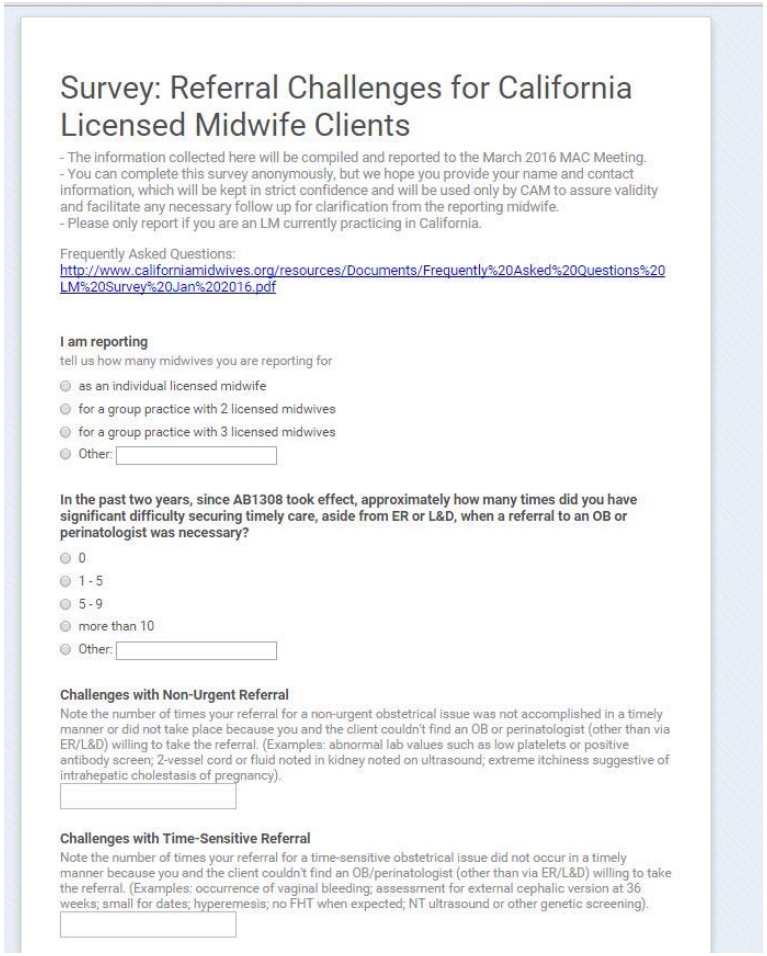
A Survey: Challenges of LM Referrals to Physicians

"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).

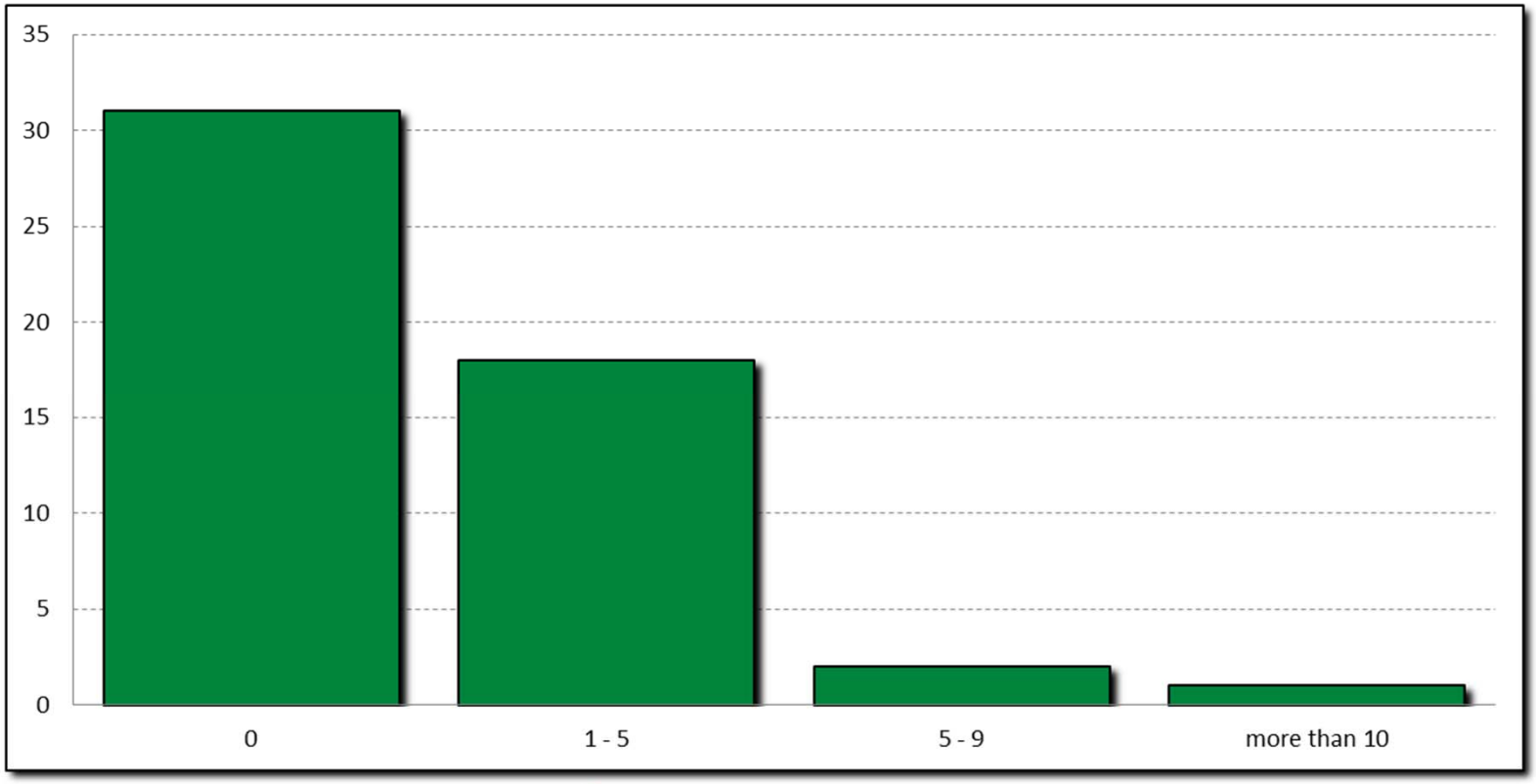
Challenges with Time-Sensitive Referral

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).

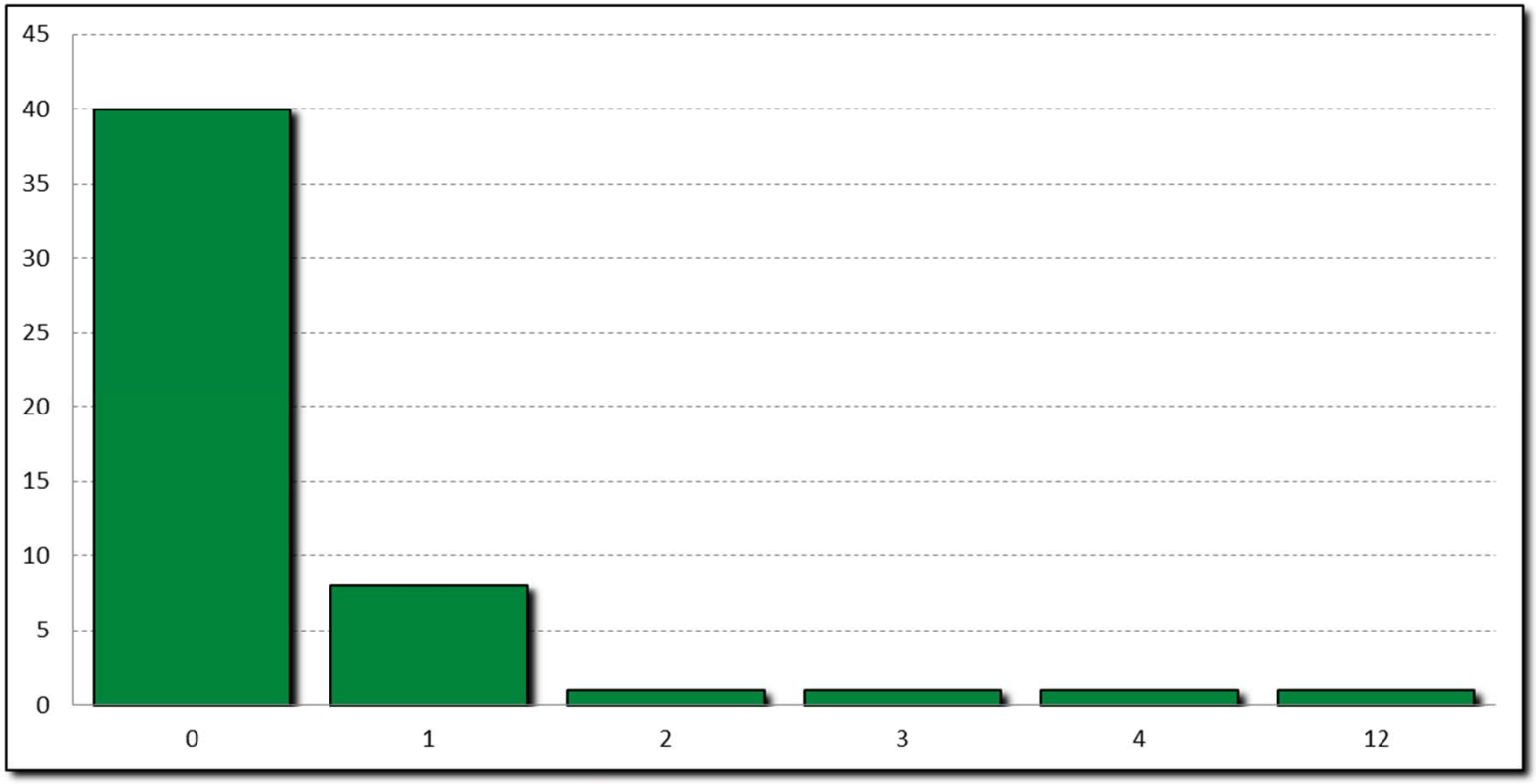
Participation

- 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

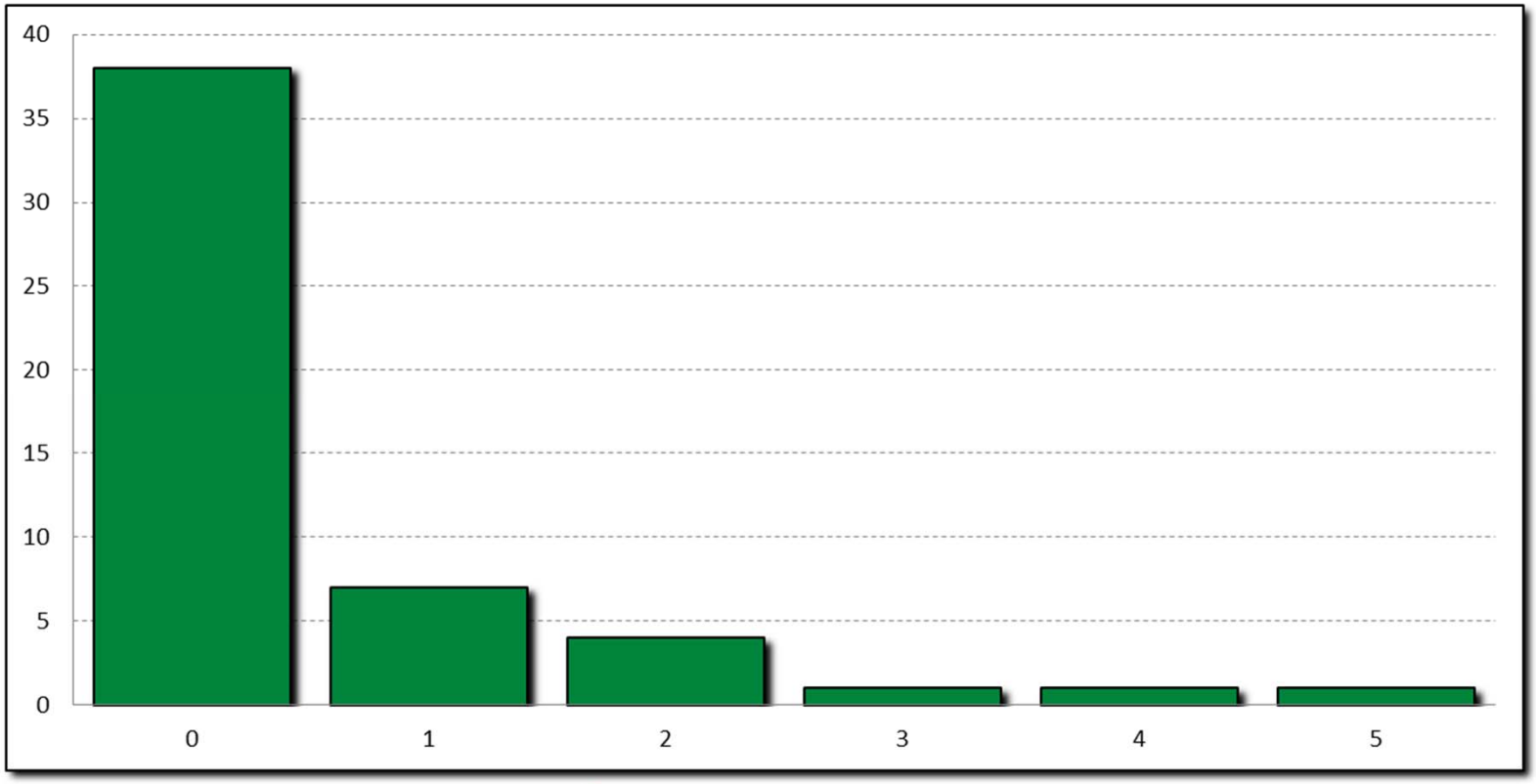
In the past 2 years, approximately how many times did you have significant difficulty securing timely care for clients?



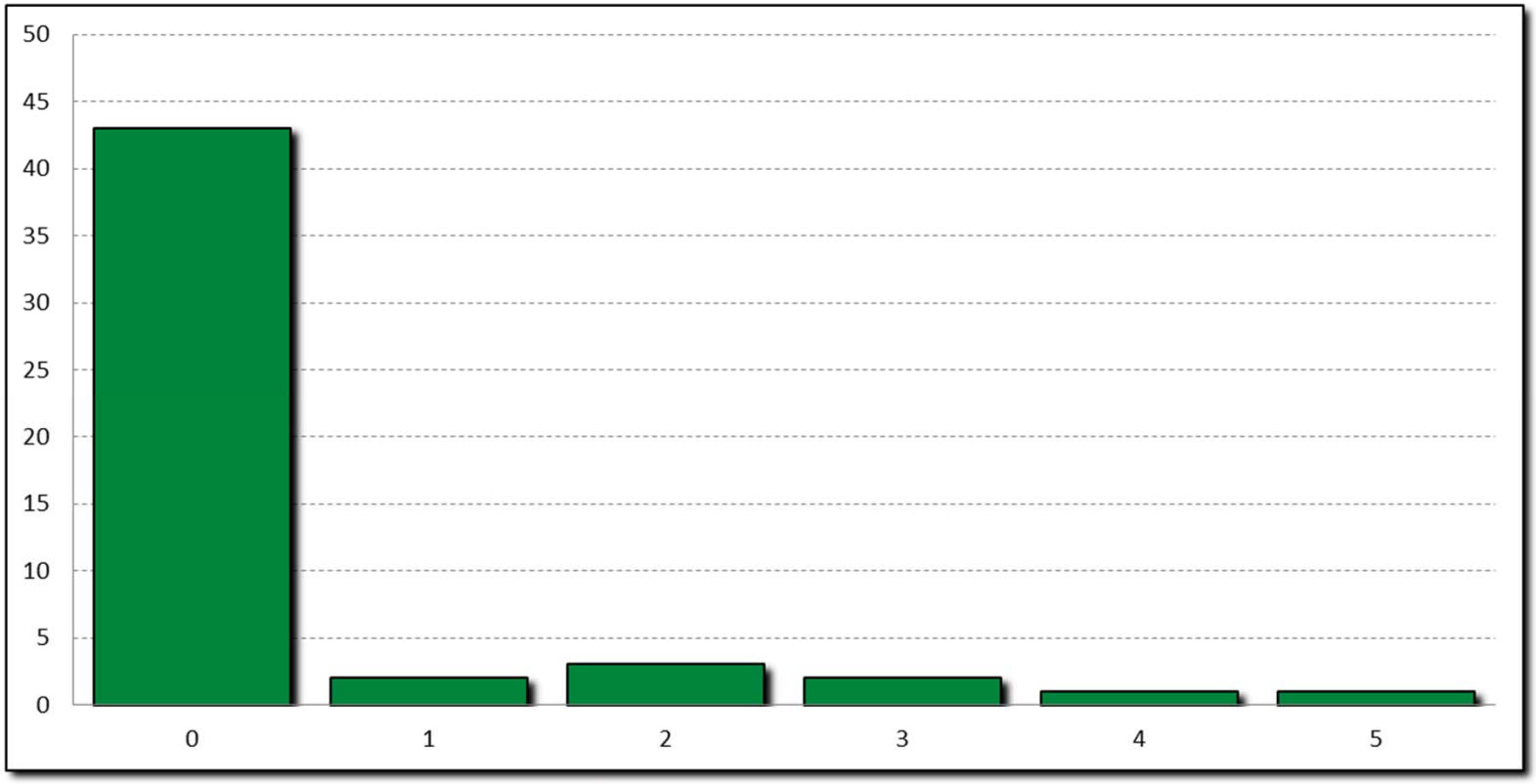
Note the number of times your referral for a non-urgent obstetrical issue was **not accomplished in a timely manner** or did not take place because you and the client couldn't find an OB or perinatologist (other than via ER/L&D) willing to take the referral. (Examples: abnormal lab values such as low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



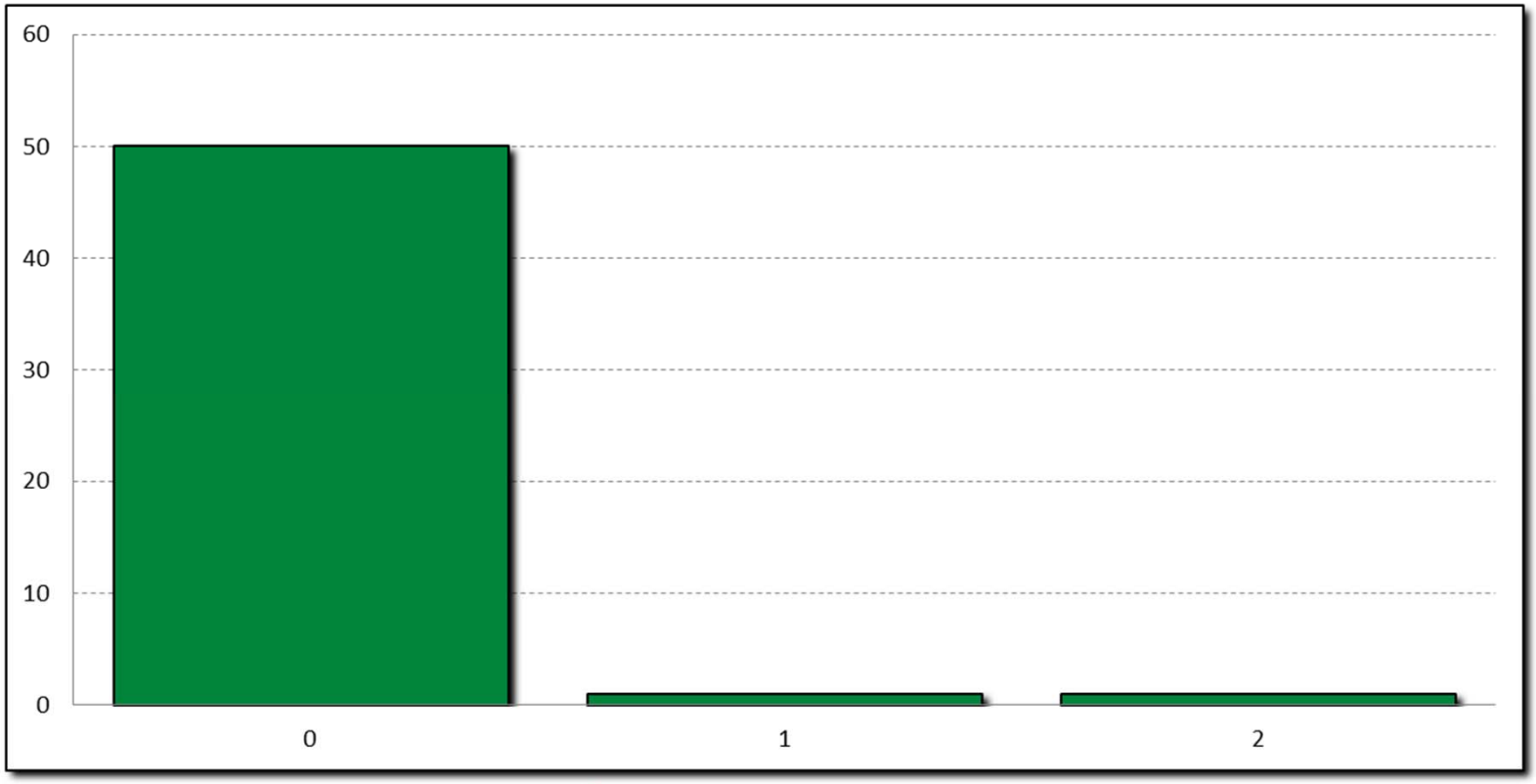
Note the number of times your referral for **a time-sensitive obstetrical issue** did not occur in a timely manner because **you and the client couldn't find an OB/perinatologist (other than via ER/L&D) willing to take the referral**. (Examples: occurrence of vaginal bleeding; assessment for external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



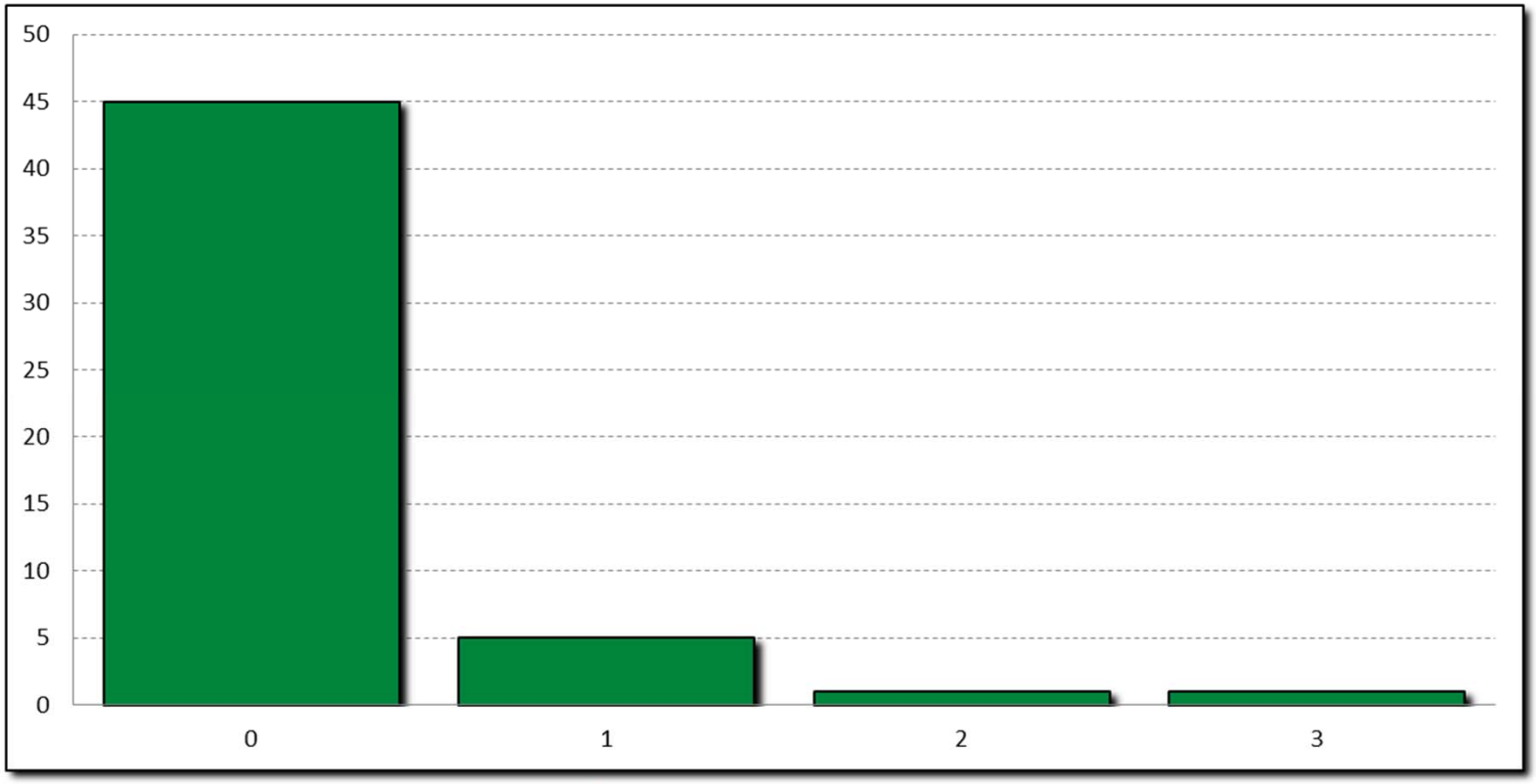
Note the number of times you had **difficulty securing transfer of care for a client who reached 42 weeks**. (Examples: only option was ER or L&D but she was not in labor and only option given was induction, despite normal AFI and NST, and client wanted to wait; and/or elective induction didn't work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



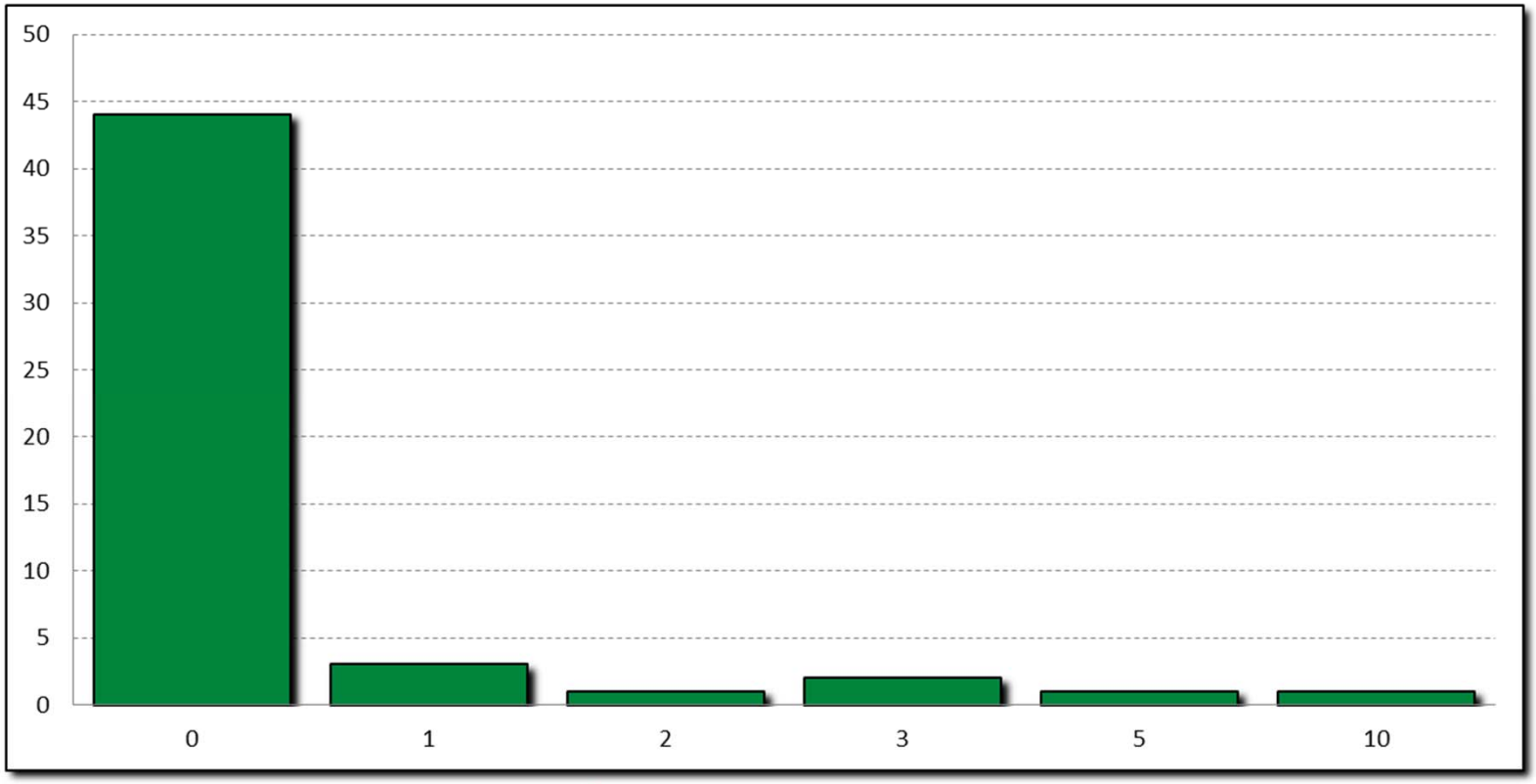
Note the number of times you had a problem securing appropriate care for a client who had **abnormal prenatal screening results**. (Example: prenatal diagnostics service would not take your referral and therefore there was significant delay in getting an OB to take on her care and get in to see a perinatologist)



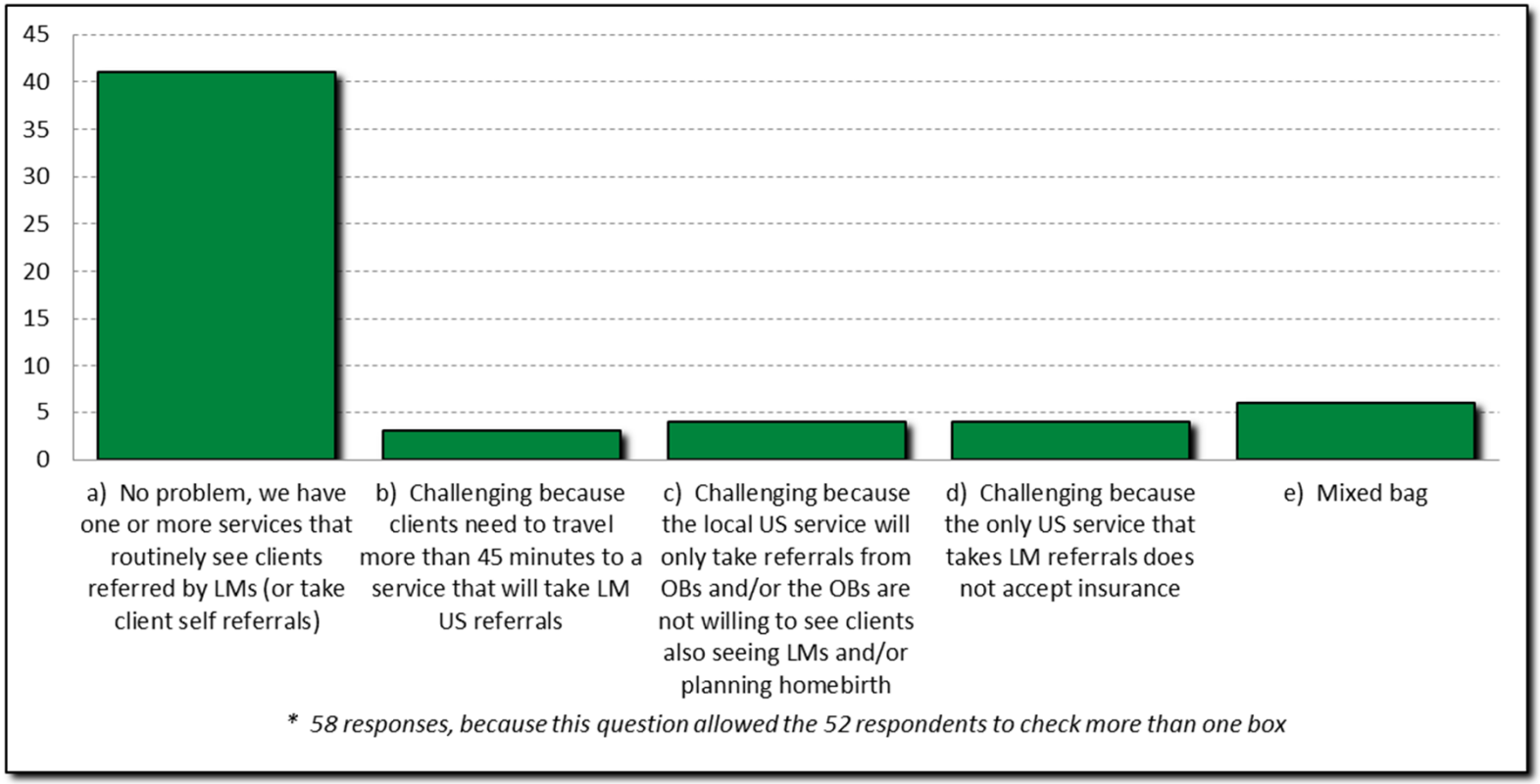
Note the number of times your referral was refused for routine anatomy ultrasound, NT ultrasound and/or biophysical ultrasound.



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**.



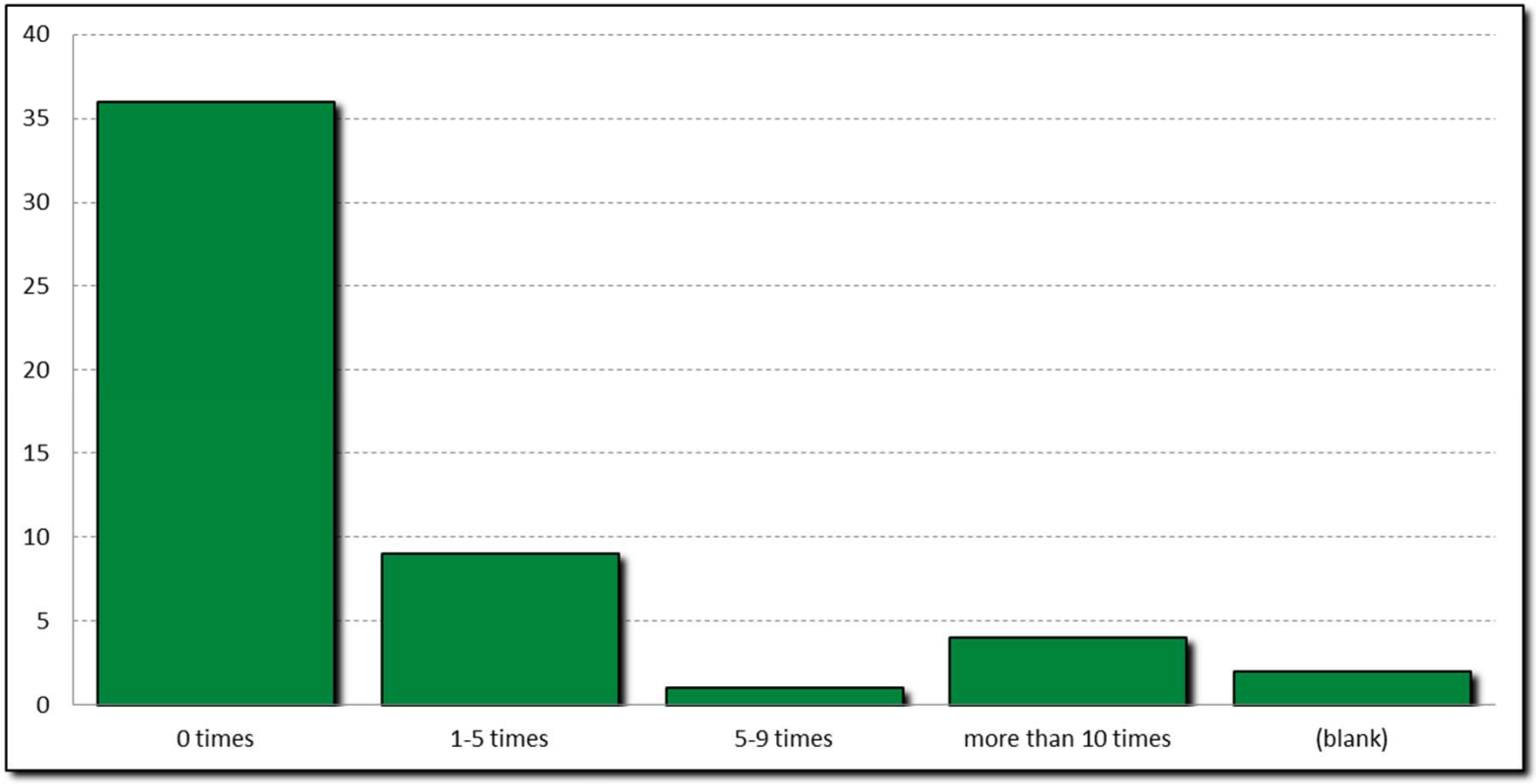
What is the availability in your community for LMs to refer clients for ultrasound?



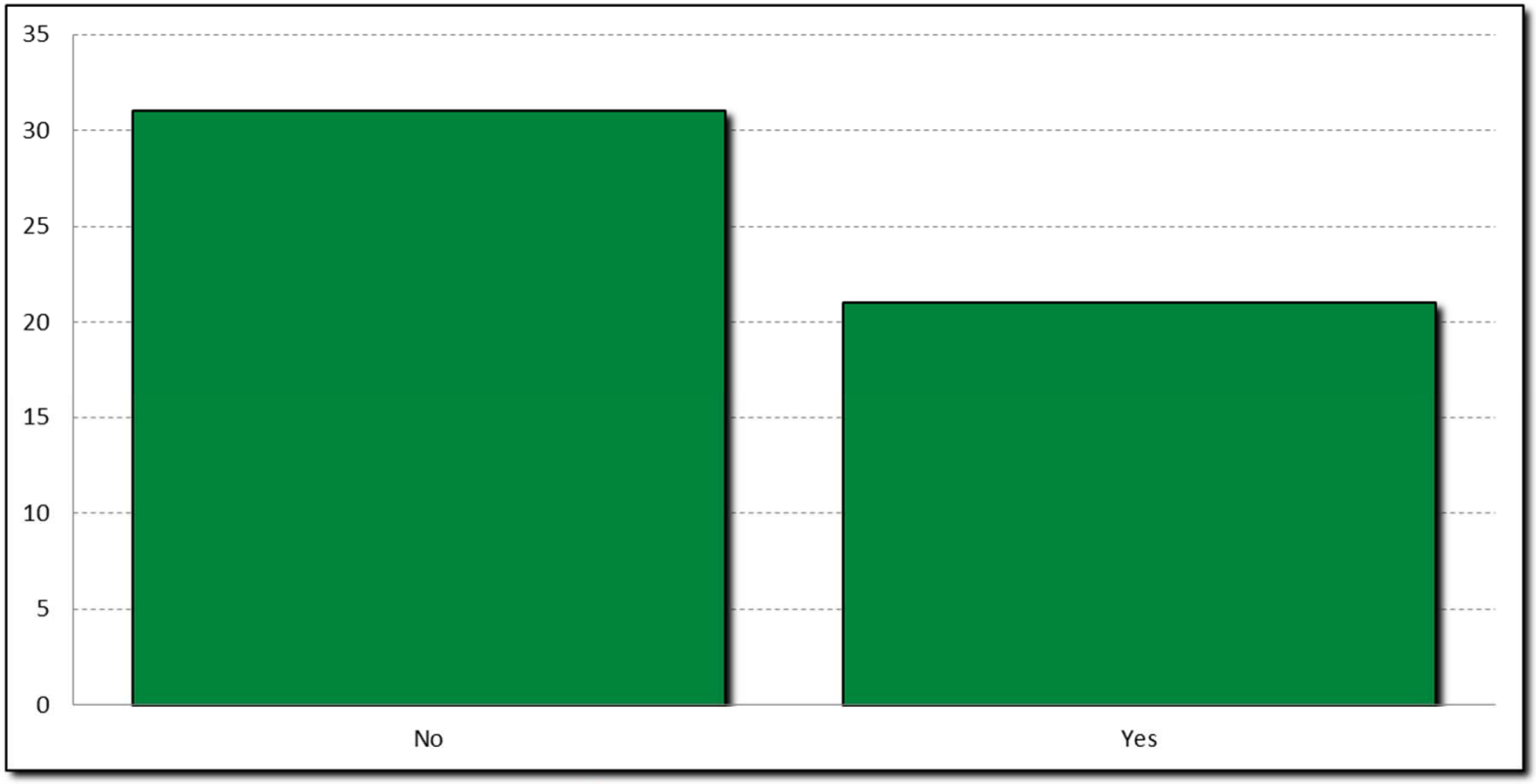
Other referral challenge(s) you would like to report

- 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.

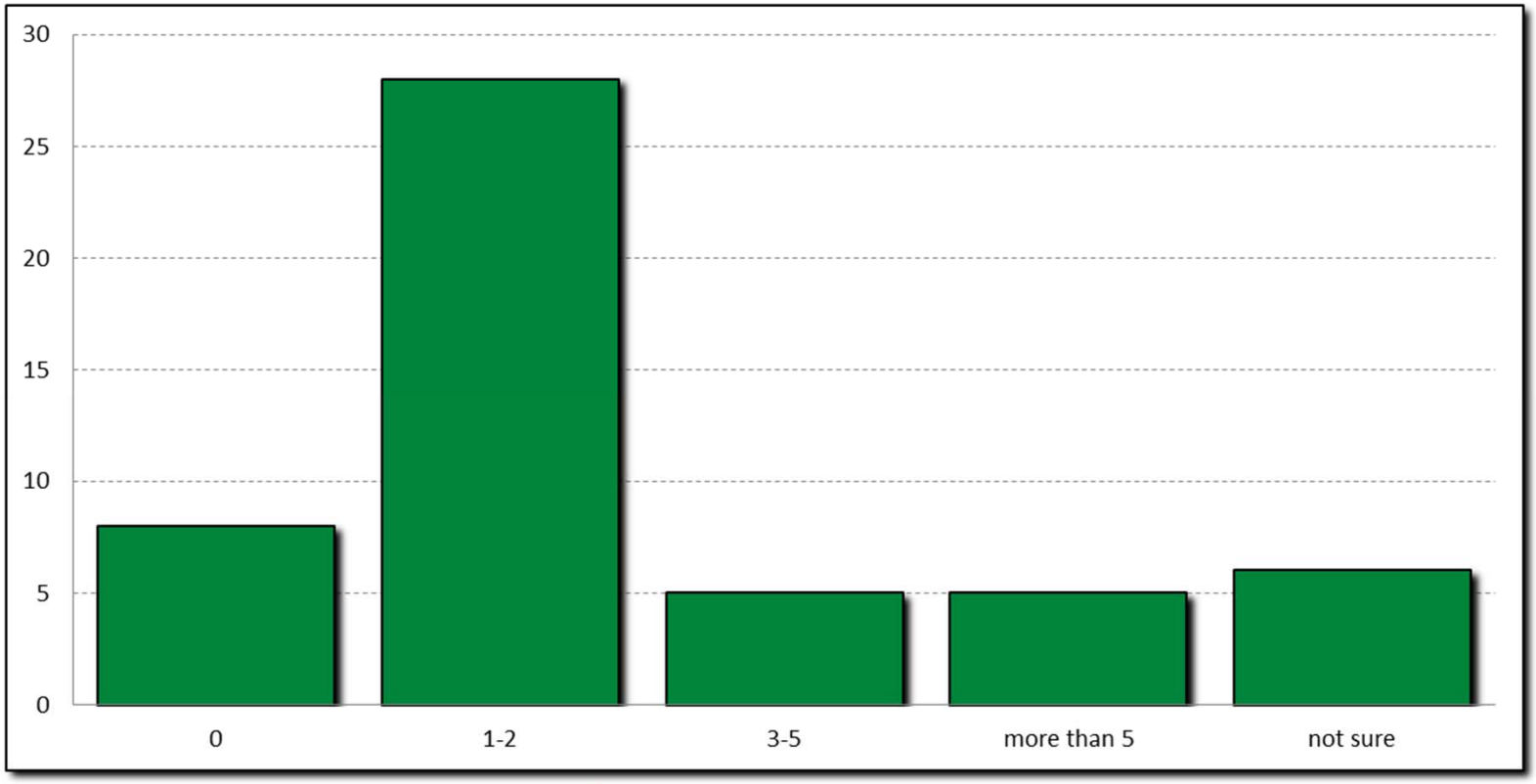
How many times in the past two years did you use alternate methods/locations outside your community to secure needed or desired care because you already knew the client couldn't access care in your community?



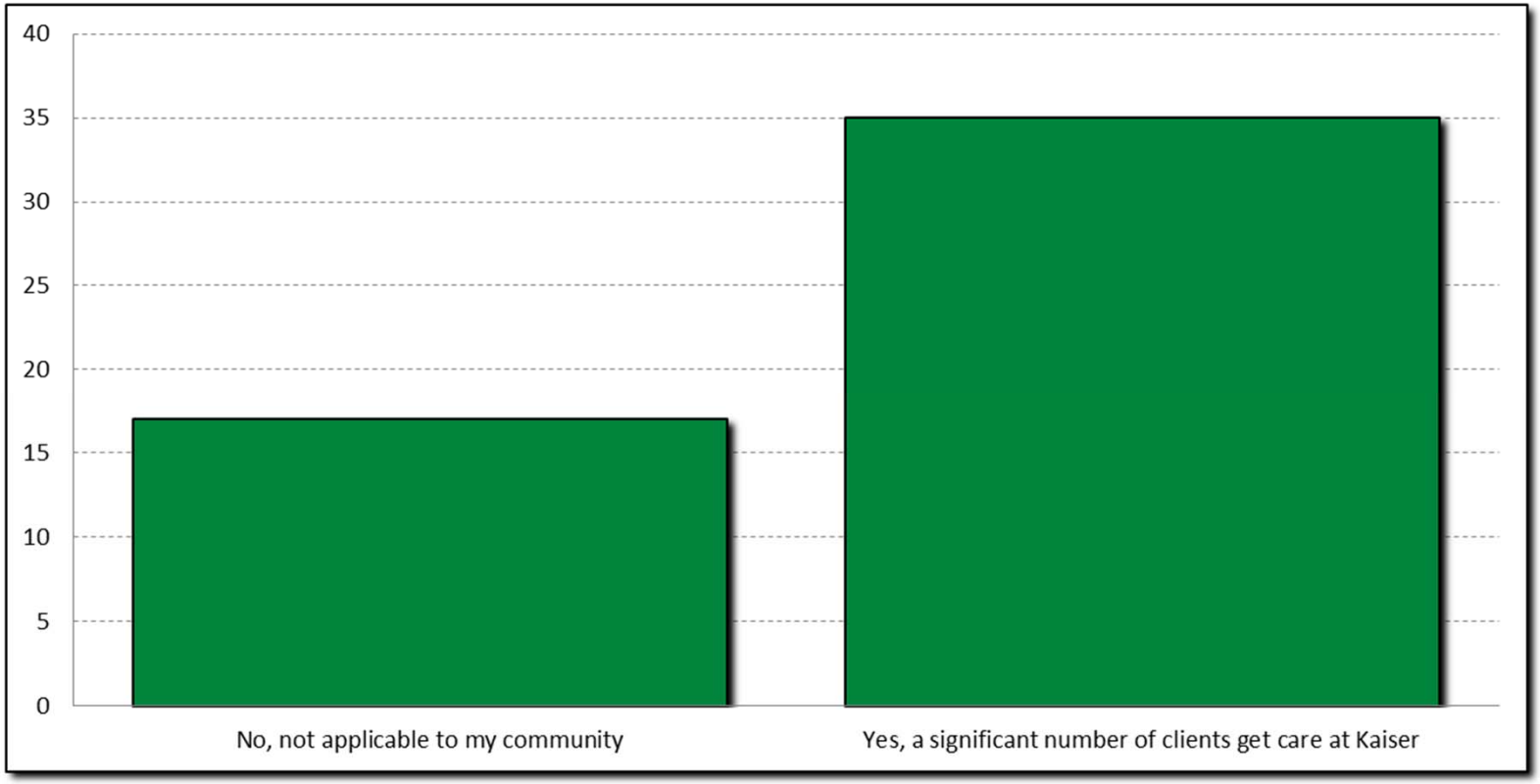
Is it relatively simple in your community to have clients see an OB if the OB knows that the client is planning a homebirth and receiving care with an LM?



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

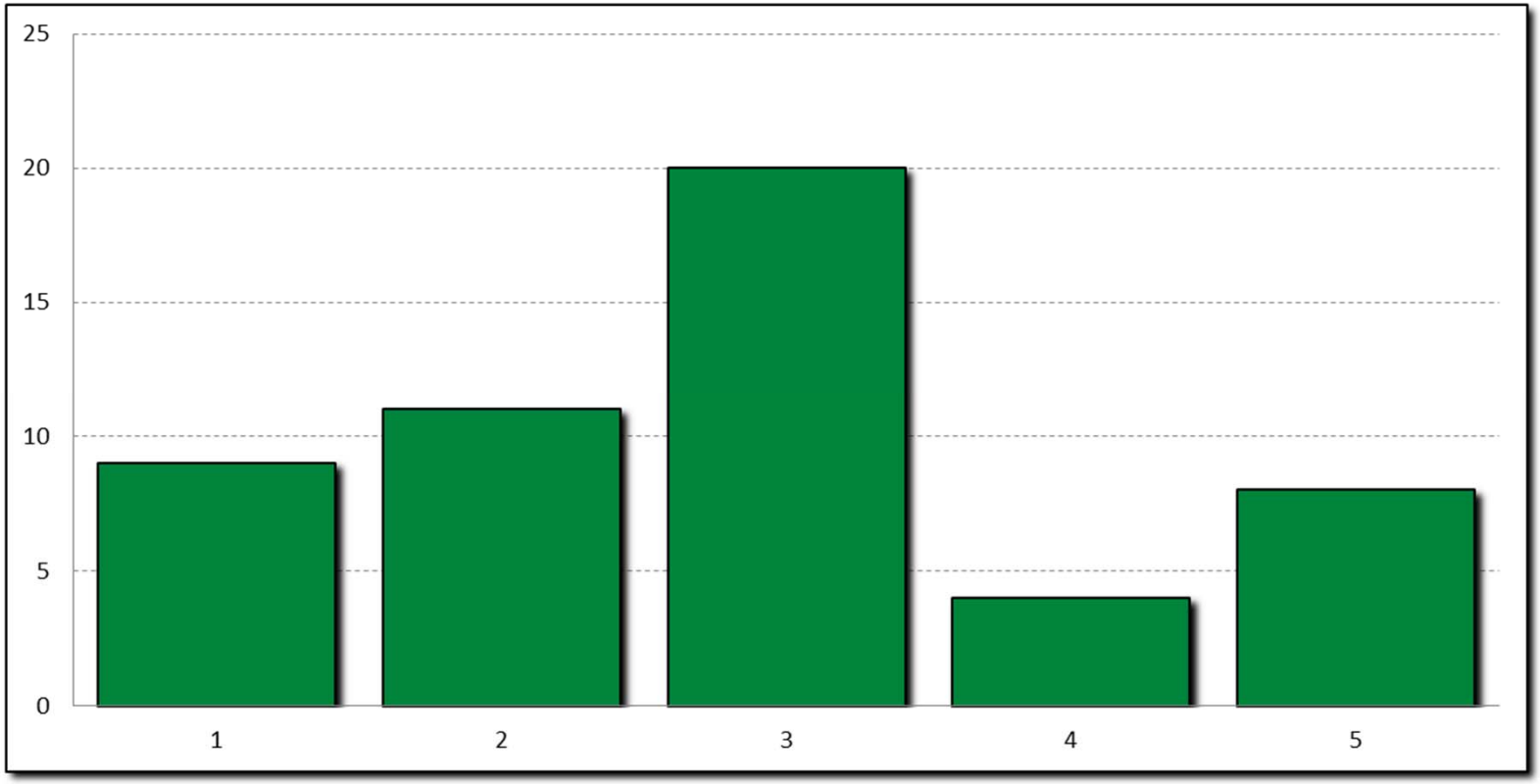


Does having Kaiser in your area take care of many of the referral problems?



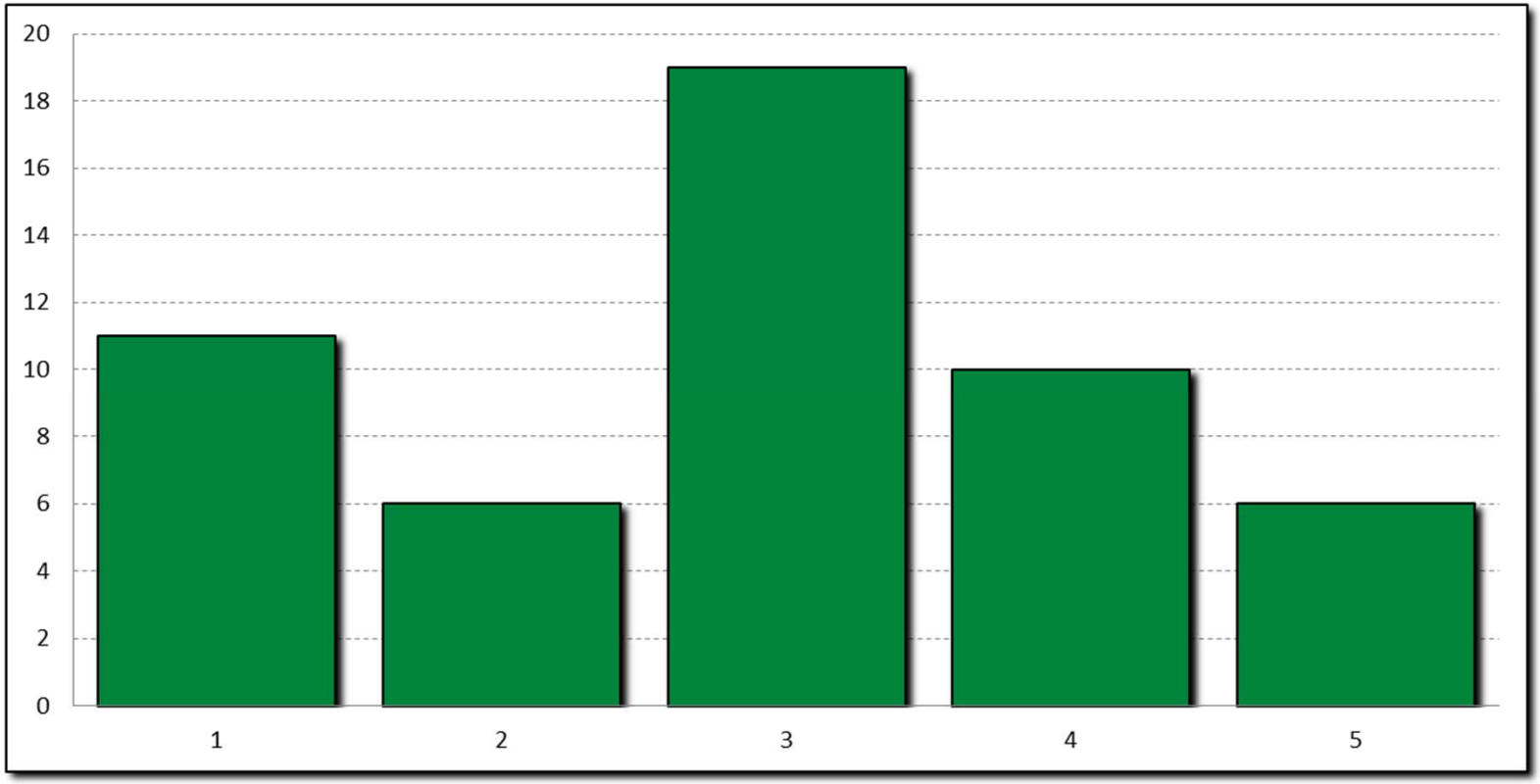
Is it ever a problem that OBs are {uncooperative} (i.e. rude or disrespectful to the client, and/or make undermining remarks about clients choices to see midwife and/or plan homebirth).

1 = major problem, 5 = not a problem



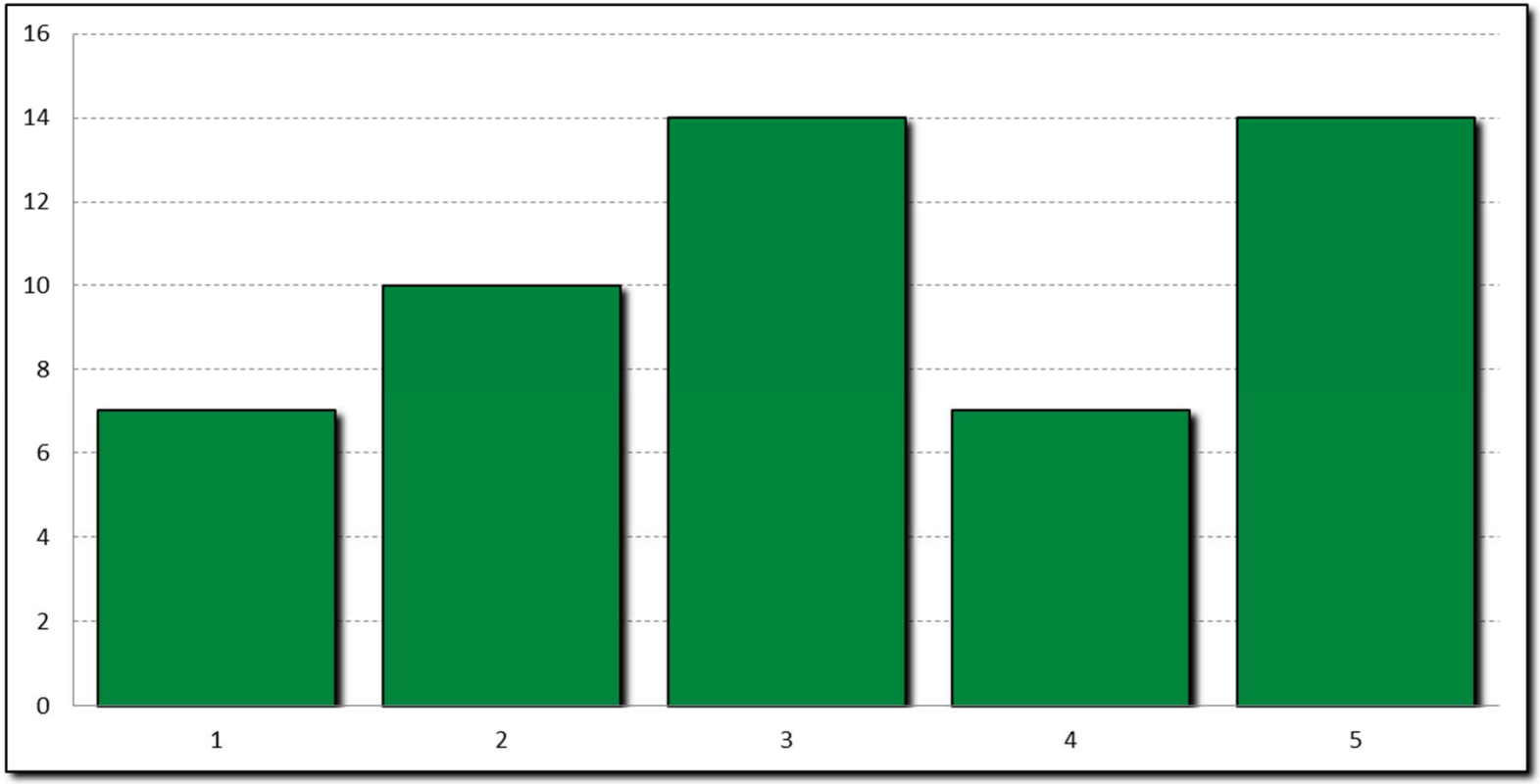
I am unable to secure OB referrals for non-urgent issues (aside from ER care).

1 = major problem, 5 = not a problem



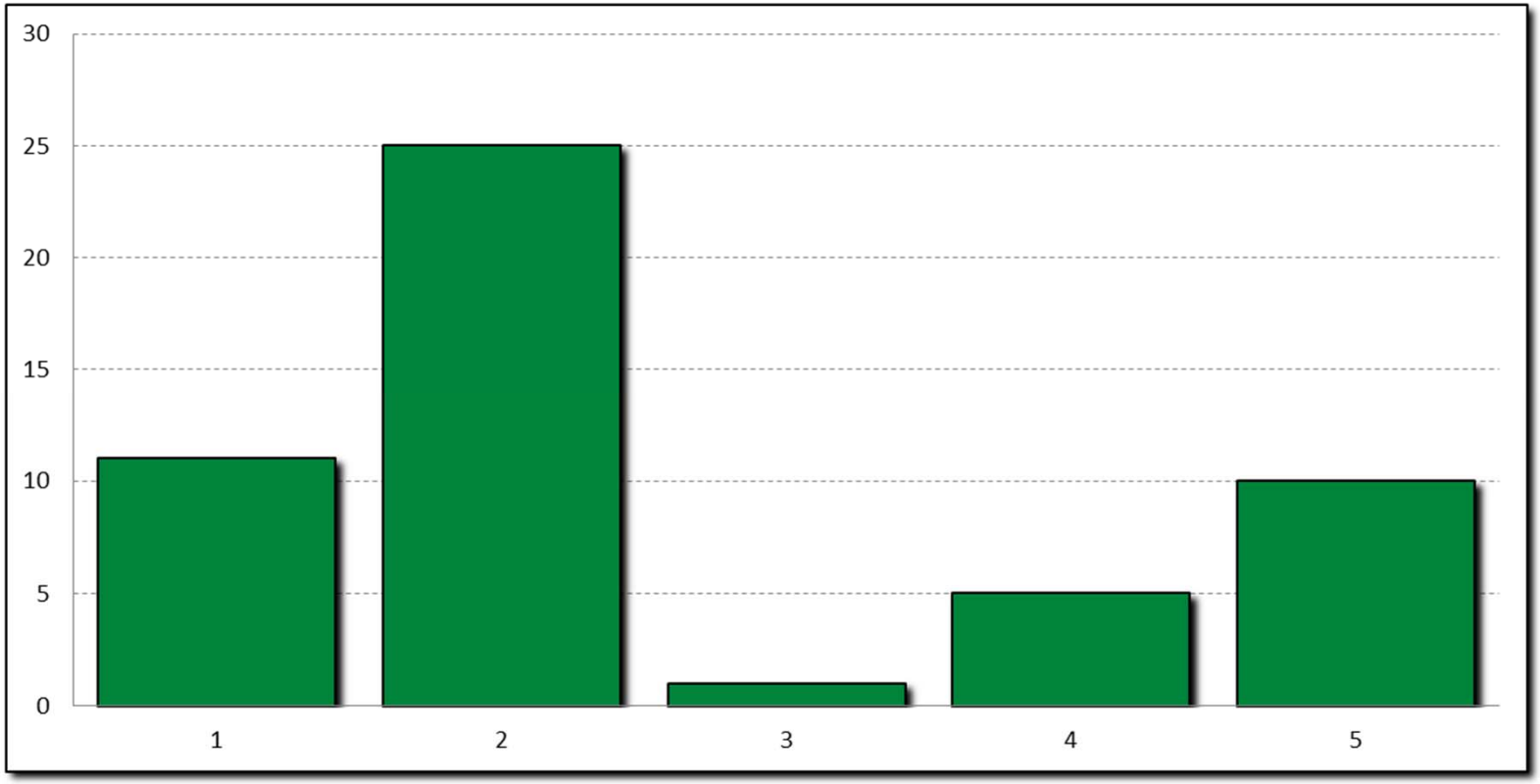
My clients incur added expense due to the way LMs need to secure care for non-urgent issues (i.e., ER visits).

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).

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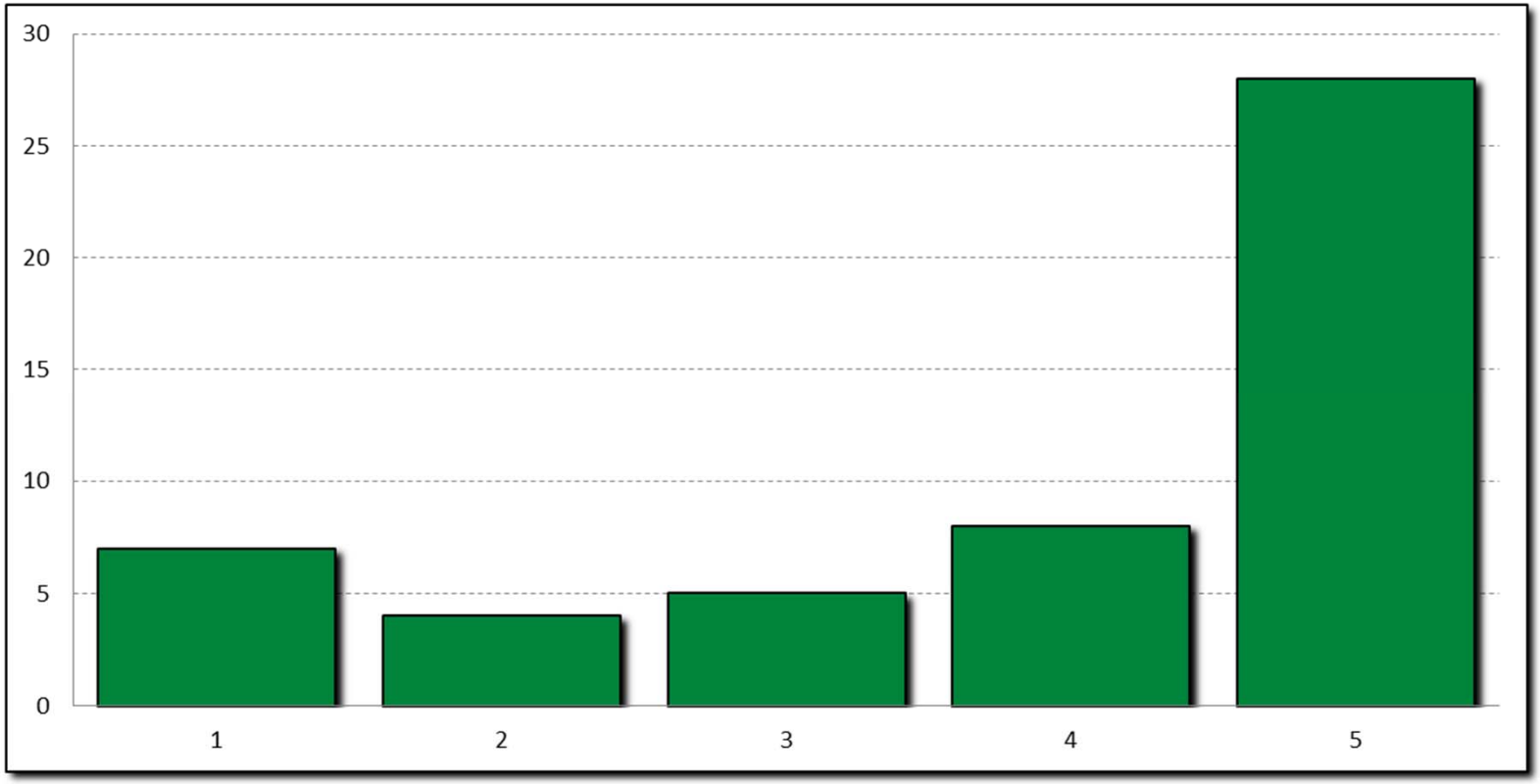
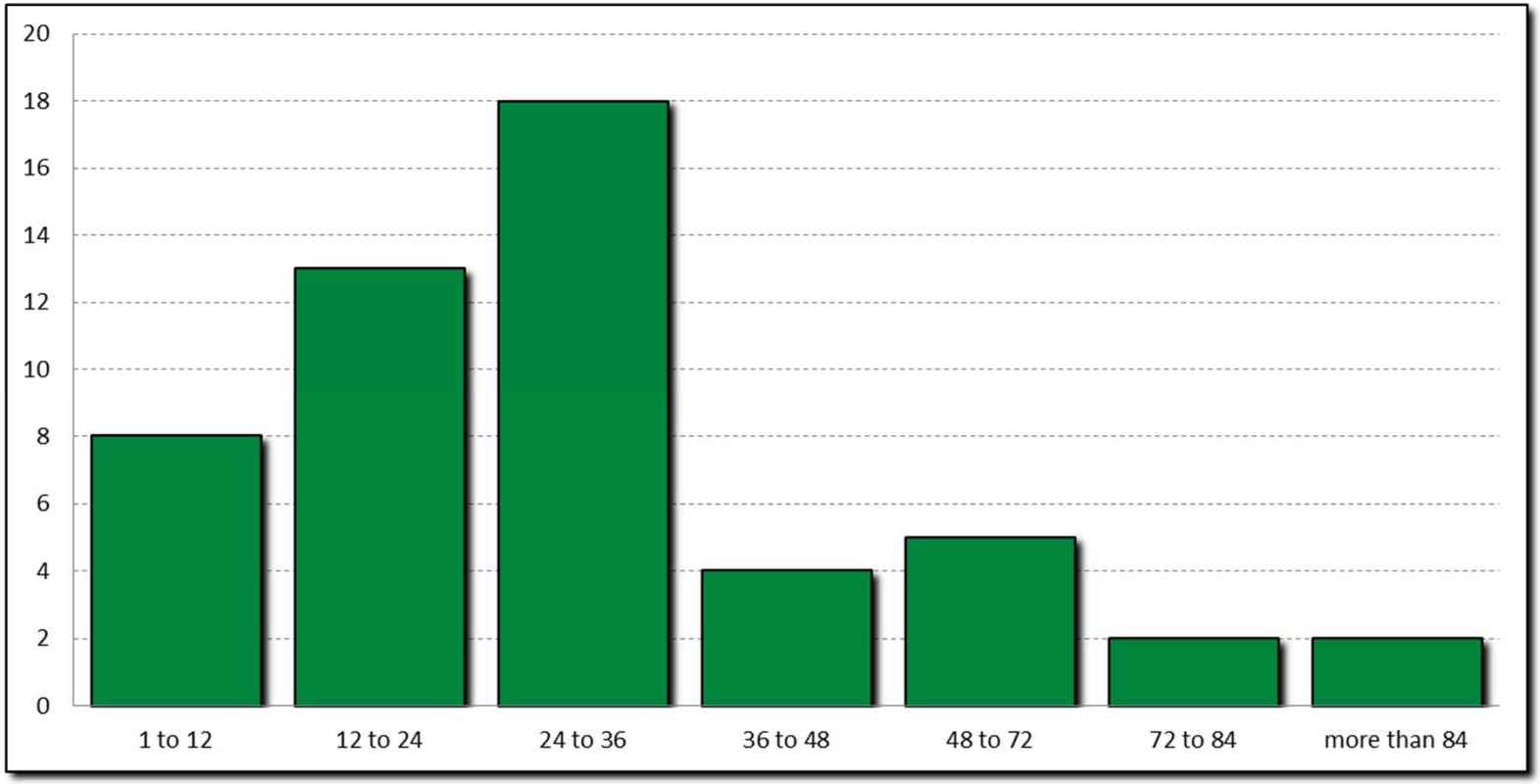
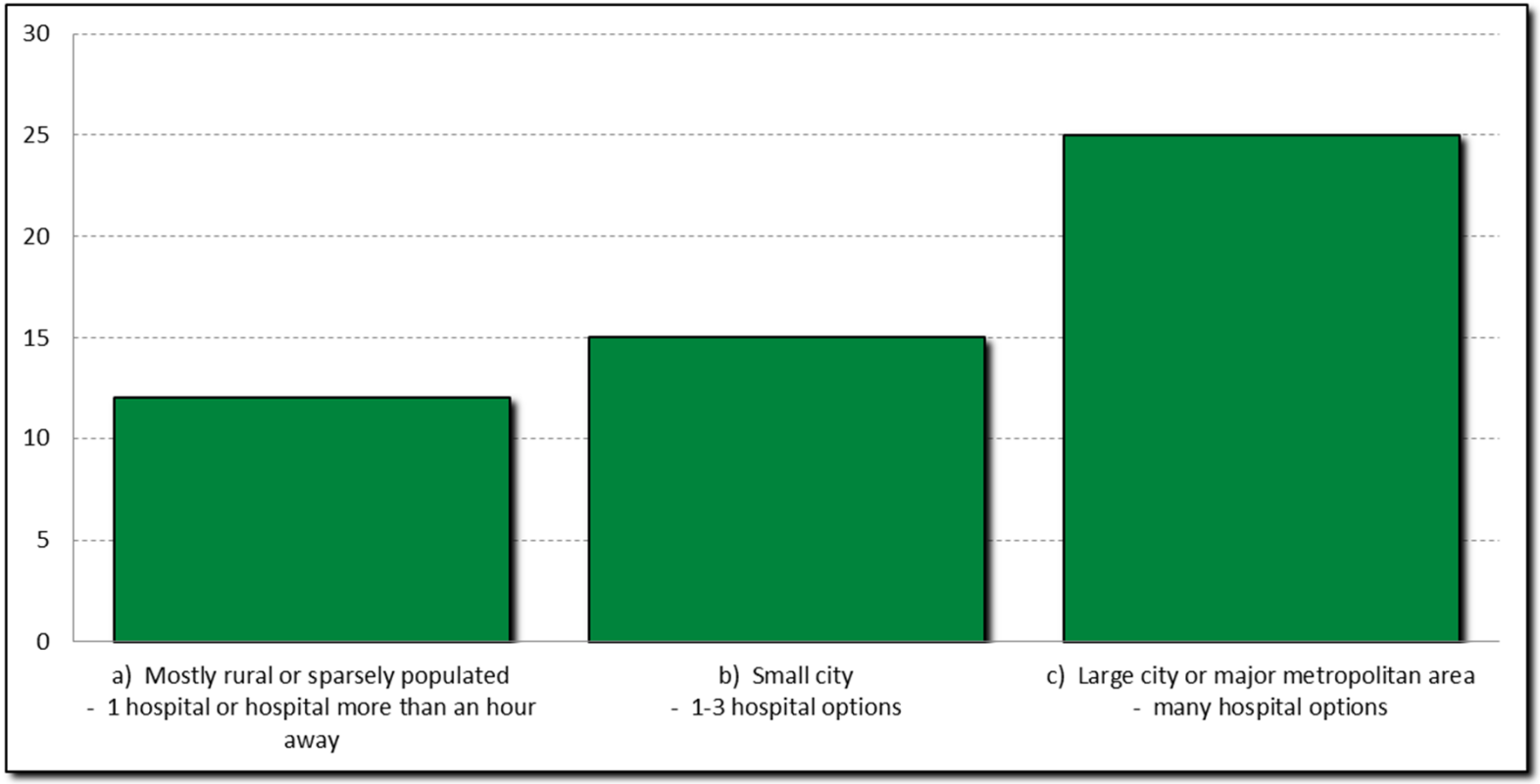


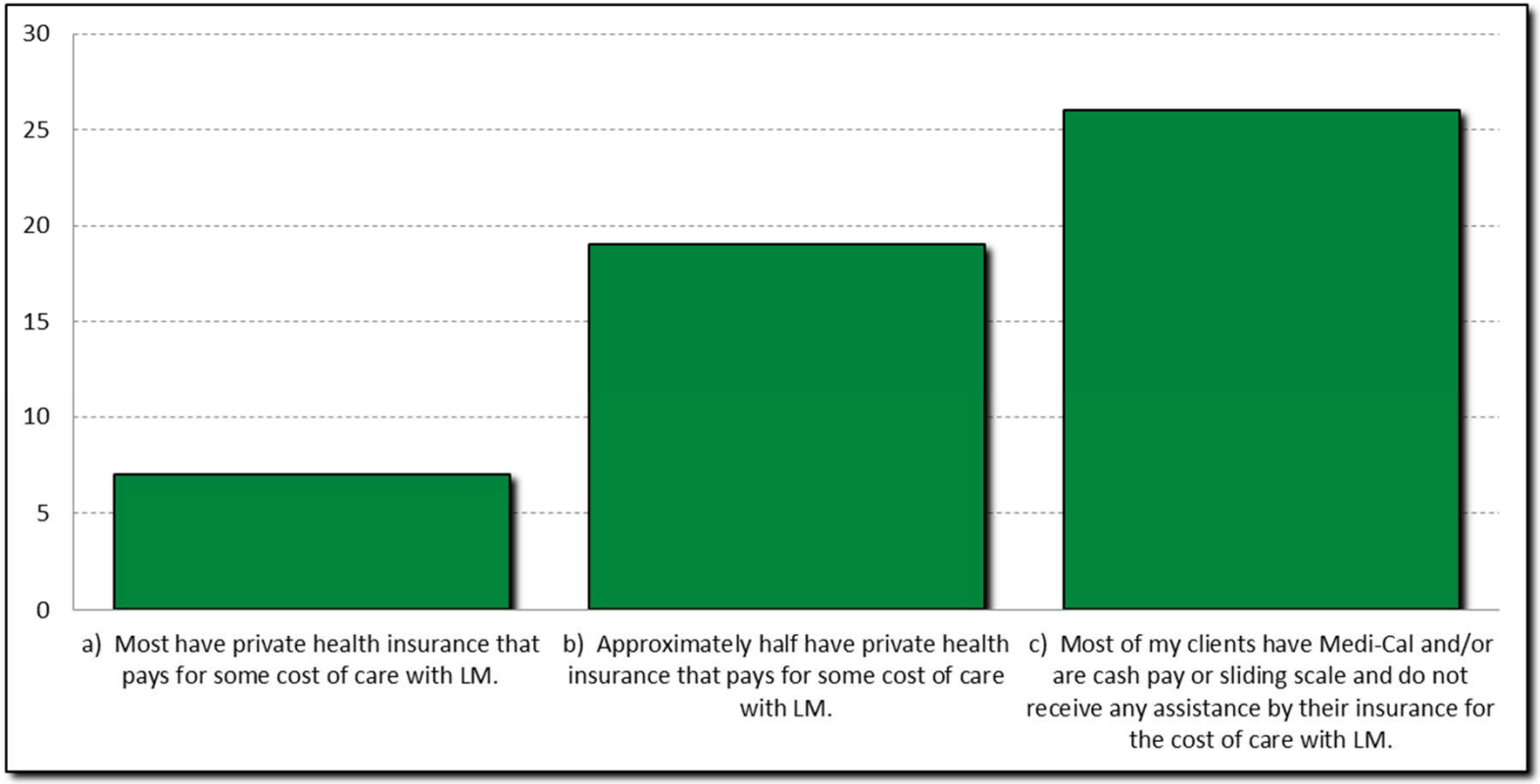
How many total primary clients delivered under your care (or your group practice) in 2014 and 2015?



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

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 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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"Include a detailed narrative of referral challenge":

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.

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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.

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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.

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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.