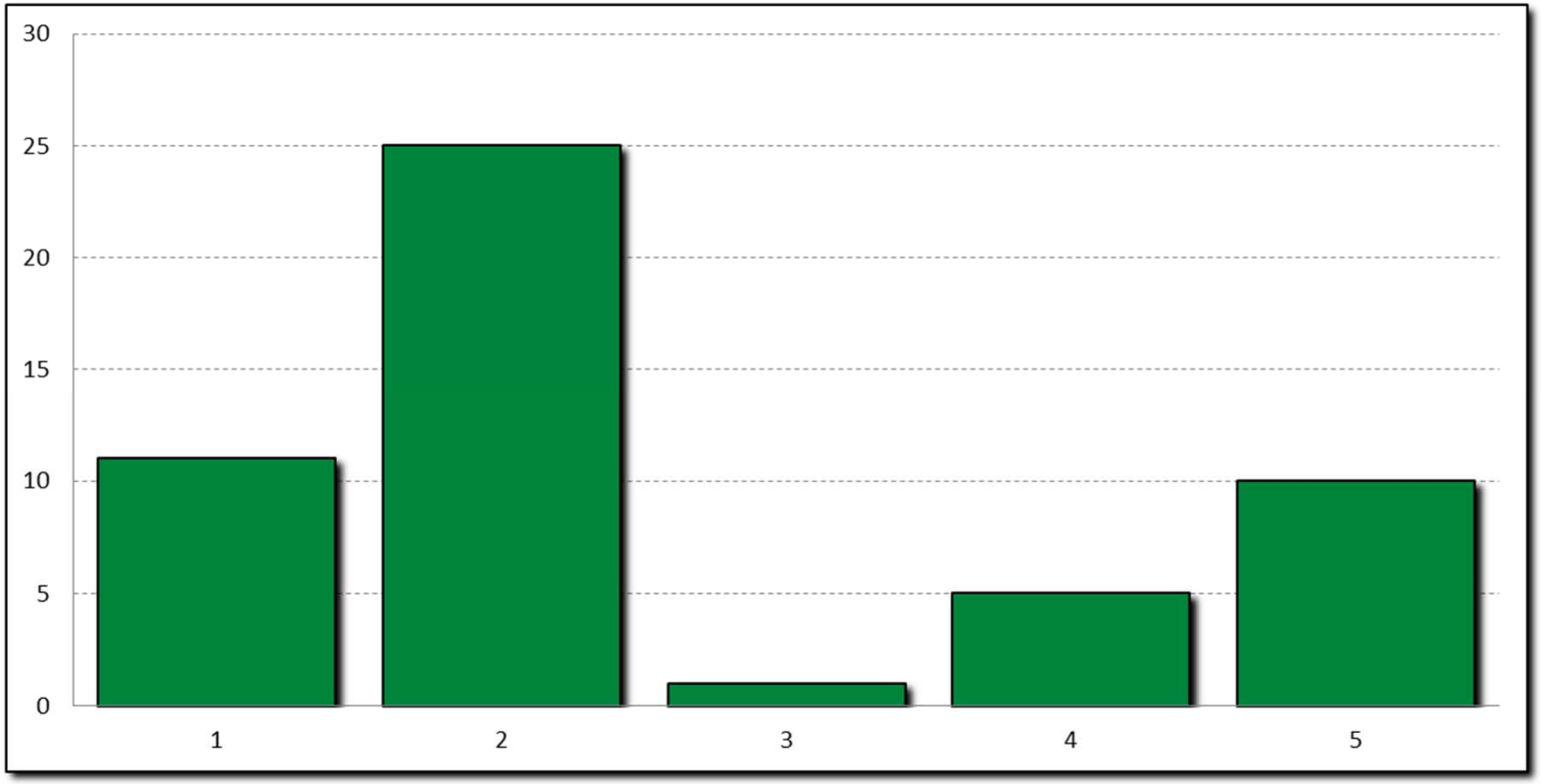
My clients incur added expense due to the way LMs need to secure care for non-urgent issues (i.e., ER visits).

1 = major problem, 5 = not a problem



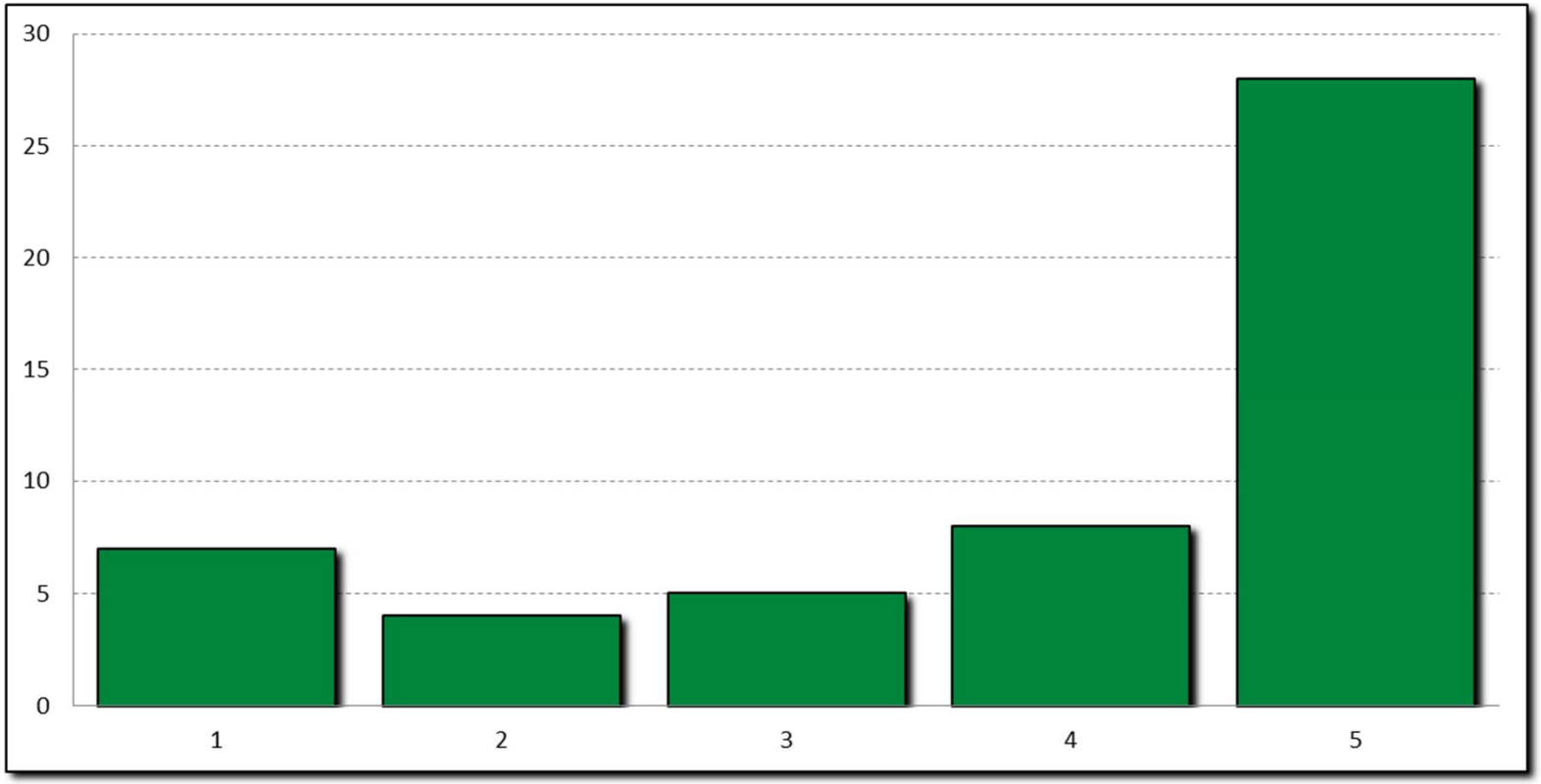
Clients find it necessary to withhold information about plans for homebirth due to risk of being dismissed from care.

1 = major problem, 5 = not a problem

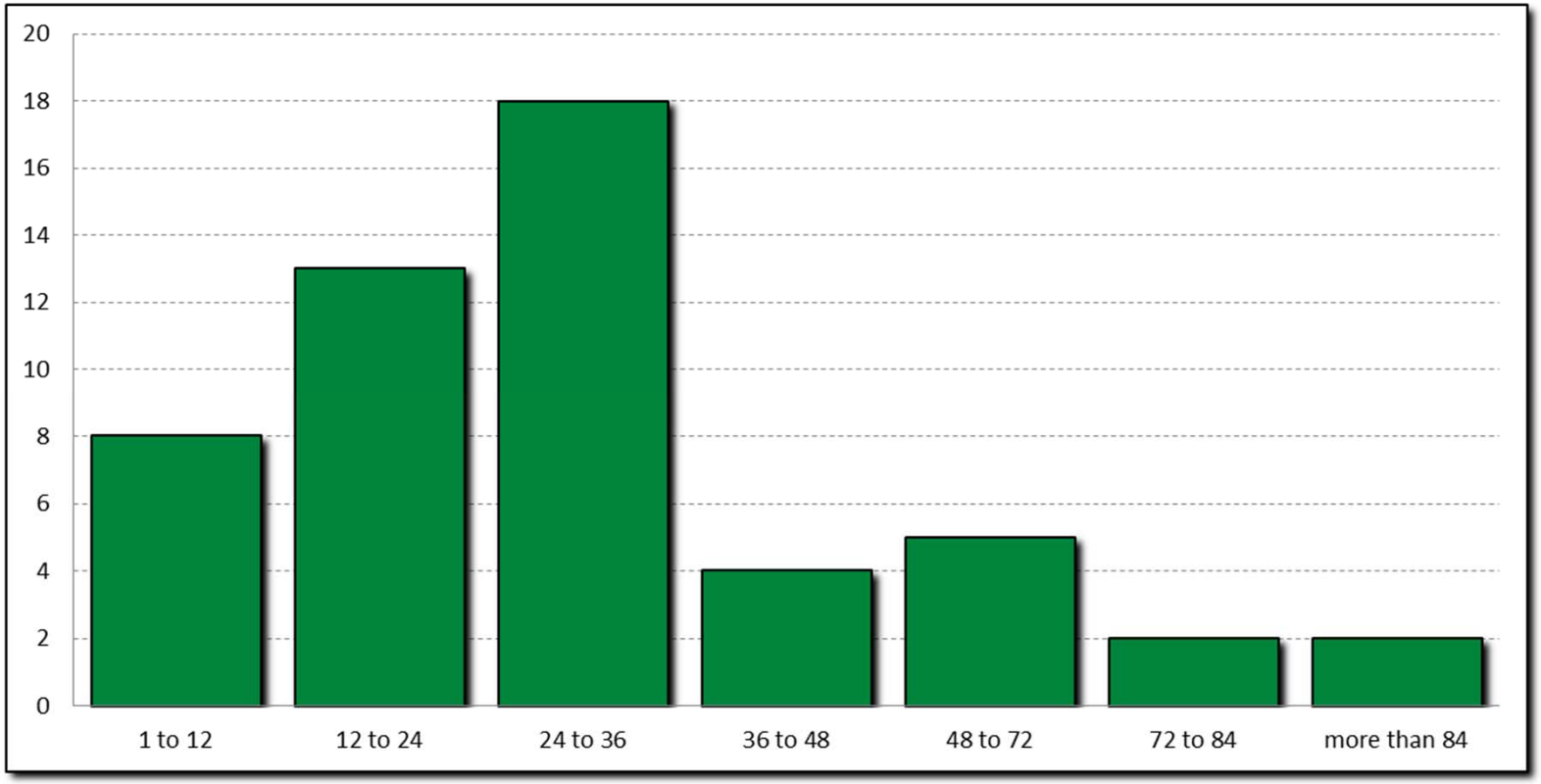


I must send clients an unreasonable distance to secure safe, timely and/or quality care (medical care and/or for ultrasounds).

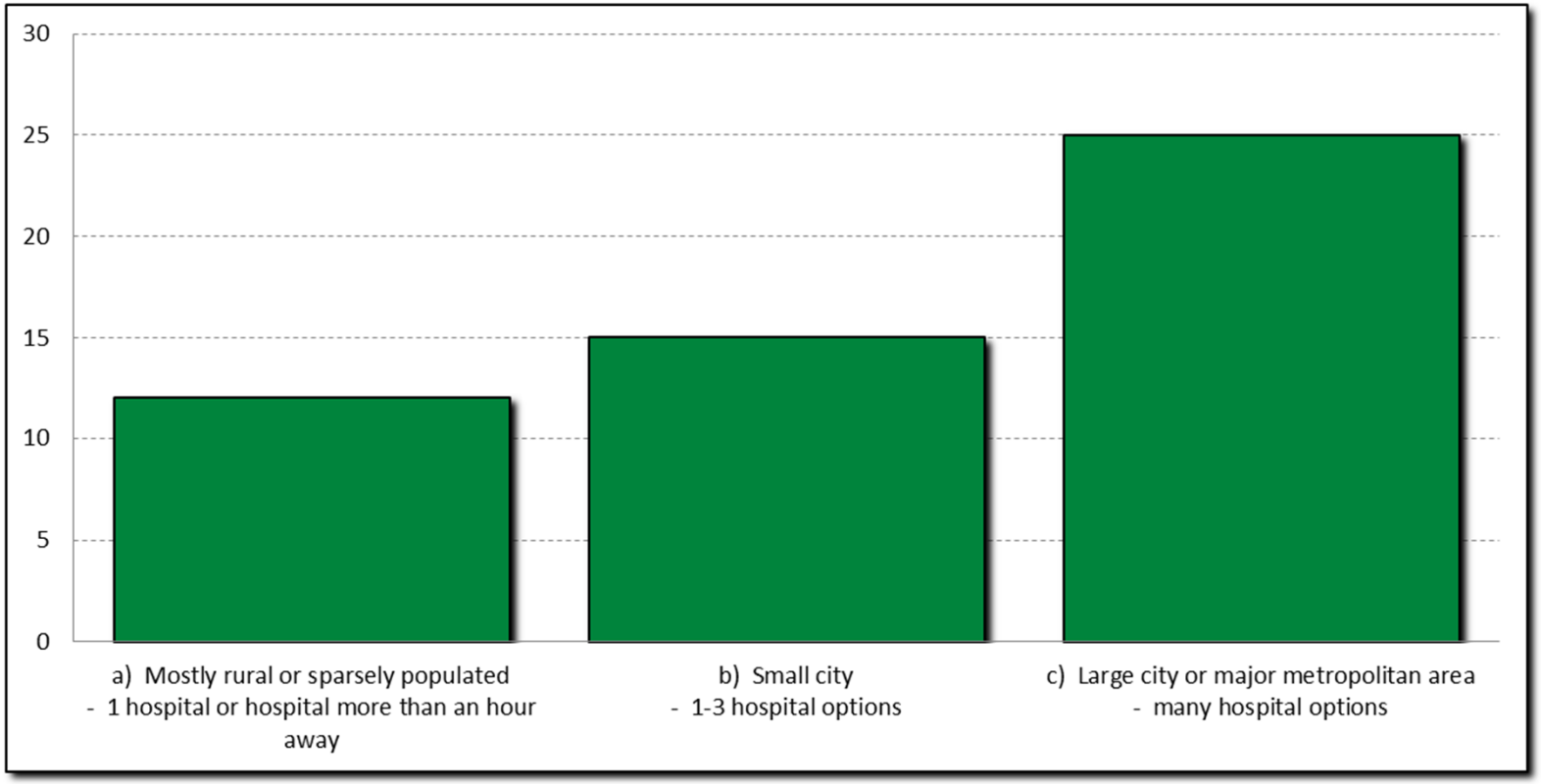
1 = major problem, 5 = not a problem



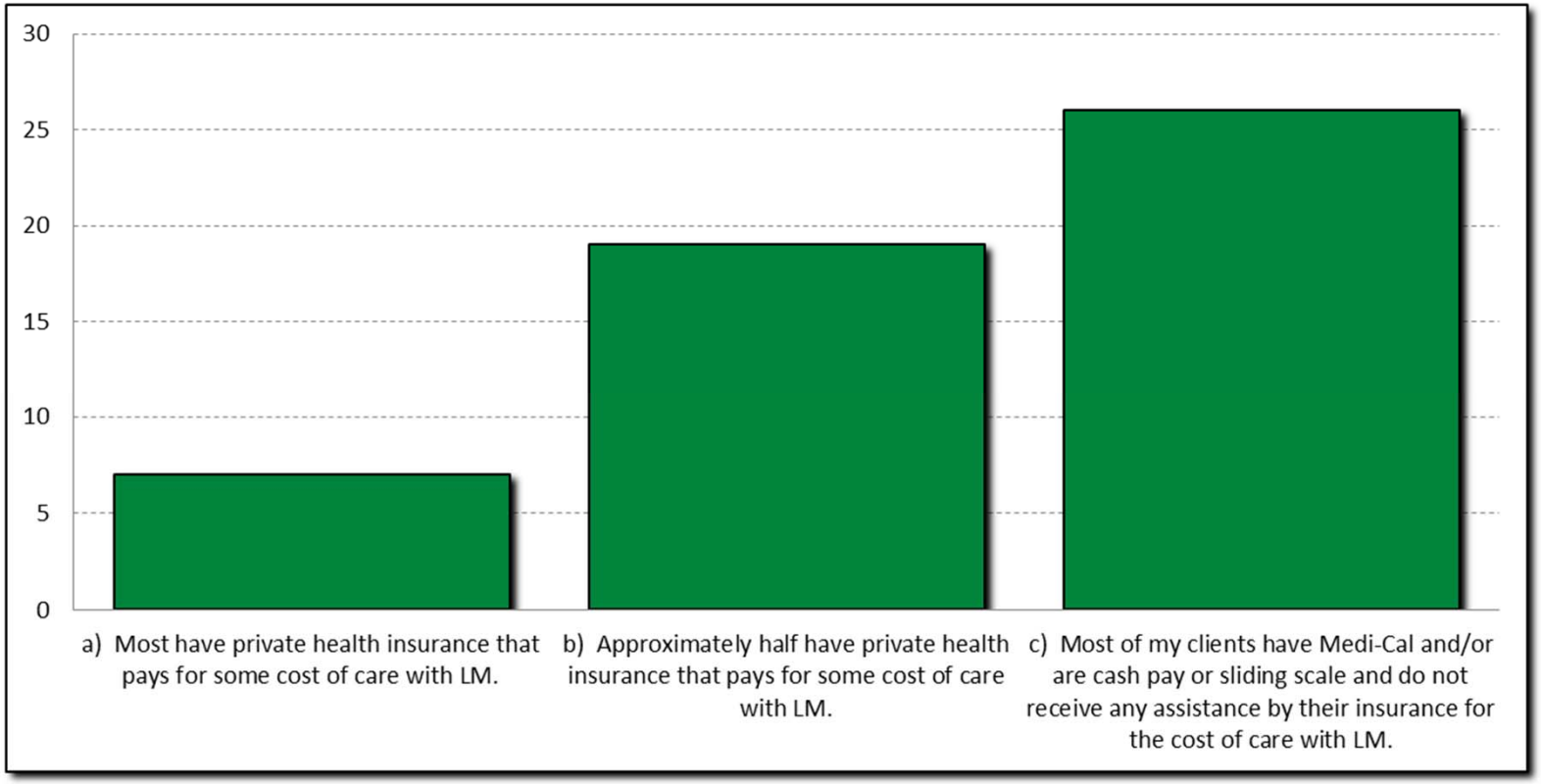
How many total primary clients delivered under your care (or your group practice) in 2014 and 2015?



Please describe where you practice.



Financial and health insurance demographics of my practice/clients.



General impressions

- There are some challenges
- Not necessarily wide spread or systemic
- One midwife shared that she sent information about LMs and AB1308 to targeted hospital administrators January 2014 – same midwife reports 'no problems'
- Address problems because individual quality of care and safety impact is significant

One avenue CAM/CALM plans

- CALM -- California Association of Licensed Midwives: a sister organization to CAM to address the specific professional needs of California licensed Midwives
- CAM/CALM Quality Care Program:
  - Standard of Care
  - Proactive communication with hospitals and letter campaign to OBs

Questions? Suggestions?

Contact us at info@californiamidwives.org

to get involved

- Speakers bureau
- Article for MBC newsletter
- Collect more information
- Discuss potential policy changes

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Some midwives did not include any narratives. 27 provided one or more narratives represented here.

"Include a detailed narrative of referral challenge":

Transferred for decelerations in fetal heart tones @ 7 cm. called ahead with explanation. Heart tones were lowest when mother was in sitting position. We explained that to ER but they insisted she must sit in wheelchair. In L& D...we had mother move to her side and nurse said "we are in charge now, stand over there". She was immediately taken in for cesarean. Though given epidural for procedure, they never came to get dad for the birth. Nurse came in to announce the birth, the couple very sad he missed the birth. No staff ever spoke to midwife.
Client has BV-needs tx. OB unwilling to provide dual care. Client withholds information about midwife care in order to get tx.
I have a wonderful OB in private practice who I can refer to women to but they must see him one time in pregnancy in order to have him accept them during a labor/birth transport, and often have to pay cash for this service. If he does not accept the type of insurance they have, or if they have a specific HMO or MediCal plan, they are unable to utilize his services at all. For these women, it's nearly impossible to secure a labor back-up plan or consultation for issues arising in pregnancy.
There is one OB practice who has privileges at one of the three local hospitals who refuses to care for women who are planning a home birth or who are obtaining care from licensed midwives. They are the only practice who have the ability to offer VBAC birth at the hospital. So the women who would like this service or who live in that city are refused care. We have one OB practice who will take referrals only before 32 weeks and it takes a month or more for the client after orientation to see a practitioner. We have one OB practice that we have a good relationship with in the adjacent town and who does take referrals easily.
Client #1: G1P0 I drew her prenatal panel and genetic screening labs. When she explained to the MD that I had already drew her labs, they redrew her anyway. She was told it was a necessary test that I didn't know of. She received 2 bills. She was also told that my advise about GBS was nonsense. I went to the MD's office and requested to see him. His FNP received me and I showed her the studies that backed what I had said. I explained that I would never give advise w/o an evidence based study to back what I said. She agreed with me and denied that they were slandering me. When it came time for the GS and anatomy screen, she did them with the MD. It was difficult for me to get copies, it took 2 months and 5 requests.
Client #2: G2P1 I drew her prenatal labs. I faxed them to the MD per request of client @ 9 weeks. She went into labor @ 31 weeks and the labs were not obtainable by the MD. His office staff didn't put them in her chart. It took 12 hours for me to be notified that they were needed. I was not properly notified by my client that she was at the hospital. She texted me, did not page me and I didn't see the text until the morning. I faxed the labs immed to the NICU 150 miles away. The NICU had still not received the labs from the MD.

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Client #3. G2P1 Previous NSVD hsp birth with OB 30 miles away. Augmented with pitocin and vacuum extraction because of fatigue. While seeing MD in town for current pregnancy, she explained that she was exploring the home birth option. MD wrote high risk all over her chart after client revealed her plan. MD explained it would be inadvisable because of the life threatening complications from her last birth of: PROM, PPH, intrauterine inf. She had none these complications. Client requested the chart be corrected. Client made an appt with the OB that delivered her 30 miles away and OB wrote me a letter explaining that Client arrived at hsp in active labor, SROM, vacuum extraction because of fatigue. discharged at 24 hours. OB wrote that my client was low risk and would be a good home birth candidate after late u/s discovery of placental placement.
The referral challenge can be both due to income and insurance in our area. We have some good referral options for private insurance or for those willing to pay out of pocket. But medi-cal is particularly hard.
Client got a positive screen for ONTD (Open Neural Tube Defect) on 2nd trimester screening. Was able to refer to Lucille Packard Perinatal Diagnostic Center for consult/ultrasound/possible amnio. However, once there, they stated they would not have accepted the referral had they known i was a midwife. And further they were 100% unwilling to give me results of the level 2 ultrasound. They forced me to find an MD who would accept the results, which was a challenge since the client had not seen an MD at all in the pregnancy. A FP MD was willing to accept the results, but she doesn't do obstetrics or even have hospital privileges. However, she was an acceptable recipient of this information, while I was not. The clients could see how ridiculous this all was, as well as how I was treated as though I were trying to get away with something rather than providing completely appropriate prenatal care *for a family in possible crisis." What did Lucille Packard think should happen....that families whose babies might have birth defects shouldn't get care if they are planning a homebirth? Further, they have not accepted referrals for NT ultrasound for clients who desire or need these. This means we have to send clients out of the community OR have them do tandem care with an OB (pretending they aren't planning a homebirth) to secure this exam.
I have not had to (as of yet) refer for a non-emergency situation, but I have trusted OBs whom I can refer to for this that have a good relationship with the midwifery community. The major issue I face is bias and rudeness to the client from OBs when we transfer into the hospital in labor for emergent issues (failure to progress, low FHTs, etc.). The majority of the time the OB fails to take the time to understand the wishes of the client and automatically defers to the need for a Cesarean section, while chastising the client for choosing an attempted home birth with a midwife. This leaves my clients feeling unwelcome, resistant to offered care because now they are suspicious of motivation on behalf of the care provider, resentful for needing to be in a hospital, and affirms their opinion of not wanting to have anything to do with the medical system for being treated in this disrespected manner.
Transferred for decelerations in fetal heart tones @ 7 cm. called ahead with explanation. Heart tones were lowest when mother was in sitting position. We explained that to ER but they insisted she must sit in wheelchair. In L& D...we had mother move to her side and nurse said "we are in charge now, stand over there". She was immediately taken in for cesarean. Though given epidural for procedure, they never came to get dad for the birth. Nurse came in to announce the birth, the couple very sad he missed the birth. No staff ever spoke to midwife.

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"Include a detailed narrative of referral challenge":

The biggest challenge is when a woman gets to 42 weeks, which does not happen too often. There aren't any doctors who will take a woman at that point. she just has to go into the hospital when in labor. if she is not in labor the hospital doesn't want her.
OB's here want clients at beginning of care - there is one who will take referrals, but he is considering retiring soon I have clients call others and they say they can't take her and she has to go to ER
In my home city, Fresno, we have some friendly OBs who are fine doing concurrent care. We have some OBs who are reluctantly getting on board. In those cases it was mostly due to having an established client who then found midwifery care and asked if she could do both. It was a "don't ask, don't tell, but if you need help in labor, we will assume your care." So, we are fortunate in that. Our "transport hospital" is a Stanford teaching hospital and has come a LONG way in treating transferred clients with respect. 5 years ago I was regularly yelled at by staff. Some doctors here will "divorce" their clients who breathe OOH.
East Bay Perinatal Medical Associates will take referrals for ultrasounds, but finding an OB who will offer a one-time consultation for a specific issue is a challenge
PowerPoint made and sent to local hospital with transport form with new law 1/1/2014 and other hospitals faxed new law and transport form in surrounding areas.
I have been told by preferred local OB office for ultrasound that they won't take Medi-Cal, but have heard from other midwives that they will. I have also contacted the community hospital (Highland) and was told they won't take referrals for routine US, only urgent or emergent issues. There is nowhere else to refer women with Medi-Cal unless they pay a private ultrasonographer like Lance Dursey out of pocket, but he is 45 minutes - 1 hour away for most clients, or they go to UCSF, which is also 45 minutes- 1 hour away
I had a woman with low platelets at 37 weeks. No OB would see her. The L &D wouldn't see her. I had to call numerous L&Ds to talk with OBs, who would be kind enough to advise me! She risked out of midwifery care due to low platelets but couldn't find an OB to see her for routine prenatal care until she delivered!!
I was not able to pre-arrange for BiliBlanket rental for a family with a history of needing one for two previous babies. I was told by local rental agencies that they only rented to clients of Stanford Hospital.

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"Include a detailed narrative of referral challenge":

We have tried to secure lab work and US at our local hospital for years. We only have one hospital. They have refused unless the client was transferred into OB care. After the law changed 2 years ago we tried again. They declined. Barton Memorial Hospital(South Lake Tahoe, California) told us they are a private hospital and this is their policy. They did add that we could go through certain channels to request access. We have tried talking to different offices in the past and have had no success. Our women have to drive 1 1/2 hours over a mountain pass to the state of Nevada to get their labs and US done. This is a great burden to our families not to mention dangerous in the winter.
We do not have one.
42 week multip who, by law needed to transfer out of my care, wasn't willing to be induced in the hospital (her only other option), therefore went home and had an unassisted delivery
Our ER/l and D is happy to see our clients but there are no physician offices that are willing to see our clients for problems such as UTI, etc.. Everything needs to be done through ER or through the woman's primary care doctor if she has one. We cannot order labs when client has Medi-Cal that is a barrier as client has to go to a clinic to get labs. There are no US places that accept our referrals only one place in San Francisco, far from where my clients live. I do however have great relations with my local hospital and they are happy to see us if need be.
We (2 LM's) have had very few reasons for referral or transfer of care. Set of twins, 22 wk preterm, 16 wk demise. These all went well. We also live in an area where we can refer or consult with an OB who does home birth.
We can refer private patients directly, but HMO or managed care need to self-refer back to their OB's because usually MD's are unaware of plans to home birth and as one MD told me "there is no mechanism to have a professional relationship with providers outside of their facility" as we know this creates a challenges in accurate communication Dealing with HMO's and managed Medi-cal is difficult when women need ultrasounds as part of postdates testing, self-referral back to those systems is full of pitfalls including pressure to induce and unwanted exams. Some of the care would be appropriate if women were not also getting care from midwives but given the veils of secrecy (or fog of war) medical providers are unaware of plans to birth elsewhere and concurrent care. Is it really concurrent care if MD's don't know about their patient's midwives?

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Twice recently we had mothers reach 36 weeks of pregnancy with breech babies despite numerous natural attempts to "get baby to go head down." We began trying to find a doctor who would see our clients for an External Cephalic Version. In the first case, Mother secured an appointment at a hospital clinic, and was referred to the hospital for the ECV, but once in the hospital was strongly advised for 10 minutes against home birth for a cephalic baby, before the doctor would perform the ECV. In the second case, the mother had Medi-Cal and could not be seen in the (above mentioned) hospital clinic in a timely manner (2-3 weeks) while her previous prenatal care clinic, Family Health Centers, would not accept her back into care, having "transferred her care to a home birth." We found a doctor who would perform an ECV, at the cost to the mother of $500 OOP.
Transferred client for PROM @ 35 wks. They had given client cervidil for 12 hrs. Before starting pitocin, client wanted to take a shower and eat breakfast. Fetal heart tones were normal. Was discouraged from doing so. In front of midwife Dr said, "midwives don't know what they are talking about and homebirth is not safe" and proceeded to tell a story of another recent transfer from another midwife.
Ultrasound interpretation referral needed for VBAC-OB is discouraging to client about wanting to have a VBAC and about having midwifery care.
The hospital that is closest to me and has NICU services has a 'policy' that any transfers from a midwife in labor will automatically receive a cesarean section, regardless of why they are transferring or the stage of labor. The midwife will not be allowed to give a report to the nurse or accompany the patient into triage area, but may be allowed back once the woman is in her patient room. The physicians at this hospital treat both the midwives and the midwifery patient extremely poorly. In one instance the OB came into the room, asked which one was the midwife (I was sitting quietly with the two Grandmothers and he didn't know who I was). When I acknowledged that I was the midwife he motioned me out of the room and had me escorted by 2 Pomona Police officers all the way out of the building without any opportunity to gather my things, notify my client of what was happening, or say goodbye. The clients thought I just left. The reasoning given for this was that he didn't want any midwife to interfere with care and that I was not welcome in his hospital. He acknowledged in front of the officers that I had not caused any commotion or problems but that I was trespassing and not welcome in his hospital.
Currently no OB in our community accepts referrals for routine ultrasound in our community. They either need to have tandem care (and not discuss that they are planning homebirth) or they need to go out of the county to get ultrasound, and that place does not take insurance, meaning it is out of pocket cost for clients. There have been times I've needed this ultrasound for a client (primarily when I suspect a breech position) and I have paid for it myself because clients couldn't afford it.

Survey February 2016 of California Licensed Midwives.
Overall survey participation: 44 respondents, representing approximately 55 LMs
Some midwives did not include any narratives. 27 provided one or more narratives represented here.

"Include a detailed narrative of referral challenge":

Transferred client for PROM @ 35 wks. They had given client cervidil for 12 hrs. Before starting pitocin, client wanted to take a shower and eat breakfast. Fetal heart tones were normal. Was discouraged from doing so. In front of midwife Dr said, "midwives don't know what they are talking about and homebirth is not safe" and proceeded to tell a story of another recent transfer from another midwife.
Kaweah Delta in Visalia is punitive towards homebirthers. My understanding is that they aren't particularly kind to laboring women in general. Women in Visalia are willing to drive to Fresno for better OB care (45 minute drive). I have had the worst treatment at Kaweah Delta.
Since 3/4 of our births are in the State of Nevada most of our challenges are there. We have had issues with Banner Hospital in Susanneville, California as well. I talked to Rosanna about is last year. The hospital declined us labs because of some issue with medical. I did not understand the issue. Of course our client needed care so we sent her to Nevada and moved on. That seems to be what we do. When we hit the road block, we do what ever we have to to get the woman the care she needs. It can't wait for appeals or politics. Then we are off to a birth and so on. Very frustrating situation. Do these doctors and hospitals realize they are harming people? Do they think if they make it harder the woman will transfer care? Do they think it will stop us from practicing? Are they afraid they will be sued? Do they feel so challenged or treated by the midwifery model of care that they can not collaborate as they may appear to be in acceptance of a model they do not understand or do not accept as adaquate? Is there any answer to this dilemma? The dilemma of getting adequate care for woman choosing the midwifery model of care? I hope this survey is another positive move to that goal. Thank you.
Many clients don't tell their MD's about their midwifery care because they are told that they will be dropped if they plan a home birth or are given fear based lectures about the dangers of home birth. It is rare for women in our area to get parallel care that is supportive and factual. Recently, a client planning a VBAC was given the statistics by her MD about uterine rupture, but was berated for not perceiving the statistics in the way the doc did...and despite those stats still considering a home birth (she went on to have a great HBAC...and her pelvis is not too small despite her doc's evaluation)!
Transferred a mother in labor who decided she wanted to deliver in the hospital. Nurse said, "good that you came in, it is not safe to have homebirth."
Recently transported a client in active labor with a surprise breech presentation. This woman had not seen my consulting OB in pregnancy so I was not able to transfer care to him. She came in in active labor and I determined the baby was non-vertex position and advancing labor >6 cm so we transported to the closest receiving hospital. The OB on-call was extremely condescending to the woman who was taken back alone. She reported later that she overheard them during the preparation for cesarean to knock her out b/c she came from a midwife. She was given a general anesthesia and separated for many hours from her baby. That night she began bleeding profusely from her incision and was told it was because she labored for 7 hours prior to having her c-section which isn't optimal and had she just came in for a planned c-section for breech that this wouldn't have happened and that if she hadn't been seeing a midwife, it would have been found that baby was breech. I just referred her for counseling for postpartum depression.

Survey February 2016 of California Licensed Midwives.
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"Include a detailed narrative of referral challenge":

I had a repeat client (G2P1, uneventful homebirth 1.5 years earlier) with suspected IUGR at 30 weeks that I needed seen asap. I called in a favor from an OB in town. She told me her practice was no longer willing to take referrals from homebirth midwives *unless* the client had an HMO that only covered that practice. Luckily this client was in their system with their HMO, although 8 days prior had switched insurance, but we kept that to ourselves. So they saw her and diagnosed likely IUGR on a Friday with weekly appointments to assess. By Wednesday of the following week, the client and had URQ pain and blurred vision. I secured her care that same day with them--since they'd seen her before--and she underwent emergency c/s under general that afternoon, having come down with HELLP syndrome. Her platelets were under 50K, she'd gained 13 pounds in 5 days, and her BP was 180/112. Baby was 2 1/2 lbs at delivery. Mama worsened before she got better, including platelets tdown to 30K. I honestly believe their lives were saved because I called in this favor to the OB and didn't disclose that this client no longer had the "only" insurance the OB practice would accept for a referral from me.
It hasn't happened recently, but a few times I've had to refer a client in the 3rd trimester. Twice for polyhydramnios and once for PIH. I have found doctors here won't assume a pregnant woman after 32-34 weeks. When I was shopping around, their advice was to wait until she went into labor, then bring her to the hospital. I have had clients whose babies had medical conditions show up on ultrasound. Once I got them into the Children's Hospital perinatologist, that office was able to get them into OB care. So that works out.
We are fortunate to have facilities for regular ultrasounds as well as specialty ultrasounds (i.e. NT, fetal echocardiogram, etc) but we can only refer families with PPO's. Regarding Kaiser, they are happy to provide care for their patients, but it doesn't take care of the referral issue because families have to self-refer and we don't always get all the records or follow up report as a result of not being able to communicate with them directly. So it is a problem for us. In addition, we are at their mercy if we want additional services that aren't provided or deemed appropriate. One month two Kaiser patients had atypical initial urinalysis...one had less han 10K mixed flora and one had over 100K e.coli...guess who got rx abx? Not the one you would expect! We can't always get the kind of care they need postpartum...fear of over prescribing diflucan so they give 1/4 - 1/2 dose instead of therapeutic dose. Although we mostly are able to treat women with botanical medicine and holistic remedies, when we need pharmaceuticals it is often difficult to refer women in when they have HMO's...managed medi-cal situation is even worse. Getting a frenulum clipped for babies of women with Medi-cal or HMO, very challenging (especially since managed med-cal is by county), some services are not available in some counties.

Survey February 2016 of California Licensed Midwives.
Overall survey participation: 44 respondents, representing approximately 55 LMs
Some midwives did not include any narratives. 27 provided one or more narratives represented here.

"Include a detailed narrative of referral challenge":

Currently I have a woman who is 33 weeks with MediCal who we have been trying to get into OB consult/care as she tested positive for GDM. The Sweet Success program will not take her without a referral from an OB and referral to Perinatology. The Perinatologist will not take a midwifery referral from me. She is going untreated with no access to testing supplies because as of today, 5 different OB practice's who take her MediCal insurance have refused her care unless she signs a form stating she will no longer access midwifery care for this pregnancy. I had a client present with a large cervical polyp with bleeding after intercourse. If that were to occur now, I would have no one to refer her to, as the only OB in our community who would accept the referral is not currently seeing OB patients. We have about 12 OBs in a 20 mile radius, all practicing at the two hospitals in town. The same goes for breech presentation, 2 vessel cord noted on ultrasound, and other issues that do not require ER L&D care but do need to be seen in a timely manner.
I see you are asking about a specific referral challenge. I didn't provide one, but gave an overall view of my area. Sorry if this is not what you were looking for.

California Code of Regulations
Title 16. Professional and Vocational Regulations
Division 13. Medical Board of California
Chapter 3. Affiliated Healing Arts
Article 6. Midwife Assistants

§ 1379.01 Licensed Midwife Supervisor
The supervising licensed midwife authorizes the midwife assistant to perform the services referenced in 2516.5(a)(1) of the code, and shall be responsible for the patient's treatment and care.

§ 1379.02 Certification in Neonatal Resuscitation
Each midwife assistant shall maintain current certification in Neonatal Resuscitation. Certification shall be obtained from the American Academy of Pediatrics.

§ 1379.03 Certification in Basic Life Support
Each midwife assistant shall maintain current certification in Basic Life Support. Certification shall be obtained from the American Heart Association or the American Safety and Health Institute.

§ 1379.04 Training in Infection Control
Each midwife assistant shall receive training in the Center for Disease Control "Guidelines for Infection Control in Health Care Personnel" and shall demonstrate to the satisfaction of the supervising licensed midwife or instructor that he or she understands the purposes and techniques of infection control.

§ 1379.05 Training to Perform Services
In order to perform the services of a midwife assistant, including technical supportive services, a midwife assistant shall have completed the minimum training as prescribed herein. Training shall be for the duration required by the midwife assistant to demonstrate to the supervising instructor or supervising licensed midwife, as referenced in Section 2516.5(a)(1) of the code, proficiency in the procedures to be performed as authorized by Section 2516.5(b) of the code, where applicable, but shall include no less than:

(a) Ten (10) clock hours of training in administering injections and performing skin tests, and/or

(b) Ten (10) clock hours of training in venipuncture and skin puncture for the purpose of withdrawing blood.

(c) Satisfactory performance of ten (10) each of intramuscular, subcutaneous, and intradermal injections.

(d) Satisfactory performance of ten (10) skin tests, and/or ten (10) venipunctures and ten (10) skin punctures.

(e) Two (2) clock hours of training in administering oxygen by inhalation.

(f) Ten (10) clock hours of satisfactory demonstration of immediate newborn care.

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(g) Five (5) clock hours and ten (10) demonstrations of satisfactory placement of the device used for auscultation of fetal heart tones during labor or by simulation.

(h) Five (5) clock hours of midwifery didactic training.

(i) Training in (a) through (h) above, shall include instruction and demonstration in:
(1) pertinent anatomy and physiology appropriate to the procedures;
(2) choice of equipment;
(3) proper technique including sterile technique;
(4) hazards and complications;
(5) patient care following treatment or test;
(6) emergency procedures;
(7) California law and regulations for midwife assistants.

§ 1379.06 Administration of Training
(a) Training required in Section 1379.05 may be administered in either of these settings:

(1) Under a supervising licensed midwife, who shall ascertain the proficiency of the midwife assistant and shall be responsible for determining the content of the training and the proficiency of the midwife assistant; or

(2) In a secondary, postsecondary, or adult education program in a public school authorized by the Department of Education, in a community college program provided for in Part 48 of Division 7 of the Education Code, or a postsecondary institution accredited by an accreditation agency recognized by the United States Department of Education or approved by the Bureau for Private Postsecondary and Vocational Education under Sections 94130 or 94311 of the Education Code. A licensed midwife shall serve as advisor to the midwife assistant training program. The instructor in a public school setting shall possess a valid teaching credential issued by the Commission on Teacher Credentialing. The instructor in a private postsecondary institution shall meet the requirements of Sections 94310 and 94311 of the Education Code and any regulations adopted pursuant to those Sections.

(b) The supervising licensed midwife, pursuant to subsection (a)(1) or the instructor pursuant to subsection (a)(2) shall certify in writing the place and date such training was administered, the content and duration of the training, and that the midwife assistant was observed by the supervising licensed midwife, or instructor, to demonstrate competence in the performance of each such task or service, and shall sign and date the certification. More than one task or service may be certified in a single document; separate certifications shall be made for subsequent training in additional tasks or services.

§ 1379.07 Approved Certifying Organizations
(a) An organization that certifies midwife assistants may apply to the division for approval. This application shall include the following information:

(1) Name and address of the applicant;

(2) Applicant's federal employee identification number (FEIN), social security number (SSN), or Individual Taxpayer Identification Number (ITIN);

(3) Name, address and telephone number of a contact person for the applicant;

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(4) Name, address and telephone number of the accrediting organization that accredited the applicant;

(5) Name, address and telephone number of the organization that validated the applicant's certifying examination;

(6) Information sufficient to establish that the certifying organization meets the standards set forth in subsection (b).

(b) For purposes of Section 1379.06, an organization that certifies midwife assistants shall be approved if it meets all of the following standards:

(1) Is a non-profit, tax-exempt organization;

(2) Requires all applicants for certification to successfully complete a psychometrically valid examination that is secure, is occupationally relevant and tests for the skills and procedures outlined in Section 2516.5 of the code;

(3) Has a requirement for certification of a midwife assistant in one or more of the following:

(A) Graduation from a midwife assistant training program accredited by an accreditation agency recognized by the United States Department of Education;

(B) Graduation from a midwife assistant training program in a postsecondary institution accredited by an accreditation agency recognized by the United States Department of Education or an institution approved by the Bureau for Private Postsecondary and Vocational Education;

(C) A minimum of two (2) years of experience as a practicing midwife assistant within five (5) years immediately preceding the date of examination;

(D) Military training or schooling equivalent to that described in subsections (A) or (B) above;

(E) Employment at the time of certification as an instructor in an accredited midwife assistant program or institution.

(4) Requires its certificate holders to obtain a minimum of 60 hours continuing educations related to the practice of midwife assistants over a 5 year period.

§ 1379.08 Report of Changes by Certifying Organization; Review by Board

(a) An approved certifying organization shall notify the Board within thirty (30) days thereafter of any changes related to the standards contained in Section 1379.05.

(b) The Board shall review each approved certifying body at least once every five (5) years for compliance with the standards set forth in Section 1379.05. The Board may, in its discretion, review any certifying organization that has submitted a notice of changes as required by subsection (a).

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§ 1379.09 Permit Processing Times - Approved Certifying Organizations

(a) Within sixty (60) working days of receipt of an application pursuant to Section 1379.07 for an approved certifying organization registration, the Board shall inform the applicant in writing whether it is complete and accepted for filing or that it is deficient and what specific information or documentation is required to complete the application. An application is considered complete if it is in compliance with the requirements of Section 1379.07.

(b) Within 100 calendar days from the date of filing of a completed application, the Board shall inform the applicant in writing of the decision regarding the application for an approved certifying organization registration.

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MIDWIFERY PROGRAM LICENSING STATISTICS

Licensed Midwives	FY 15/16	Q1	Q2	Q3	Q4
Applications Received	8	4	4		
Applications Pending	N/A	1	3		
Applications Withdrawn	0	0	0		
Licenses Issued	12	9	3		
Licenses Renewed	80	37	43		
Licenses Cancelled	1	0	1		

Licensed Midwives	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15
Applications Received	41	31	31	30	45
Application Pending	2	0	2	3	N/A
Applications Withdrawn	0	0	0	0	1
Licenses Issued	40	31	31	28	42
Licenses Renewed	98	123	126	141	153
Licenses Cancelled	3	1	0	2	0

Licensed Midwife License Statuses[1]	
Data as of:	12/31/2015
Renewed / Current	345
Current Inactive	2
Delinquent	47
Cancelled	42
Revoked	4
Surrendered	5
Deceased	5

Licensed Midwife License Statuses[1]					
Data as of:	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015
Renewed / Current	252	270	297	N/A Due to BreEZe Conversion	361
Current Inactive	0	0	0		1
Delinquent	20	28	26		43
Cancelled	26	31	33		39
Revoked	3	3	4		4
Surrendered	4	4	6		6
Deceased	3	3	4		5

[1]Data is a snapshot of all midwife licenses as of the date listed.

MIDWIFERY PROGRAM - ENFORCEMENT STATISTICS

LICENSED MIDWIVES	FY 14/15 Total	FY 15/16 Q1	FY 15/16 Q2	FY 15/16 Q3	FY 15/16 Q4	FY 15/16 Total
Total number of complaints received	10	4	1			5
Total number of complaints closed	9	4	5			9
Total number of complaints referred for investigation	3	0	0			0
Total number of investigations closed	5	1	0			1
Total number of investigations currently open		N/A	3			N/A
Total number of cases referred to the Attorney General (AG)	2	0	0			0
Total number of cases referred for criminal action	0	0	0			0
The number of probation violation reports referred to the AG	0	0	0			0

UNLICENSED MIDWIVES	FY 14/15 Total	FY 15/16 Q1	FY 15/16 Q2	FY 15/16 Q3	FY 15/16 Q4	FY 15/16 Total
Total number of complaints received	4	0	0			0
Total number of complaints closed	3	0	1			1
Total number of complaints referred for investigation	0	0	0			0
Total number of investigations closed	0	0	1			1
Total number of investigations currently open	0	N/A	0			N/A
Total number of cases referred to the Attorney General (AG)	0	0	0			0
Total number of cases referred for criminal action	0	0	0			0
The number of probation violation reports referred to the AG	0	0	0			0

LICENSED AND UNLICENSED MIDWIVES	FY 14/15 Total	FY 15/16 Q1	FY 15/16 Q2	FY 15/16 Q3	FY 15/16 Q4	FY 15/16 Total
Hospital Reporting Forms Received	137	33	29			62