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Understanding the Practice of Midwifery Care in Sacramento

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Appendix A – Survey Findings

Presented are the survey findings for the 27 respondents who indicated that they are currently practicing midwifery in Sacramento and the surrounding counties. The survey included 10 closed-ended questions and 3 open-ended questions. Closed-ended survey questions examined characteristics of midwives and clients, midwifery services provided, setting of midwifery practice, and reimbursement of midwifery services. Open-ended questions examined successes, challenges, and areas of improvement for midwifery services in the Sacramento area, particularly for underserved individuals. All percentages displayed are calculated from non-missing responses. Data with small numbers have not been included for confidentiality reasons.

1. CLOSED-ENDED QUESTIONS

1.1 Characteristics of respondents

Demographic characteristics of respondents

The age of respondents ranged from 28 to 72 years (average of 49.8 years). The largest age group was 45-54 years (Table 1). Almost all respondents identified as being women. Seventy-seven percent of respondents identified as being white and the remaining respondents identified as being another race, including white and other race, Asian, and Black or African American.

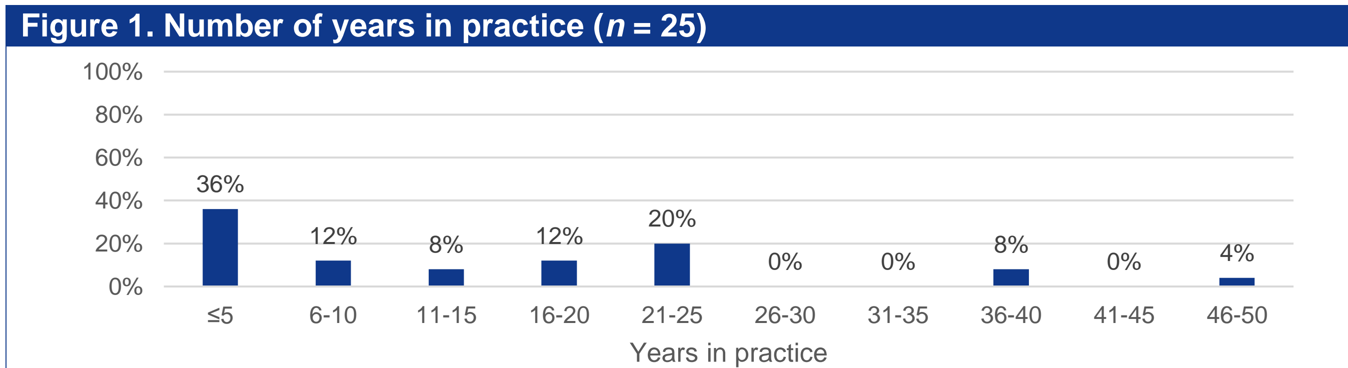
Table 1. Demographic characteristics of respondents (n = 27)	
Demographic characteristics	Number (%)
Age (years)	
Under 35	4 (15%)
35-44	5 (19%)
45-54	8 (31%)
55-64	5 (19%)
65 and older	4 (15%)
Missing	1
Gender identity	
Woman	24
Other[a]	-
Missing	-
Race/ethnicity	
White	20 (77%)
Other[b]	6 (23%)
Missing	1

[a] Other gender identity includes trans.
[b] Other race/ethnicity includes white and other race, Asian, and Black or African American.
Note: - indicates that the number was small and was not included for confidentiality reasons.

Professional characteristics of respondents

Almost half (48%) of respondents have been in practice for 10 years or less (Figure 1).

Figure 1. Number of years in practice (n = 25)



1.2 Characteristics of midwifery clients

Figure 2. Estimated racial, ethnic, and gender identity distribution of clients (*n* = 27)

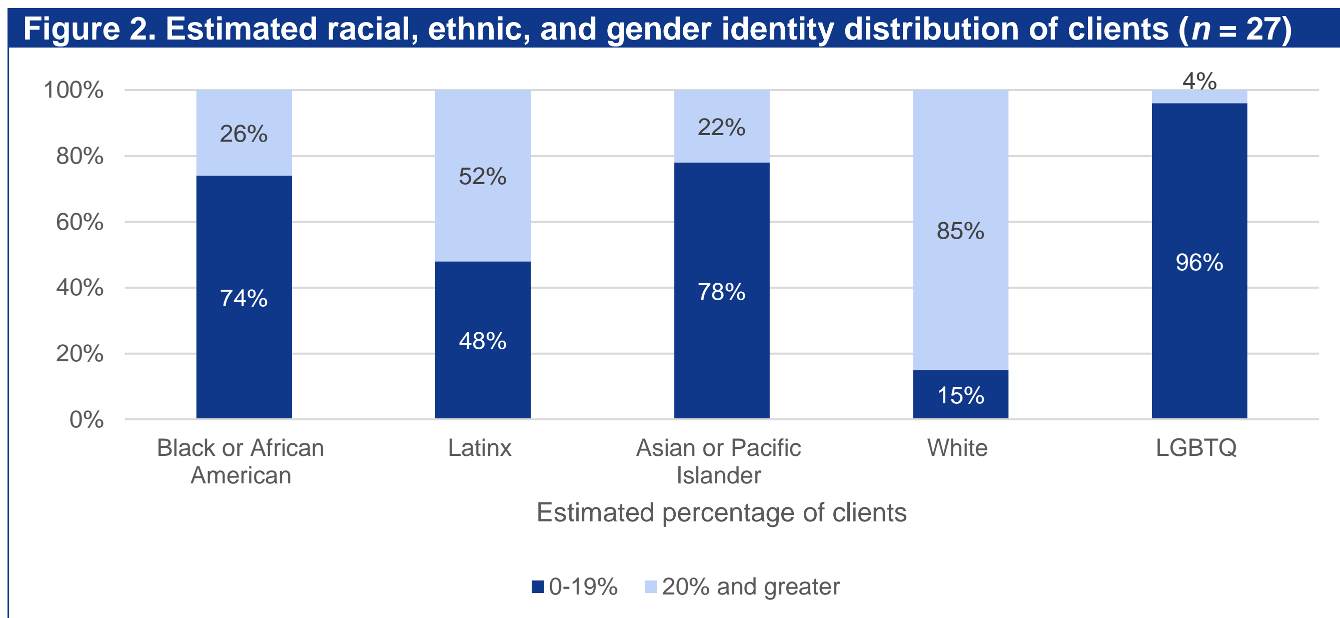


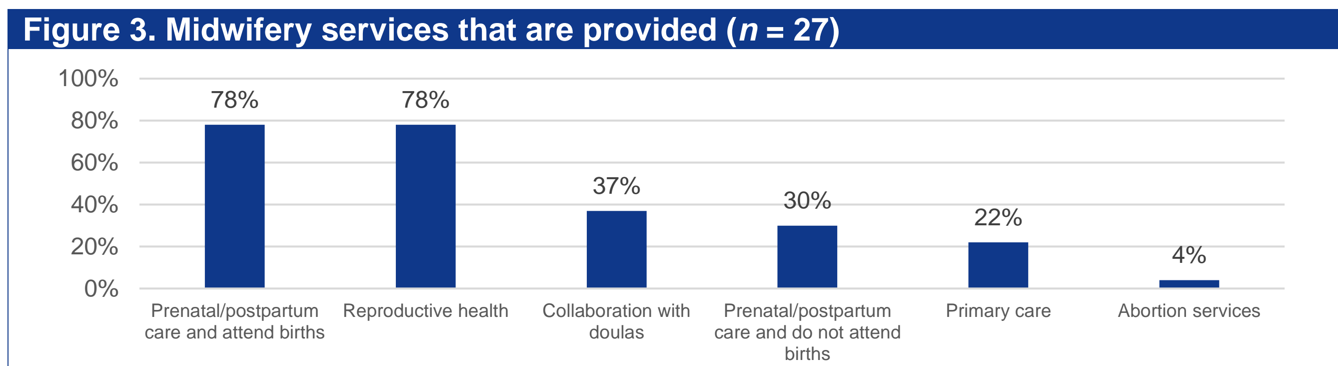
Table 2. Estimated racial and ethnic distribution of clients (*n* = 27)

Estimated percentage	Black or African American Number (%)	Latinx Number (%)	Asian or Pacific Islander Number (%)	White Number (%)
0-9%	12 (44%)	3 (11%)	14 (52%)	3 (11%)
10-19%	8 (30%)	10 (37%)	7 (26%)	1 (4%)
20-29%	5 (19%)	2 (7%)	4 (15%)	4 (15%)
30-39%	1 (4%)	3 (11%)	2 (7%)	4 (15%)
40-49%	1 (4%)	2 (7%)	0	1 (4%)
50-59%	0	2 (7%)	0	2 (7%)
60-69%	0	2 (7%)	0	4 (15%)
70% and greater	0	3 (11%)	0	8 (30%)

1.3 Midwifery services provided

The most common midwifery services provided are prenatal/postpartum care and attend births (78%), reproductive health (78%), collaboration with doulas (37%), and prenatal/postpartum care and do not attend births (30%) (Figure 3).

Figure 3. Midwifery services that are provided (*n* = 27)



Note: Respondents could choose all services that apply. Reproductive health includes family planning, STI, and well women services regardless of age.

The most common combination of midwifery services provided are prenatal/postpartum care and attend births and reproductive health (26%), prenatal/postpartum care and attend births, reproductive health, collaboration with doulas, and primary care (11%), prenatal/postpartum care and attend births and collaboration with doulas (11%), and prenatal/postpartum care and do not attend births, and reproductive health (11%) (Table 3).

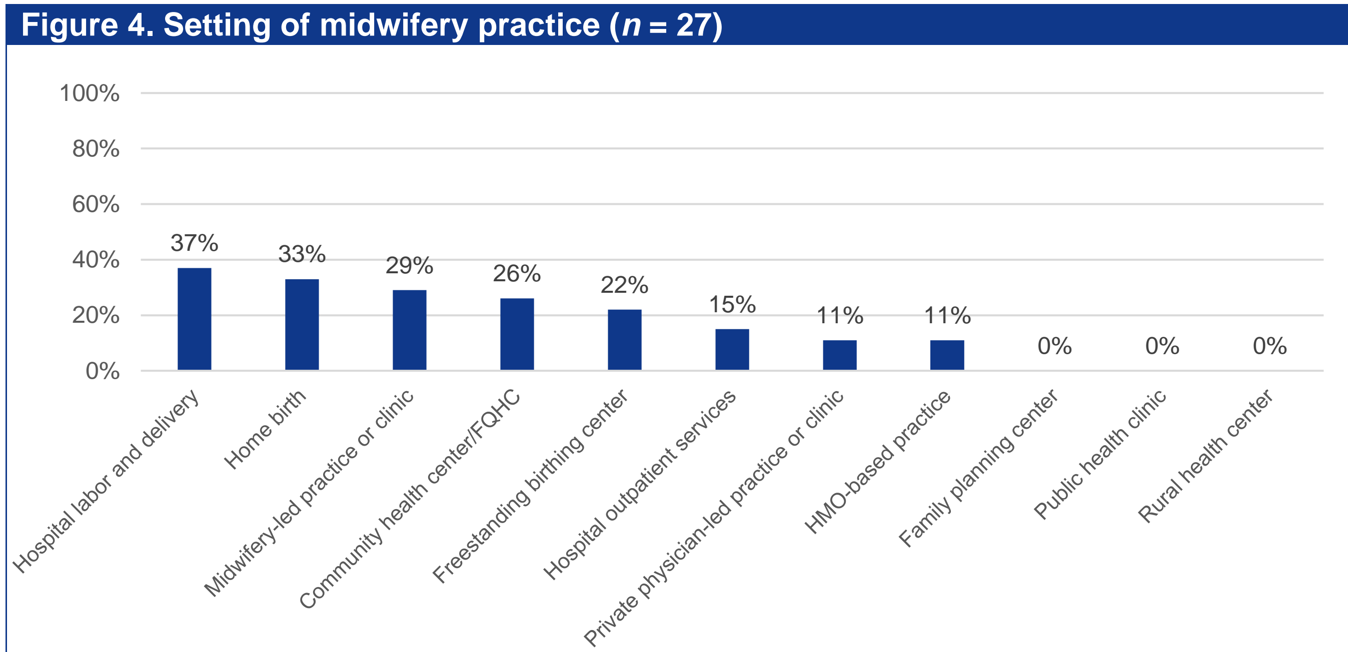
Table 3. Combination of midwifery services that are provided (*n* = 27)

Combination of services	Number (%)
Prenatal/postpartum care and attend births and reproductive health	7 (26%)
Prenatal/postpartum care and attend births, reproductive health, collaboration with doulas, and primary care	3 (11%)
Prenatal/postpartum care and attend births and collaboration with doulas	3 (11%)
Prenatal/postpartum care and do not attend births and reproductive health	3 (11%)
Prenatal/postpartum care and attend births, reproductive health, and collaboration with doulas	2 (7%)
Prenatal/postpartum care and attend births, reproductive health, and prenatal/postpartum care and do not attend births	2 (7%)
Prenatal/postpartum care and attend births, reproductive health, collaboration with doulas, primary care, and abortion services	1 (4%)
Prenatal/postpartum care and attend births, reproductive health, collaboration with doulas, and prenatal/postpartum care and do not attend births	1 (4%)
Prenatal/postpartum care and attend births and primary care	1 (4%)
Prenatal/postpartum care and do not attend births, reproductive health, and primary care	1 (4%)
Prenatal/postpartum care and attend births	1 (4%)
Reproductive health	1 (4%)
Prenatal/postpartum care and do not attend births	1 (4%)

1.4 Setting of midwifery practice

The most common setting for midwifery practice was labor and delivery within a hospital (37%), followed by home birth (33%), midwifery-led practice or clinic (29%), community health center/Federally Qualified Health Center (29%), and freestanding birthing center (22%) (Figure 4).

Figure 4. Setting of midwifery practice (*n* = 27)



Note: Respondents could choose all settings that apply.
Abbreviations: FQHC = Federally Qualified Health Center, HMO = health maintenance organization.

The most common combination of settings for midwifery practice were labor and delivery within a hospital and other setting (33%), midwifery-led practice and other setting (22%), community health center/Federally Qualified Health Center (15%), and birth center and home birth (7%) (Table 4).

Table 4. Combination of settings of midwifery practice (*n* = 27)

Combination of settings	Number (%)
Hospital labor and delivery and other setting	9 (33%)
Midwifery-led practice or clinic and other setting	6 (22%)
Community health center/FQHC	4 (15%)
Birthing center and home birth	2 (7%)
Hospital labor and delivery	1 (4%)
Hospital outpatient services	1 (4%)
HMO-based practice	1 (4%)
Private physician-led practice or clinic	1 (4%)
Birthing center	1 (4%)
Home birth	1 (4%)
Midwifery-led practice or clinic	0

Setting and volume of births attended

Six respondents indicated that they do not attend births. Of the 21 respondents who attend births, most attended births in a hospital (30%), home (25%), hospital, birth center and home (25%), and birth center (10%) (Figure 5).

Figure 5. Setting of births attended (*n* = 21)

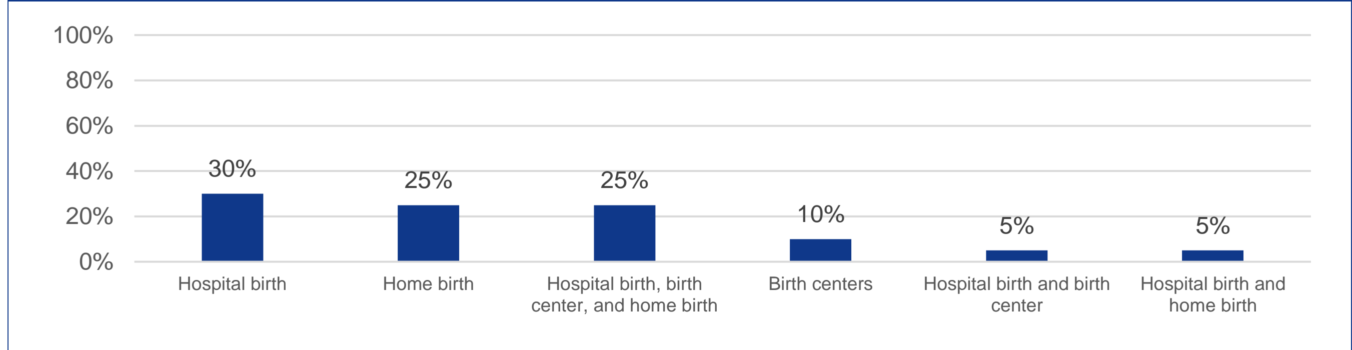


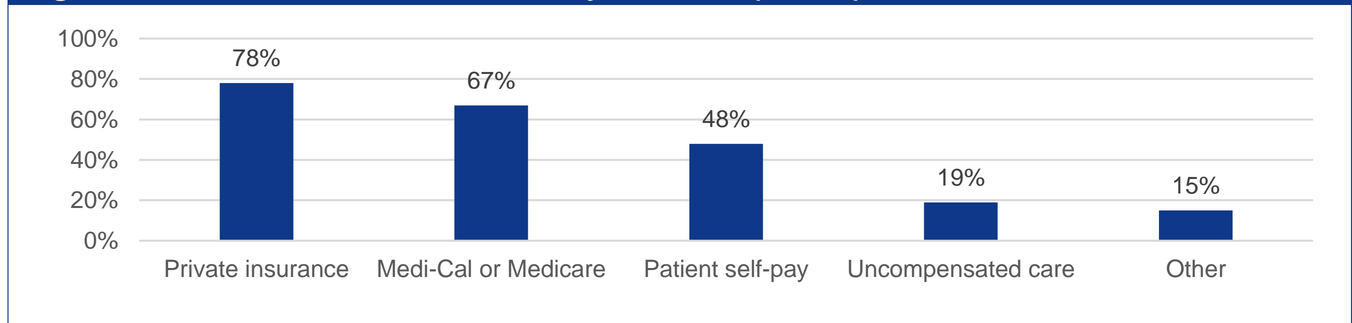
Table 5. Setting and volume of births attended (*n* = 21)

Volume	Hospital Number (%)	Birth center Number (%)	Home birth Number (%)
0	8 (42%)	14 (74%)	11 (55%)
1 to 35	5 (26%)	2 (11%)	5 (25%)
36 or more	6 (32%)	3 (16%)	4 (20%)
Missing	2	2	1

1.5 Reimbursement of midwifery services

The most common forms of reimbursement for midwifery services were private insurance (78%), Medi-Cal or Medicare (67%), and patient self-pay (48%) (Figure 6). The most common combination of forms of reimbursement were private insurance and Medi-Cal or Medicare (26%), private insurance and patient self-pay (19%), private insurance, Medi-Cal or Medicare, and patient self-pay (15%), and Medi-Cal or Medicare (15%) (Table 6).

Figure 6. Reimbursement of midwifery services (*n* = 27)



Note: Respondents could choose all settings that apply. Private insurance includes Anthem Blue Cross, Blue Shield, Aetna, United Health Care, etc. Other includes charity, county employee, donor-funded pregnancy center, and sliding scale for financial hardship/Medi-Cal eligible.

Table 6. Combination of reimbursements of midwifery services (n = 27)	
Combination of reimbursement	**Number (%)**
Private insurance[a] and Medi-Cal or Medicare	7 (26%)
Private insurance and patient self-pay	5 (19%)
Private insurance, Medi-Cal or Medicare, and patient self-pay	4 (15%)
Medi-Cal or Medicare	4 (15%)
Private insurance, Medi-Cal or Medicare, patient self-pay, and uncompensated care	2 (7%)
Private insurance, patient self-pay, uncompensated care, and other[b]	2 (7%)
Other	2 (7%)
Private insurance, Medi-Cal/Medicare, and uncompensated care	1 (4%)

[a] Private insurance includes Anthem Blue Cross, Blue Shield, Aetna, United Health Care, etc.
[b] Other includes charity, county employee, donor-funded pregnancy center, and sliding scale for financial hardship/Medi-Cal eligible.

2. OPEN-ENDED QUESTIONS

Three open-ended questions examined successes, challenges, and areas of improvement for midwifery services in the Sacramento area, particularly for underserved individuals. The main findings were: midwives provide a range of services; the midwifery workforce lacks racial concordance; reimbursement of midwifery services is a challenge, there is a need for structural changes to improve midwifery services to underserved populations.

2.1 Midwives provide a range of services

Delivering high-quality health care and working in collaborative teams were some of the successes of the midwifery services in the Sacramento area. Many respondents described how they provide *"full-spectrum prenatal, birth, and postpartum care for moms and babies"* in a manner where *"families feel heard, seen, and safe in our care to have the births and midwifery care they desire."* Some respondents attributed their high quality, comprehensive, family-centered care to improved birth outcomes, as one midwife said, *"We are able to provide kind and high-quality midwifery care and excellent outcomes to families who otherwise may not have access to midwifery care due to payer. We have a 0% preterm birth rate."*

2.2 Midwifery workforce lacks racial concordance

Many respondents pointed to the need for expanding the midwifery workforce to meet the demand for midwifery services, particularly in underserved communities. Respondents noted that midwifery staff were predominantly white and that there was a shortage of midwives to provide culturally congruent care. Many respondents called for an increase in midwives of color, particularly Black midwives, and mentors for Black student midwives, due to the need to provide culturally congruent health care for Black and underserved families.

2.3 Reimbursement of midwifery services is a challenge

A main challenge with providing midwifery services in Sacramento was the limited accessibility and amount of reimbursement from Medi-Cal and health insurance companies. There was a shared sentiment from respondents that it would be beneficial to have *"More midwives taking*

Medi-Cal and working to serve specifically low-income Black families." However, there were monetary and regulatory challenges, particularly for midwives in individual practices, in becoming a Medi-Cal provider. For example, one midwife said, *"It is very difficult for self-employed midwives to take Medi-Cal, the liability insurance required for reimbursement makes it really impossible due to prohibitive cost which would increase costs for everyone, also Medi-Cal pays poorly."* Many respondents recommended an increase in the amount of reimbursement from Medi-Cal and health insurance companies *"to reflect the value of the care"* that midwives provide. One respondent further elaborated on reimbursement being *"built on medical/OB model and not reflective of standards of midwifery care."* Other recommendations included extending Medi-Cal and health insurance reimbursement coverage for facilities with midwifery services and for midwifery care and home births with licensed midwives, and having medical facilities located in underserved areas accept Medi-Cal insurance for prenatal and intrapartum services.

Regulatory challenges with reimbursement included being able to qualify as a Medi-Cal provider, licensing, and the time-consuming process of requesting reimbursement from health insurance companies. One respondent recommended providing assistance for midwives to apply for coverage. Another respondent recommended reforming birth center licensure to overcome the regulatory challenges they faced in serving families with Medi-Cal, *"I want to take Medi-Cal and cannot due to our license being rejected for our building being too old - not meeting the mechanical requirements for OSHPD."*

2.4 Desire for structural changes to improve midwifery services to underserved populations

The main areas of improvement that respondents shared were a need for an increase in midwives, midwifery schools, and clinics, and for greater awareness of midwifery services. Respondents discussed the need for structural changes to improve midwifery services in underserved individuals. To address the shortage of midwives, respondents suggested increasing the number of midwifery educational programs and supporting midwifery students. One respondent suggested that the University of California, Davis could *"restart its midwifery program."* Another respondent suggested providing *"More available tuition and preceptor options."* Respondents also suggested providing more clinics. One respondent noted the benefits of providing an adequate number of clinics to serve families, *"I believe we have many [Federally Qualified Health Centers] in this area so we do well."* While respondents discussed the quality of midwifery care they also noted that there could be greater awareness of and access to midwifery services among community members, particularly those in underserved communities, and a greater awareness of midwifery services among other health care providers.

Respondents noted that there could be greater awareness of and access to midwifery services among community members, particularly those in underserved individuals, and a greater awareness of midwifery services among other health care providers. Respondents shared a desire to provide more outreach to communities about the services midwives provide and how to access these services. For example, one respondent said, *"I think a lot more could be done prenatally to make sure individuals from underserved communities are aware they have the option of seeing a midwife."* Respondents also expressed a desire to educate clinic and

hospital staff about the full scope of midwives' *"skills, experience, philosophy"* and an interest in expanding midwifery services in the outpatient setting. Respondents described how communication and a shared vision of care among collaborative teams within midwifery practices and with physicians, OB/GYNs, and nurses in other settings *"who support midwifery and recognize the value of serving an underserved population"* was one of the successes of midwifery services in Sacramento. Yet, many respondents described difficulties in developing and maintaining support and respect for midwifery care from physicians and hospitals, with one respondent stating, *"Midwives are sometimes treated not as collaborative providers but as subservient workers."*

Appendix B – Interview Findings

Presented are the interview findings for the eight survey respondents who participated in follow-up interviews (Table 1). The interview guide contained 20 questions plus follow-up prompts. Interview questions examined midwives' practice, client needs, and ideas for addressing the challenges and opportunities for expanding midwifery access in the Sacramento area, particularly for underserved individuals, and especially for Black people. Racial identifiers and clinical practice names are omitted from quotes to de-identify participants.

Table 1. Demographic characteristics of interview participants (*n* = 8)

Demographic characteristic	Number (%)
Race	
White	6 (75%)
Other	2 (25%)
Age, median (range)	50 (32-72)
Years in practice, median (range)	12 (5-40)
Credentials	
Licensed midwife	4 (50%)
Certified nurse-midwife	3 (38%)
Women's health nurse practitioner (WHNP)	1 (13%)

Note: Percentages may not add to 100 due to rounding.

1. MODEL OF CARE

In this section, interview participants describe how they provide midwifery care in the Sacramento region. This includes their philosophical approaches to care, types of services offered, and how they accept payment.

1.1 Midwives model of care

The Midwives Model of Care[1] differentiates itself from other medicalized obstetric approaches to perinatal health care. The midwifery model is client-centered; builds a trusting relationship between the midwife and client; emphasizes the physical, psychological, and social well-being of the client; and minimizes unnecessary interventions.

Some interview participants credited the centering of the midwifery model to the successes in their practice:

> *"... but what I think is working well is the fact that the midwives have really infused within the staff the midwifery model of care." – Licensed Midwife, Federally Qualified Health Center (FQHC)*

> *"And in this particular birth center, it, it's not just a birth center, it started out breastfeeding medicine clinic. And then the birth center was like a second-tier service line that we offered. So we have a robust clinic and the birth center is a nice compliment to it. And they compliment each other and it's a very comprehensive practice that we run now. We do women's health. We take care of babies until they establish with a pediatrician. It's quite comprehensive*

at this point. The business model was based solely on community need.” – WOMEN’S HEALTH NURSE PRACTITIONER, Birth Center

“The patient feels heard, feels supported, feels she's part of the team and she's also making decision for her plan of care. It's not one way, it's two ways and it's like a group. The same way we want to be treated if I go to any you know, centers. That's how I look at the picture as, and many of them appreciate that.” – Certified Nurse-Midwife, state hospital and health system A

“We really do try to talk to people openly and make sure that home birth is affirmatively what they want and not just that they're trying to avoid a bad situation in the hospital. Because if they aren't really comfortable and motivated to have an out of hospital birth, then they're more likely to transfer out of our care at some point. People who don't feel safe in labor don't tend to labor effectively and have their babies.” – Licensed Midwife, independent group practice

“I don't wear a coat into my appointments. I don't wear a white coat. I've never worn a white coat. I sit down, I never stand up. I sit down, I'm always at the level of a patient. I don't do anything. I don't do any charting while I'm there with patient. I sit there, I ask them if they have any questions, I ask them questions to pull out what's most important to them. What do they want to know, and to try and break down any barriers. Over the years, it seems to have worked. Almost all of my patients are -- they're the patients that have always been marginalized and they gravitate towards me. Because I do things where it's a level playing field. You're a human being, I'm a human being. And I always tell my patients, I treat everyone as if I were the person sitting across from me, how would I want to be treated? How would I want to be respected? And you can always find something with another person to, in common, you know? If you can find that one thing in common, you build off of that.” – Certified Nurse-Midwife, health system A

Participants also spoke about how the demands from their administrators or clinical structure got in the way of them providing ideal midwifery care:

“We constantly have to fight for more time, because the medical director is like, ‘Well, you know, we do our, we do our 10-minute visits.’ Like, no, no, no, no, no. That's not midwifery care.” – Licensed Midwife, FQHC

“It was almost like they said, oh, this is why we have nurse midwives because they're great educators and they can connect with the marginalized population. However, they don't give you the time to do that. I wanted to make sure that every person that I saw that all their questions were answered, that they felt that they could ask any questions and that their values and their opinions and their wishes were valued. And that they were truly a team member. …A lot of times I would run one to one and a half hours behind in clinic. But interesting thing is I had some of the highest satisfaction ratings, and my patients would not leave to see another provider. ‘I want to see her’ –

because I would always tell them I'm not done until you are done." – Certified Nurse-Midwife, health system A

"Hey, patients like midwives. They like the idea of midwifery care, but it's not midwifery care in reality. It was just another kind of – something to get people to say, 'Hey, let's pick this particular insurance because they have midwives.' But we're not allowed to practice midwifery in the true sense of it... And if you want to do that, it's on your own time." – Certified Nurse-Midwife, health system A

"Basically, administration support is the main issue. If they allow us to expand more and provide us the necessary support, I think can do a lot of things more. I just recently last week wrote a brief description of what a midwife can do to our administration. To let them know this is more than what you think we are. We can do a lot more. And I think they accept it and they're looking at us differently. I think we need to more educate our population and administration about the capability of a midwife." – Certified Nurse-Midwife, state hospital and health system A

"So, including our administration, they're not familiar what is the role of midwife. And there they haven't been passionate about midwifery care that will be diminished. I'm currently actively battling to explain ourselves that our patient needs us, and we need to have more presentation in the clinic and in labor and delivery and provided more access for our OB patients." – Certified Nurse-Midwife, state hospital and health system A

1.2 Services offered

Interview participants described the diverse services midwives offer across the Sacramento region. Services vary by clinical setting:

"It's a home birth service, although if somebody needs us to go into the hospital with them, we always go, we never send people in by themselves. We also have a sort of an adjunct service, where if people want post-partum care, but they're having a hospital birth, we meet with them once or twice during their pregnancy… If they've had a cesarean section, we'll go visit them in the hospital if that's allowed. And then we do home care for four visits after that as well. Our service includes all the pre-natal care, people have to pay for their labs themselves, unless they're low-income, and ultrasounds. And then we do monthly visits till 32 weeks, twice monthly visits till 36 weeks, and then weekly visits until they have their baby. Afterwards we do a one-day, three-day, five-day, two-week, four-week, six-week, and any other visits that they need, because of nursing or any other problems that they're having, are just included." – Licensed Midwife, independent group practice

"The FQHC model isn't Black-centric necessarily. It's not Black culture. But the good stuff that we did is also there. We do have social worker, nutritionist, health educators, lots of programs, lots of connections to stuff. It's not

necessarily a Black-centric space, but it's a pregnant person-centric space, within the context of what we can do in the Federally Qualified Health Center." – Licensed Midwife, FQHC

"And in this particular birth center, it, it's not just a birth center, it started out breastfeeding medicine clinic. And then the birth center was like a second-tier service line that we offered. We have a robust clinic and the birth center is a nice complement to it. And they complement each other and it's a very comprehensive practice that we run now. We do women's health. We take care of babies until they establish with a pediatrician. It's quite comprehensive at this point. The business model was based solely on community need." – WOMEN'S HEALTH NURSE PRACTITIONER, Birth Center

"I would say, like a third of my births are at home, and two thirds are at the birth center." – Licensed Midwife, birth center and home birth practice

"At [health system A] midwives are only allowed to do prenatal and immediate postpartum care and then, you know, delivery. There's some complicated things with the nursing union and nurse practitioners who are unionized and nurse midwives are not, but there's some concerns like if midwives were practicing full scope of midwifery, that there might of infringement upon the nurse practitioner practice." – Certified Nurse-Midwife, health system A

"Patients are getting sicker. A and a lot of times you end your shift with 'whew, glad nobody died on my shift,' or, you know, glad that didn't happen on my shift. And everyone just says, you know, it's just a time bomb and it's getting worse and worse and worse. Now the big thing is how what's the minimum number of visits that we can do during a pregnancy for somebody to have an okay outcome. And now it's, 'let's cut that down even more and let's just do it through video.' So, C-sections, we do a visit video visit postpartum at six weeks after a C-section." – Certified Nurse-Midwife, health system A

"There are currently three of us and we practice according to California law for licensed midwives. We do what we think of as full spectrum perinatal care for low-risk clients." – Licensed Midwife, independent group practice

1.3 Billing and reimbursement

Billing and reimbursement was a reoccurring topic in the interviews. Billing and reimbursement are seen as a barrier to expanding or diversifying clientele base, or to expanding their practice more generally. Offering midwifery services to clients who have Medi-Cal or low-er incomes was seen as essential across clinical settings.

"It's a set fee, but we have a sliding scale. And I think we're the only ones in our area who have a sliding scale. We give people this little page that say, here's our minimum and here's our maximum, and here are the things that would make you think you're more maximum than minimum." – Licensed Midwife, independent group practice

“I work with about 90% Medi-Cal. Medi-Cal is the primary payer for midwifery in my practice.” – Licensed Midwife, birth center and home birth practice

“Our goal is always to make our client mix reflective of the actual community in Sacramento that has Medi-Cal, right?” – Licensed Midwife, birth center and home birth practice

“The fact that you need [specific Medi-Cal plan] to be seen with us is like, right from the get-go is a, is a barrier.” – Certified Nurse-Midwife, health system A

“I feel like it feels like when we don't get fully paid, there's probably some karmic reward there that we've put a lot of loving energy into somebody's care, even if it wasn't possible for them to pay us with money.” – Licensed Midwife, independent group practice

“For people who have PPO insurance, we can build those plans and the reimbursement varies a lot. For people who have HMOs or no insurance, or Medi-Cal, we can't get, you know, any reimbursement from insurance. We have a sliding scale that we offer for clients.” – Licensed Midwife, independent group practice

2. DISPARITIES AMONG MIDWIVES AND CLIENTS

Interview participants described several disparities in access and health outcomes, as well as structural barriers to alleviating these disparities. This section also covers their views on the importance of racially/culturally concordant care.

2.1 Patient barriers to care

Clients in the Sacramento region can face several structural barriers to accessing midwifery care, including economic, cultural, and racial barriers.

“I had a patient who had not done what she needed to do to get her Medicaid. She had presumptive Medi-Cal, which is a kind of temporary thing that we can do in the clinic… She had an ultrasound scheduled. But it was scheduled on next week, Tuesday. And the staff person noticed that presumptive Medi-Cal was going to end on Saturday, the 31st, because it ends at the end of the month. So [the staff person] called around to all of the [health care system B clinics] to find an appointment for that patient that before her [insurance expired]... She [asks the patient] and says, ‘Are you able to drive to Roseville?’ Because that's where she was able to find an appointment, which is an hour away, right?” – Licensed Midwife, FQHC

“[Health system A], for example, a lot of working Black women have [health system A insurance], it's like they've gotten midwifery hidden. If you're going to Roseville, you get a midwife. They have a full staff in Roseville. Who knows about that, if you're a [health system A] member, you know? Yeah, they've got like a couple of midwives in South Sac, but it's not a midwife practice. The hospitals have no midwives at our main hospitals in Sacramento. [Health

system B] doesn't have midwives, neither does [de-identified hospital C]. They are doctor-centric. It's crazy that no nurse midwife has gotten privileges at either one of those hospitals in years." – Licensed Midwife, FQHC

"I think that birth centers are the answer to disparities, but the huge roadblock is Medi-Cal and life and birth center licensure. That is the problem." – WOMEN'S HEALTH NURSE PRACTITIONER, Birth Center

"As far as I know we're the only practice guaranteeing a female care provider in Sac right now. So we got a lot of folks who just have spiritual or religious restrictions." – Licensed Midwife, birth center and home birth practice

"…especially nowadays because people don't have transportation. People have kids at home that are being homeschooled. They can't come to appointments and they may not have the technology or the resources to connect on video." – Certified Nurse-Midwife, health system A

"And now we've made it even harder. No one under the age of 14 can come in, or nobody can come back with you. They can only come back if you're having an ultrasound, people don't have phones or phones get changed emails. Stuff isn't written in their language. We do Spanish and English, you know, or we don't have an interpreter. I don't blame them" – Certified Nurse-Midwife, health system A

2.2 Addressing disparities among clients

Interview participants described several interventions to addressing racial disparities in access to midwifery care and maternal health outcomes. These include policy or regulatory ideas as well as ways to improve care within a clinical setting.

"We need more midwives. We need a birth center in Sacramento. The cost of a midwife opening a birth center is so huge that that we're not going to see that in Sacramento, a Black-owned birth center for a very long time unless someone's able to commit some resources, some significant resources." – Licensed Midwife, FQHC

"The FQHC model isn't Black-centric necessarily. It's not Black culture. But the good stuff that we did is also there. We do have social worker, nutritionist, health educators, lots of programs, lots of connections to stuff. It's not necessarily a Black-centric space, but it's a pregnant person-centric space, within the context of what we can do in the Federally Qualified Health Center." – Licensed Midwife, FQHC

"I think that birth centers are the answer to disparities, but the huge roadblock is Medi-Cal and life and birth center licensure. That is the problem. I can't fix the disparities if I can't take Medi-Cal patients. And I can't take Medi-Cal patients 'cause I can't get paid at all. Not even like, not even like the tiny amount of pro fee. I can't get paid, at all, a facility fee." – WOMEN'S HEALTH NURSE PRACTITIONER, Birth Center

“I think it's reaching out to these women. I'm still so shocked at when women come in and they're like, I didn't, ‘I don't know what a midwife is. I had never heard of a midwife.’ Once we get people to just one visit, they're hooked... ‘This is what I need.’ Most of us will go to whatever lengths it takes to make sure that that person is taken care of. And that means working after hours and calling them at home and unpaid time to make sure that they're okay and that they're getting everything that they need and that we are their advocates. But I said, I think right now a lot of it is just word of mouth within the community, but I'm just shocked at how many people out there don't know about it.” – Certified Nurse-Midwife, health system A

“I got my license [and] immediately applied to be a Medi-Cal provider, because that's why I became a midwife. I wanted to take the insurance that everybody had. I'm very, very pro single payer. I'm very, very pro universal health care, and Med-Cal is the closest I can get to that in this stupid ass country, right?... So immediately had all these clients as soon as I was licensed, really like had a full deck.” – Licensed Midwife, birth center and home birth practice

“We started a project that where we were looking to see, like looking upstream. If we were having more Black patients who were needing blood transfusions, what was going on with that? And what we uncovered was that in our Black patient populations, we were much more likely to either miss or somehow not communicate well around anemia. We… looked at our data for the last couple years, looked at all the Black moms who had delivered, who had required blood transfusions and then looked back to see like what percentage of them were anemic. And then we actually reached out to these patients and had them gave them the opportunity to tell us more about their experience. I think 30 of those patients opted to participate and we were able to interview them.” – Certified Nurse-Midwife, health system A

“I think that staffing wise, giving us more capacity to care for patients in outpatient setting in the inpatient setting is going to really help access.” – Certified Nurse-Midwife, health system A

“There started to be a lot more coverage in the media of that disparity, both locally and nationwide. I would say that the majority, if not all, of the black women who call me looking for care say that one of the reasons they're coming to midwives is because they're afraid of dying in the hospital. And that's just horrifying to me. The idea that not only is that true, but that people are thinking about it, stressed by it, it adds to the stress that contributes to those bad outcomes. It just feels like a horrible cycle. It’s definitely important to us to provide that kind of attentive care. We can't, of course, according to law, take care of people who are at high risk, based on conditions that we see developing, such as a client with preeclampsia or somebody who's having a very high risk of a preterm birth or the things that are playing into some of these outcomes. Which makes me wish again, that we had a more integrated care system and more ability to get paid by Medi-Cal, because I think those

would really the two things that could make it possible for more people to have the kind of individualized and attentive care that midwives can provide." – Licensed Midwife, independent group practice

2.3 Racial concordance

Interview participants were asked about the importance of racially concordant care.

"Yeah, also what's not working is you have mostly White midwives. Just in the last two years, we finally have another Black midwife who's there … I've been there for 15 years, and I've been the only Black midwife." – Licensed Midwife, FQHC

"But there's a requirement to speak Spanish. You have a majority of, or very large portion of your clients that are Spanish speaking. Like, yeah, you need to speak their language. But what that doesn't to is it doesn't create cultural competency for other groups. We have mostly White midwives, and then almost 100% Hispanic staff. …We have this assumption that Hispanic people all speak Spanish. No, some of them, Spanish is like their third language, right? If they're Spanish speaking Hispanic, then yes, they're like, 'Oh yeah, this is cool, you know. I feel welcomed here. I see myself here.' But then, they see the midwives and they're mostly White, you know. We finally got one Hispanic midwife about six months ago. Congruent care or concordant care is really not happening. Just in terms of staffing, we actually desperately need someone who speaks Farsi." – Licensed Midwife, FQHC

"It's a type of security for patient. The patient feels heard, feels supported, feels she's part of the team and she's also making decision for her plan of care. It's not one way, it's two ways and it's like a group. The same way we want to be treated if I go to any you know, centers. That's how I look at the picture as, and many of them appreciate that." – Certified Nurse-Midwife, state hospital and health system A

"I know with Latino patients' language, a lot of times can be a big barrier. I think it depends on your individual implicit bias because it can impact certain people's perception of their care that they're getting. And they may be resistant to care if they feel that they're not being understood culturally, or they might shut down if they feel that that they're just not being understood or that they don't feel comfortable receiving care in a place that seems foreign to them." – Certified Nurse-Midwife, health system A

"It is really important that I think to patients that their care providers are from similar racial backgrounds or, you know. We recognized it, and specifically hired so that we would – that means like it meant took on taking on some, it means investing. But like worth the investment." – Certified Nurse-Midwife, health system A

3. MIDWIFERY PROFESSION AND PRACTICE

Interview participants described structural challenges to entering midwifery practice, maintaining their current practice, successes in midwifery in the region, and areas for improvement. Structural barriers included educational barriers, financial barriers, workforce pipeline issues, and impacts of the current regulatory structure in California.

3.1 Educational barriers

> *"... when you talk to a midwifery student, of whichever pathway, they really describe their midwifery education as a beat down. And a lot of people don't finish. A lot of people of color don't make it. Nursing schools are, are very difficult challenging places. And the direct entry route -- there just isn't support in the in the system. They might not be as expensive as, as a nurse midwifery program, but you don't have any financial aid." – Licensed Midwife, FQHC*

> *"I mean, part of the problem in me being able to diversify my staff is that me being able to hire any staff is a problem because it's such a super-duper specialty. It's a micro-specialty. You know, just not everybody who's a midwife knows how to do out-of-hospital birth. They don't even teach it. Your average midwife graduating from UCSF, I'm sorry to say, just really does not know how to do an out-of-hospital birth, that does not know how to take care of a newborn. So, I'm already dealing with a very, very small pool of people. And then a microscopic pool of people of color." – WOMEN'S HEALTH NURSE PRACTITIONER, Birth Center*

> *"To diversify the workforce, I think that starts early. This is the result of systemic racism." – WOMEN'S HEALTH NURSE PRACTITIONER, Birth Center*

> *"I started from being a midwife in [another country] and I came here with my husband and at the beginning I was not familiar with the system. I asked schools, nobody could help me to find a midwifery practice or transfer my education here. I contacted board of registered nursing, nothing was clear. So I decided to go back, well I had to, I had no choice in order to practice OBGYN same field, I had to be an RN they told me. After I received my RN license I started working in labor and delivery unit at [state hospital]. There I started working with midwives over there. That was the door that opened for me to come work the rest of my education from [another country] and then I was able to pursue education and finish my post-master in midwifery." – Certified Nurse-Midwife, state hospital and health system A*

> *"I learned that being a student midwife is really, really cost prohibitive. I took out pretty much all of the loans that I could get at like community college, so I was like a full-time community college student in order to pay for my full-time midwifery education as well." – Licensed Midwife, birth center and home birth practice*

> *"You're trying to precept a student and that's part of your job as a midwife to continue the profession, but then you're going to be like, 'you know what we*

don't have enough people for you to be doing this right now.'... And I know that people are finding it very hard. Students are finding very hard to find preceptors, because that's the thing it's, I don't have the time to teach. They don't give me the time to teach." – Licensed Midwife, birth center and home birth practice

"Being a midwife, you have to have a strong spirit. There's so many easier things to do and financially probably get more pay for it, being a nurse, being a bedside nurse, being a clinic nurse, but you do this because you have a passion because you have spirit for it. We're used to hard work and we're used to fighting for our patients. We haven't lost that yet." – Certified Nurse-Midwife, health system A

"I definitely know that the financial part is a challenge, certainly for a student who doesn't have another income in the home or a large enough other income in the home to become a single income family. It's a challenge. It was a challenge for me. I made a real leap of faith to become a student midwife at that time." – Licensed Midwife, independent group practice

"We do all of our visits in homes. That can be a really great... We don't have a clinic, or an office that we have clients come to typically, it's just a back office. Since we cover a large area, we often are driving for hours every day. It's not unusual for me to have days where I'm driving for three hours to see four or five clients... That can be challenging and has been challenging for at least, -- I'm sure it's been challenging for all our students, but especially really challenging for one or two of them. One was a single mom, it was really hard for her to put that much time into the driving, but there wasn't really any way for her to learn as part of our practice without being at those visits." – Licensed Midwife, independent group practice

3.2 Financial barriers

These are examples of financial burdens and barriers midwives face in the Sacramento region.

"It's so hard to become a midwife, and one of the big things is pay equity." – Licensed Midwife, independent group practice

"And we had [a birth center started by a doctor] in Sacramento, I don't know, maybe, 10 years ago maybe. And it was actually a very busy Medicaid practice, and one of the Medicaid managed care companies that they cooked up this idea to save money. They actively recruited Black women to the birth center... They hired a midwife, a nurse midwife from San Francisco. I was excited. I was like, 'Well, it's started by doctors, but okay,' you know. And I, you know, encouraged people who wanted a midwife, you know, birth to go there. But yeah, lasted six months. All that money down the drain, you know, because they had spared no expense. A lot of times when Black midwives start birth centers, you know, it's like, you know, they start with one birth suite. And, you know, and they found a tub somewhere. And they got somebody to

do the bathroom. And, you know, and then they have another like, you know, small little room, you know, that just has the basics. And then, you know, maybe five years later, they get that up and running." – Licensed Midwife, FQHC

"Okay, so you're at her house for 14 hours, and Medicaid pays you $700 for the birth and $700 for the prenatal care, that's California... you're at their house for 14 hours, and then you leave after the baby's born. And then, you go back the next day. Then you notice that baby's having a difficult latch. So then, you're like, 'Okay, I need to see you tomorrow,' right? Who knows, that person might need three postpartum visits in the first two weeks. And they're going to get them. Maybe they're going to be on the phone, maybe they're going to be in the office. At a minimum, the community-based midwives, wherever their background do at a minimum about four postpartum visits... If there's any little problem, that number goes up. And you're not going to get paid. You know, you're not going to be reimbursed for that. The dominant system is six-week postpartum visit. If you have c-section, you get an incision check at one week. We need payment models that are grounded in health." – Licensed Midwife, FQHC

"Our goal is to take every major insurance plan. It's been a difficult process. We have insurance plans that will contract with us for lactation services, but not for birth center. So, like [health system B] is an example, [health system B] insurance. We have a contract for lactation, but not for birth center. We take Aetna. We take Cigna. We take United. We are not contracted with the Blues because they won't contract with mid-level providers." – WOMEN'S HEALTH NURSE PRACTITIONER, Birth Center

"A lot of midwives, as our midwifery practice has expanded at [health system A], a lot of midwives who were working in birth centers have taken jobs with us, so there's been a lot of turnover in our local birth center staffing. Some financial strain and otherwise on those on those groups…which kind of breaks my heart. At the same time, I'm part of the people that are recruiting them." – Certified Nurse-Midwife, health system A

3.3 Policy barriers

These are state-level and internal policy/regulatory issues participants described as hindering their midwifery practice.

"[to improve access to midwifery services]... have a midwifery board of our own, so that we can actually have more influence in the legislature, and serve the midwives that we have better." – Licensed Midwife, independent group practice

"[With] birth center billing you have a facility and you have a professional fee, and those are two separate entities. Medi-Cal won't pay a facility fee unless you are licensed by the state. It is actually impossible to become licensed by

the state since 2018, since the regulations changed, they've made it nearly impossible to be licensed. There are 49 birth centers in California and eight are licensed. All were licensed prior to 2018. They centralized the licensure process. And the requirements that were put in place are impossible to meet. I will give you an example. We applied for licensure, took us a year. We did everything that they needed us to do, and we were unable to achieve licensure for one tiny thing. And it's that our facility is too old to be licensed because it doesn't comply with OSHPD 3. OSHPD 3 is the building code for a hospital. My 1903 Victorian building downtown would have to be built to the same mechanical standards as a hospital in order to get licensed. So your answer, whether or not I take Medi-Cal is no, we can't take Medi-Cal for the facility fee because they won't license us. But we take some managed Medi-Cal plans." – WOMEN'S HEALTH NURSE PRACTITIONER, Birth Center

"Prior to the physician supervision being removed, I used to have to pay a physician group to 'supervise me.' I had to pay them monthly and it amounted to extortion. Yeah, it was not appropriate. It did not increase the safety of anyone and it was, it was just so unethical." – WOMEN'S HEALTH NURSE PRACTITIONER, Birth Center

"Did you know that I can't do a pregnancy test in my office without a physician signing my CLIA waiver? I can't do a pregnancy test that someone could buy at the dollar store and do it home. I can't do it unless I have a CLIA waiver. In order to get a CLIA waiver, I would have to have CLIA license, and in order to have CLIA license, I have to have a medical director. There are physician supervision requirements embedded in the other accessory places that prevent us from being able to do our job fully, prevent other birth centers from opening because most people hit a roadblock and just give up." – WOMEN'S HEALTH NURSE PRACTITIONER, Birth Center

"I am a birth center and home birth midwife. I've been trying to get hospital privileges for five years now but none of the hospitals here will grant privileges to a licensed midwife despite it being our legal scope of practice." – Licensed Midwife, birth center and home birth practice

"The [challenge] that concerns me most is difficulty in access to referrals and professional communication in a referral situation that, especially during COVID of course, when you have an urgent or not even emergency, but just a transport or transfer that needs to happen in a very timely way, we are not able to go into the hospital with people. Most of the time there have been exceptions, but the rules change all the time and that is really hard for us and of course, for our clients who would like to continue to have our support." – Licensed Midwife, independent group practice

"We do never know what the legislature is going to come down with." – Licensed Midwife, independent group practice

3.4 Racial disparities among midwives

In addition to discussion a lack of racial concordance between patients and midwives, some participants described a lack of racial diversity among midwives in general.

> *"... when you do have the few Black midwives, the community-based midwives, a lot of them are just overwhelmed with requests. The same thing in the systems of care, sometimes the Black nurse midwives are hidden. People don't even know that they're there until finally maybe they lucked out. I can't imagine [health system A] telling their staff, 'Oh, if you have a Black patient, make sure they get to the Black midwife.' Or, 'If you have a Hispanic patient.' We just don't do that in our system." – Licensed Midwife, FQHC*

> *"When you look at midwifery as a whole, it's White. You know, it's changing. But when you talk to a midwifery student, of whichever pathway, they really describe their midwifery education as a beat down." – Licensed Midwife, FQHC*

> *"We started out with a very, with pretty much no diversity. At least not along racial lines. It was something that really bothered both of us. We actually really did try to work with some of our colleagues down at UCSF, … California nurse midwifery association, like groups that were specific like around midwives of color. We added a lot of diversity questions to our interviewing process, and we really did try to seek out applicants would bring some diversity to our group." – Certified Nurse-Midwife, health system A*

> *"We rarely recognize the shortage of midwives who are not White in this country and the need to help develop midwives who can best serve those communities. We will of taking care of women of color, but we also think that people who are pregnant are so vulnerable that for them to be able to have a choice of a midwife who looks like them, or comes from a similar experience [is] really valuable. We do want to grow more midwives who can serve more communities." – Licensed Midwife, independent group practice*

3.5 Practice structure

Some participants discussed other issues within the structure of their practice.

> *"Why isn't it cost effective? I mean, let's just put it this way, it's cost effective for the hospital, but it's not cost effective for the people that we serve." – Licensed Midwife, independent group practice*

> *"With the company that I work for, it's pushing 'see more patients, get them through. See as many as you can, as fast as you can.' And yet most of the patients that I saw were the ones that needed the most amount of care, not necessarily physically, but emotionally and psychologically they needed. My biggest frustration is that you lacked the time you weren't given the time." – Certified Nurse-Midwife, health system A*

"If folks come in and they end up starting care within obstetrician, and then sometimes even if they want to see a midwife, the medical assistant for the OB, just kind of keeps scheduling them for follow up appointments with that obstetrician. They just feel like they don't know how to get an appointment with us. It's just sort of an ongoing source of frustration and it's, it, it really is a structural issue. We've tried like a hundred million ways to try to fix it." – Certified Nurse-Midwife, health system A

"At [health system A] midwives are only allowed to do prenatal and immediate postpartum care and delivery. There's some complicated things with the nursing union and nurse practitioners who are unionized and nurse midwives are not. There's some concerns like if midwives were practicing full scope of midwifery, that there might be infringement upon the nurse practitioner practice." – Certified Nurse-Midwife, health system A

"We do all of our visits in homes. So that can be a really great... We don't have a clinic, or an office that we have clients come to typically, it's just a back office. So since we cover a large area, we often are driving for hours every day. It's not unusual for me to have days where I'm driving for three hours to see four or five clients... That can be challenging and has been challenging for at least, – I'm sure it's been challenging for all our students, but especially really challenging for one or two of them. One was a single mom, it was really hard for her to put that much time into the driving, but there wasn't really any way for her to learn as part of our practice without being at those visits." – Licensed Midwife, independent group practice

4. MIDWIFERY COMMUNITY IN THE SACRAMENTO REGION

These subcategories relate to the community of midwives in the Sacramento region, how they communicate, how they see themselves, and how they see each other.

4.1 Communication

Participants described how midwives in the Sacramento region communicate with each other, how they communicate with other providers, and whether there is a shared sense of community among midwives in the area.

"If you're a home birth midwife, and you, say, for instance, have a patient who's RH negative, that person needs an injection of immunoglobulin within 72 hours of her delivery. That one injection costs $85, right? If you do four births a month you can't stockpile that. You can't even purchase it... someone who has a busy practice, they'll put on an email and say, 'Okay, I'm ordering RH immunoglobulin. I'm getting six for my practice. Anybody need any more?' So, people would be like, 'Oh, I need one!'" – Licensed Midwife, FQHC

"I would love to do work with the Medicaid eligibility workers, to tell them about midwifery, but it doesn't make sense to tell them if there isn't a place to go, right? When we had the Birthing Project clinic, we used to go and talk to the

Sacramento eligibility workers. Once a year or something, we'd go and do a presentation, and like tell people about our practice… I think that... for the Medicaid population, the social service providers need to be educated about midwifery." – Licensed Midwife, FQHC

"I have been around for so long that I have good relationships with the other providers in the community. So with the breastfeeding medicine clinic- we get referrals from pediatricians because most of the pediatricians in the area know about us and trust us, and would much rather their patients see us than some questionably licensed person that shows up at their house." – WOMEN'S HEALTH NURSE PRACTITIONER, Birth Center

"I think that community of midwives generally is very tight. We are in connection with each other regardless. I'm in connection with many of [health system A] Modesto midwives. They were my students… [health system A] Sacramento and [health system A] Roseville, I have a lot of friends who were colleagues or we've been working with each other. So it's really tight community and we reach each other, we have a Facebook group. I'm part of UCSF Alumni, they invited me. And [American College of Nurse-Midwives] also, so I think we're we have a connection going on and I really appreciate that." – Certified Nurse-Midwife, state hospital and health system A

"It's kind of a very lonely experience because you've got your clinic, that's it. There, you don't have any time to do anything else. You run in, run out patient after patient, after patient, the shifts there in the hospital, there's one midwife on per shift. So the only interaction you have with any of the other midwives is report, when you come on or when you go off giving report, and we have an occasional meeting one hour every month." – Certified Nurse-Midwife, health system A

"There definitely is a common theme that there's so much frustration, so many are getting burnt out, because there's now patients that didn't necessarily need more time, need more time because of COVID." – Certified Nurse-Midwife, health system A

"For the most part, we have really positive relationships. We have monthly peer review, which currently is over Zoom. I think it was really valuable when it was in-person for building those real relationships. It feels like on, Zoom, it's nice to see the people you already know, but there's not really any relationship development that's happening, it's really just the business. So I miss that a lot." – Licensed Midwife, independent group practice

"And although we've encouraged [nurse-midwives] to be part of our peer review group, I think they see themselves a little bit in a different category. That can feel uncomfortable at times when I feel like we're really practicing mostly in the same way, to feel as though the birth center midwives somehow feel set apart from the home birth midwives when we're all practicing

community birth or out of hospital birth, and generally in the same ways. I think being mutually supportive would be really valuable, but maybe they're doing their own peer review in their own ways and feels different to them." – Licensed Midwife, independent group practice

"For the most part, the licensed midwife community in Sacramento is fairly open, friendly, welcoming, cohesive. There have been a few situations where, people have been part of our peer review group and then kind of wandered away to do their own thing. And even though we sort of reached out to them and invited them to rejoin us, they didn't, they kind of disappeared." – Licensed Midwife, independent group practice

4.2 Future of midwifery in Sacramento

Participants were asked about their views on the future of midwifery in the region. Responses included views about the future of midwifery practice, education, and demand.

"One, train more midwives of color, because I'm not, but it's so hard to become a midwife, and one of the big things is pay equity. We can't take Medi-Cal, because of all, well, you know why, so I don't have to go into that. And a midwifery board of our own, so that we can actually have more influence in the legislature, and serve the midwives that we have better. But this thing with Medi-Cal, and also educating doctors so that they understand what working with the midwife is. Maybe this will come with more nurse midwives now being independent practitioners. But most of them are going to be employees of hospitals or doctors' practices." – Licensed Midwife, independent group practice

"With this [Sacramento County Midwives Scholarship], having some money on the table, that's going to make things happen. The social media reawakening of midwifery is going to make a difference as well. Having doula programs that are paying people to be doulas, and recruiting doulas to work in the community in the pipeline for people to get excited about midwifery." – Licensed Midwife, FQHC

"The way we're expanding at [health system A] I think it's very optimistic. They're letting us increase our numbers at [health system A] Roseville. We're doubling up basically. They hired 10 more midwives. Is we can do that the more exposure is going to bring more reputation and probably more recognition in the community." – Certified Nurse-Midwife, state hospital and health system A

"I'm worried about [the future]. I'm very worried about it. Talking to my younger colleagues who are new in the profession, they're very disenfranchised. They're very stressed. They're on the brink of burnout. When they went into this profession, you get in the art of midwifery. And the first thing that they're doing is I, 'I wanna get a job. I need to get a job.' That's every graduate's worst

fear. I've got to get my experience first, because then I can go to where I want to go." – Certified Nurse-Midwife, health system A

"I've seen an increase in the number of people that want to utilize home birth midwives. I have been sought out because I'm one of the HMO midwives that will not scold or refuse to see a patient that wants to have a home birth, because I will tell them what my requirements are." – Certified Nurse-Midwife, health system A

"There was already increased interest in the last several years and a growth in the number of midwives, but the practices have all been fairly busy and we have many more birth centers than we had a few years ago in the Sacramento area." – Licensed Midwife, independent group practice

4.3 Midwifery education

Interview participants noted if they were involved in midwifery education.

"I precept for all the schools." – WOMEN'S HEALTH NURSE PRACTITIONER, Birth Center

"I'm also a clinical preceptor. So I train student midwives… My birth center is a nonprofit organization. So we're actually an education organization. I try to really center the needs of students in my practice." – Licensed Midwife, birth center and home birth practice

"I became a preceptor for Frontier midwifery, and they're cranking out midwives like anything, but when I have my students [they say], 'I just need to get my deliveries. I just need to get my deliveries so I can get out there and practice.' I've had several students [say] 'just let me know when it's time to catch the baby and I'll catch the baby.' And it's like, 'no, you're here to learn the art or midwifery.' And if this person's going to be pushing for two hours, you don't just put the nurse in there and have them push with the patient for two hours. You're going to be in there pushing with them because that's what we do. You support them. I can only speak for myself, but I've seen it. And, and it's like, they just want to get their numbers. But they're not learning midwifery. They don't want to learn midwifery. It's getting lost. I demand that they go in there, 'no, this just part of your practice. And if you miss a birth because you're in with somebody else, so be it. Because you are here to learn how to be a nurse-midwife, you're not here to learn how to deliver a baby.'" – Certified Nurse-Midwife, health system A

"That's been frustrating because you're trying to precept a student, and that's part of your job as a midwife to continue the profession, but then you're going to be like, 'we don't have enough people for you to be doing this right now'… Students are finding very hard to find preceptors, because that's the thing it's, I don't have the time to teach. They don't give me the time to teach." – Certified Nurse-Midwife, health system A

4.4 Perception of midwifery/midwives

Participants described how they feel midwives are perceived by the general community and other providers in the region. Many noted an increased demand for midwifery services in the area, and a generally positive view of midwives from their clients. However, interviews also revealed a negative perception of midwives from physicians, administrators, and other clinicians.

> *"At [health system A] Roseville, Sacramento area, I think we are as midwives, we are more appreciated. Clients desire and seek midwifery care more actively. Compared to [state hospital], our definition is not being advertised. Our job experience and the capabilities of midwives are not being published or advertised as much. So, including our administration, they're not familiar what is the role of midwife." – Certified Nurse-Midwife, state hospital and health system A*

> *"About our education level. Many of the people think that we're home births midwives, we're a lay midwife, we're not, 'Oh you work at the hospital or home?' I say 'Home? No. We do it at the hospital.' I think that's the mentality of our general population from a midwife." – Certified Nurse-Midwife, state hospital and health system A*

> *"I've seen an increase in the number of people that want to utilize home birth midwives. I have been sought out because I'm one of the HMO midwives that will not scold or refuse to see a patient that wants to have a home birth, because I will tell them what my requirements are." – Certified Nurse-Midwife, health system A*

> *"There was already increased interest in the last several years and a growth in the number of midwives, but the practices have all been fairly busy and we have many more birth centers than we had a few years ago in the Sacramento area." – Licensed Midwife, independent group practice*

> *"It's amazing because there's a big community within the community -- word gets passed around. So many times I've had people come see me like, 'Oh, you saw a friend of mine,' Or, 'You took care of my mom,' or, 'You took care of my sister.' And it's interesting because, a lot of times someone will come in and they'll just happen to get scheduled with a midwife. They don't want to go back and see anybody but a midwife and most people that you ask that have had maybe prenatal care with a physician, and then they – I can't explain it -- but never want to have anything but a midwife again." – Licensed Midwife, independent group practice*

> *"I love physicians, but I think that they were taught to distrust midwives, and we're not all in the same bucket. I'm going to be honest with you and you can quote me here: I don't tell people that I'm a midwife. When people ask me what I do, I don't say midwife because, because it's embarrassing. Like somebody could roll out a bed tomorrow and call themselves a midwife and it's*

not fraud. There's just not a standard education. It's just not a respectable profession unfortunately. And I get that. So, when people ask me what I do, I tell them I'm a nurse practitioner. I think that in general, physicians, by not entirely the fault of their own, distrust midwives in general. I think we need to look at nurse midwives a little bit differently than we look at everyone else." – WOMEN'S HEALTH NURSE PRACTITIONER, Birth Center

"I would like us to have hospital privileges. We cannot get them… I mean like they all say that we can get them, but they make it so difficult... So I would like to be able to be credentialed at a hospital just as easily as a physician. But the problem is we have to ask physicians permission to practice and the physicians don't want to give us permission to practice." – WOMEN'S HEALTH NURSE PRACTITIONER, Birth Center

"There's a model where doctors have – they do this all over the country – they look at birth as a cash cow, and they're like, 'Oh, I can, I can hire some midwives, you know, pay them 1/6 of what make, have them run my birth center.' So, they build the birth center. They have the money, they throw it in, and they hire midwives. And they usually fail." – Licensed Midwife, FQHC

"… the institution only wants the midwives to see [the most difficult patients] because the doctors have more important things to do, and can't take the time that's needed. And it's very, very frustrating. I don't see those patients. That's what I would hear from physicians. Those are midwife patients. Those are not our patients." – Certified Nurse-Midwife, health system A

"We get told sometimes, 'Hey, I got a great midwife patient for you.' And you knew what was coming, but in some ways, it, it hurt me. But in other ways I felt honored because it's like, yeah, you don't know how to deal with them. You don't know how to give them the care that they need, but yet we were seeing these patients in a system that said, you're going to see just as many patients as anybody else... Everybody has the same time slots." – Certified Nurse-Midwife, health system A

"Unfortunately, even physicians are getting very cavalier about things, you know, 'why aren't you seeing as many patients as me?' Or 'why does it take you longer to get through your patients?' Because they don't understand. They don't understand our value that we bring." – Certified Nurse-Midwife, health system A

4.5 Role as a midwife in the Sacramento community

Participants describe their role as midwives in the Sacramento community.

"I sought it out and quickly found that [nonprofit birth centers] didn't exist... the only way to get that done was to create that." – Licensed Midwife, birth center and home birth practice

“That’s been frustrating because you're trying to precept a student, and that's part of your job as a midwife to continue the profession.” – Certified Nurse-Midwife, health system A

“It’s interesting being in a large community because I think it might feel different in a smaller community, or maybe it's just partly because I haven't taken the initiative to make these things happen. Sometimes I hear about, especially in small towns, sometimes a midwife has a place that becomes sort of a community center for people in her area where there might be classes, and as well as client care, there are also other resources going on there. I think that's kind of an ideal thing for a midwife, because we don't have an office and we're kind of out in our cars all the time. It's a little bit different for us, it feels like our relationships are really with the individual families that we're working with rather than the community.” – Licensed Midwife, independent group practice

REFERENCES

1. Midwives Alliance of North America. 2020. “The Midwives Model Of Care.” mana.org. Retrieved June 1, 2022 (https://mana.org/about-midwives/midwifery-model).