University of California San Francisco

UCSF School of Nursing

UCSF Philip R. Lee Institute for Health Policy Studies

Understanding the Practice of Midwifery Care in Sacramento

Prepared by: Renee Mehra, PhD, MS; Nikki Lanshaw, MPH; Keridwyn Spiller, BS; Catherine Woodward Calder, BS; Linda S. Franck, PhD, RN, FAAN; Joanne Spetz, PhD

August 31, 2022

Introduction

Maternal mortality rates are increasing in the US, contrary to trends in other high-income countries. In the US, substantial racial and ethnic inequities in maternal health outcomes exist, with Black individuals experiencing the greatest inequities and the worst health outcomes.[1] To improve birth outcomes and reduce mortality for Black infants, the California Department of Health provided funding to counties to improve perinatal health equity through interventions implemented at the county level that are evidence-based, evidence-informed, or reflect promising practices.[2] The Sacramento Perinatal Health Equity Initiative has prioritized access to midwifery care as an important strategy to improve perinatal health equity. However, little information is available about the midwifery workforce in the Sacramento region and the challenges and opportunities for expanding midwifery practice. Researchers at the University of California, San Francisco (UCSF) were commissioned to survey and interview midwives in Sacramento and surrounding counties to learn more about where and how midwives practice and to identify challenges and opportunities to improving access to midwifery care for Black/African American and underserved individuals.

Methods

SURVEY AND INTERVIEW GUIDE DEVELOPMENT

The project team consisted of nurses, midwives, and health service researchers from UCSF and a representative of the Sacramento Perinatal Equity Program. A protocol and brief survey and interview guide were developed. The survey included 13 questions: 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. The interview guide included prompts to explore participant views on topics such as midwives' practice, client needs, and ideas for addressing challenges and opportunities for expanding midwifery access in the Sacramento area. This project was deemed exempt from human subjects review by the institutional review board of UCSF (#21-34841).

RECRUITMENT

We obtained a list of midwives with addresses in Sacramento and the surrounding counties through publicly available data at the State of California Department of Consumer Affairs.[3] The publicly available data contained only postal addresses of midwives; no emails or telephone numbers were accessible. We distributed an introductory letter and the brief survey by mail. Respondents could complete the paper-based survey and return by mail or access the online survey through a QR code or link included in the introductory letter. To maintain confidentiality, the survey was anonymous; however, respondents who volunteered to participate in a follow-up in-depth interview provided their names and email or telephone contact details.

DATA COLLECTION AND ANALYSIS

The survey was conducted between October 14, 2021 and February 28, 2022. Survey data were collected using Qualtrics; paper survey data were entered into Qualtrics by a study team member. Data were analyzed using SAS software (version 9.4, SAS Institute Inc., Cary, NC, USA). Interviews were conducted between January 13, 2022 and January 28, 2022. Interviews lasted 30 – 60 minutes. Interviews were recorded and transcribed verbatim. Interview transcripts were coded by two researchers. A thematic analysis was used for the interview data.

Results

PART ONE – SURVEYS

A total of 142 licensed midwives and nurse-midwives were invited to participate in the survey. Forty-five people initiated the survey and 39 of those completed the survey. Twelve respondents indicated they were not currently practicing. Reasons for not practicing included retiring for health or COVID-19-related reasons, inability to find full-service midwifery jobs, changing nursing specialty for health reasons, quitting due to conflict with supervisors, and taking a break. The final survey sample included 27 respondents (19% participation rate). Detailed survey findings are in Appendix A.

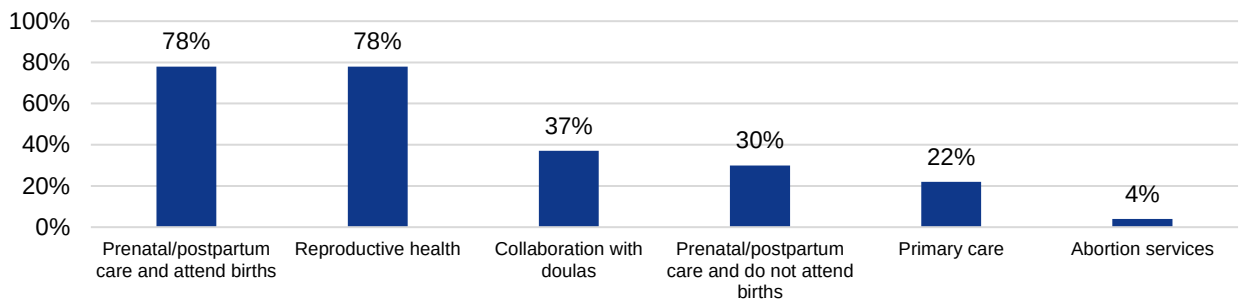
The main findings from the survey were:

1. Midwives provide a range of services
2. Midwifery workforce lacks racial concordance
3. Reimbursement of midwifery services is a challenge
4. Structural changes are needed to increase access to midwifery care

Midwives provide a range of services

Over three-quarters of respondents provide prenatal/postpartum care and attend births, and more than three-quarters provide reproductive health services (Figure 1). Over a third of the respondents work in collaboration with doulas. However, nine out of ten respondents (90%) provide more than one service. The most common combination of midwifery services provided were 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%) (see Appendix A).

Figure 1. Midwifery services that are provided (*n* = 27)



e 4. Reimbursement of midwifery services (*n* = 27)

In responses to the survey open-ended questions, respondents described delivering high-quality health care and working in collaborative teams as successes of 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."*

Midwifery workforce lacks racial concordance

The surveys revealed a lack of racial concordance between midwives and the clients they serve. Racial concordance means having a shared racial identity between a midwife and a client. Over three-quarters of respondents (77%) self-identified as being white (Figure 2). In contrast, of all births in Sacramento county between 2018 and 2020, 38.4% were white, 27.7% were Hispanic, 19.7% were Asian or Pacific Islander, 11.1% were Black, and 0.5% were American Indian or Alaska Native.[1] About a quarter (26%) of respondents estimated that 20% or more of their clients were Black or African American, over half (52%) of respondents estimated that 20% or more of their clients were Latinx, and 22% of respondents estimated that 20% or more of their clients were Asian or Pacific Islander (Figure 3). In response to the open-ended questions, many respondents called for an increase in midwives of color, particularly Black midwives, and mentors for Black student midwives to improve the provision of culturally congruent health care for Black and underserved families.

Figure 2. Racial and ethnic identify of midwives (*n* = 26)

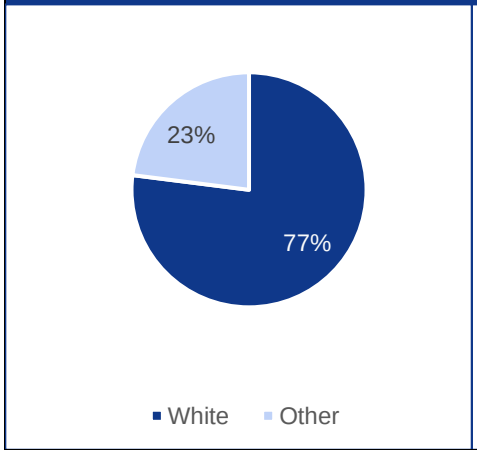
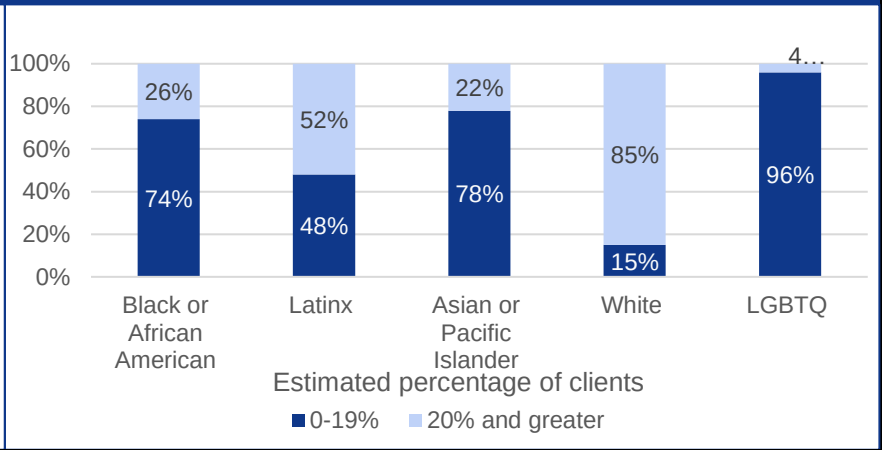


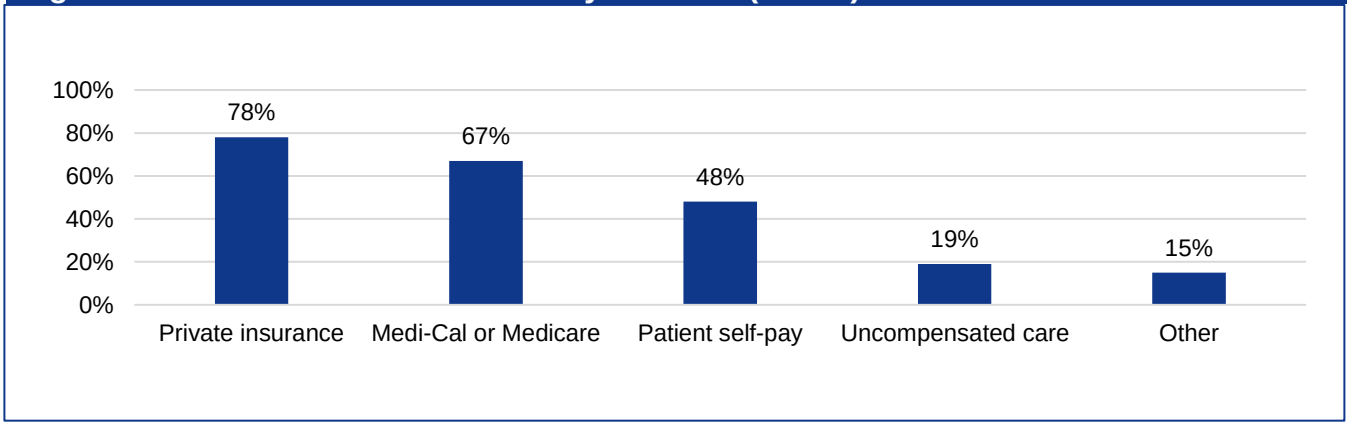
Figure 3. Estimated racial, ethnic and gender identity distribution of clients (*n* = 27)



Reimbursement of midwifery services is a challenge

The most common forms of reimbursement for midwifery services were private insurance (78%), and Medi-Cal or Medicare (67%) (Figure 4). Survey respondents reported challenges with providing midwifery services in Sacramento related to limited accessibility and reimbursement from Medi-Cal and health insurance companies.

Figure 4. Reimbursement of midwifery services (*n* = 27)



There was a common sentiment expressed by respondents in their write-in responses 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. 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.

Structural changes are needed to increase access to midwifery care

Midwifery education programs

Respondents discussed their strong desire for structural changes to improve midwifery services for underserved individuals. Many respondents pointed to the need to expand the midwifery workforce to meet the demand for midwifery services, particularly for underserved individuals. To address the shortage of midwives, respondents suggested increasing the number of midwifery educational programs and supporting midwifery students. One respondent suggested providing *"more available tuition and preceptor options."* Respondents also suggested providing more clinics.

Awareness of midwifery services

Respondents noted the need for raising greater awareness of and access to midwifery services among community members, particularly those in underserved individuals, as well as 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, and philosophy, with an interest in expanding midwifery services in the outpatient setting.

PART TWO – INTERVIEWS

Of the 27 respondents who completed the survey, 8 participated in an in-depth interview. The in-depth interviews further probed the views of midwives practicing in the Sacramento, California, region and facilitators and barriers to access to midwifery services for communities of color. The interviews gave a general sense of the landscape of midwifery practice in the Sacramento region and added nuance to the survey results. Six of the eight interview participants identified as white and two identified as other race (see Appendix B).

The interviews revealed several subthemes related to successes in the current midwifery workforce in the Sacramento region, including:

1. Midwives deliver client-centered care
2. Midwives are aware of racial and economic disparities in health outcomes and access to care and want to address these issues in their practices
3. Midwives perceive community-members have generally positive views of the profession

The main subthemes related to challenges and areas for improvement included:

1. Lack of racial diversity in the workforce
2. Structural barriers to becoming a midwife or practicing midwifery
3. Negative perception of midwifery among some community members, physicians, and hospital administrators.

Additional interview findings are in Appendix B.

Midwifery successes in the Sacramento Region

The survey results indicated that midwives in Sacramento deliver multiple services in the region; the interviews also suggested this.

> *"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… 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*

> *"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*

The interviews also demonstrated how the midwifery workforce strives to deliver ***client-centered care***. Across practice settings and midwifery credentials, the participants discussed their commitment to the Midwives Model of Care,[4] which differentiates itself from medicalized obstetric approaches to perinatal health care by being client-centered, building a trusting relationship between the midwife and client, emphasizing the physical, psychological, and social well-being of the client, and minimizing unnecessary interventions.

> *"The [Federally Qualified Health Center] 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, Federally Qualified Health Center (FQHC)*

> *"We have a robust clinic, and the birth center is a nice compliment 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." – Women's Health Nurse Practitioner, Birth Center

"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 any charting while I'm there with patient." – Certified Nurse-Midwife, health system A

Interview participants were ***aware of race- and class-based disparities in health outcomes and access to midwifery care***. Some were seeking ways to address these disparities in their practice, such as conducting internal research, recruiting more midwives of color, offering flexible payment plans, and assisting clients with insurance issues.

"I had a patient who had not done what she needed to do to get her Medicaid. She 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 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

"We started a project that where we were 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. Then we 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

Interview participants generally described the ***perception of midwifery by the broader Sacramento area as positive***. Clients who know about midwifery may seek out their services because they are seen as an alternative to typical obstetric care.

"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. And 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

Challenges and areas for improvement

The midwives we interviewed were aware of social determinants of health and the barriers their clients face in accessing care. They also spoke extensively about ***a lack of racially concordant care available in Sacramento*** for communities of color. This lack of racially concordant care reduces the availability of culturally competent midwifery care. Cultural competence refers to the ability of the clinician to engage with clients from diverse backgrounds and to provide personalized care based on the client's needs and experience.

"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 do is it doesn't create cultural competency for other groups. We have mostly white midwives, and then almost 100% Hispanic staff.… 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 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

Midwives described that the midwifery workforce does not reflect the community or clients they serve, which feeds into the lack of racially concordant care:

"... 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

"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

The interview participants identified ***several structural inequities that make becoming midwives or practicing midwifery extremely difficult.*** These educational, financial, and policy barriers may contribute to the lack of diversity in the midwifery workforce, as well as prohibit midwives in Sacramento from expanding the reach of their practices.

Interviewees indicated that barriers to entering the midwifery profession begin at least with the educational pipeline for midwives. Participants described a lack of social support for learners, confusing educational pathways, insufficient financial aid, and too few preceptor opportunities for aspiring midwives.

"... 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 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." – Certified Nurse-Midwife, state hospital and health system A

"You're trying to precept a student and that's part of your job as a midwife to continue the profession… Students are finding very hard to find preceptors, because that's the thing -- 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

Midwives who are currently practicing also face significant financial barriers to providing the kind of care they would ideally like to provide, or providing care to all the client populations they would ideally like to reach.

"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... so 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." – Licensed Midwife, FQHC

"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

Some of these financial or payment issues, especially related to Medi-Cal reimbursement, are related to other regulatory or policy issues described in interviews.

> *"[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." – 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*

Although interview participants perceived that midwifery was viewed positively among clients who knew about midwifery, they also discussed that ***many people do not understand what midwifery is or how midwives practice***. They noted that knowledge of midwifery services, and access to the services themselves, may also be inequitably distributed along class or racial lines.

> *"[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*

> *"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

Interviewees discussed that physicians, hospital administrators, and other perinatal health providers may have incorrect or negative notions of the scope of midwifery practice or the midwifery model of care.

"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

"So, including our administration, they're not familiar what is the role of midwife… 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

A lack of respect and/or understanding from hospital administrators and physicians has created a maldistribution of labor among much of the midwifery workforce and keeps midwives from fully practicing the *"art of midwifery,"* as one participant described it.

"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

"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.' 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

Conclusions

Midwives in the Sacramento region provide a range of client-centered services that are rooted in the midwives model of care when their clinical setting allows it. Most of the midwives in this study – nine out of 10 in the survey and virtually all interview participants – provided multiple services in their practices. They were not just *"catching babies"* – midwives in Sacramento provide client-centered prenatal care, lactation consulting, postpartum care, infant health, and general women's health care. Several interview participants described the ways in which they go above what clinic administrators or health insurance reimbursement structures acknowledge – often working extra or uncompensated time. Interview participants who worked in hospitals or other large health care provider settings often described a maldistribution of labor between midwives and physicians, and an administrative structure that did not allow them to fully practice midwifery.

The midwifery workforce in Sacramento lacks racial diversity, and therefore clients in the Sacramento region do not have access to racially concordant and culturally competent care. Seventy-seven percent of survey respondents identified as white, and the interviews affirmed that most of the midwives in the region are white. Six out of eight interview participants also identified as white. The interviews discussed potential reasons why people of color do not enter the midwifery workforce, such as high costs of education, the needs for childcare in school, and a lack of training opportunities. Hiring practices are also an issue; some interview participants discussed needing to change recruiting practices to attract more midwives of color. The framework of cultural competency in the region is often limited to hiring Spanish-speaking midwives or clinical staff, which ignores the languages and cultures of other communities of color.

Interview participants were knowledgeable about what they and their clients need to improve access and quality of perinatal care in the area and offered several policy and practice solutions to the challenges they and their clients face. Reimbursement for services is an issue, especially for midwives in independent practice, and was cited as a barrier to expanding practice to clients with lower incomes. Sixty-seven percent of survey respondents said they accepted Medi-Cal or Medicare, suggesting that a third of midwives in the region may not be accepting a form of insurance that covers half of the births in California.[5] Survey and interview responses illuminate the various regulatory and financial hurdles independent midwives must overcome to be reimbursed by Medi-Cal. Survey respondents also discussed how Medi-Cal has such low reimbursement rates that going through the bureaucratic hoops to become eligible Medi-Cal providers often is not worth it.

Many of the biggest barriers to providing and receiving midwifery care in the Sacramento region are structural: regulatory systems that price midwives out of providing care to clients with lower incomes, a workforce pipeline that discourages people of color from entering or staying in the field, and increasing demands on *“less expensive”* clinicians who want to provide an alternative to contemporary perinatal health care. The successes of midwifery care in Sacramento are driven by the midwives who manage to provide holistic, compassionate care despite these structural barriers when and where they can.

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