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Medicaid Pays for That? An Exploratory, Mixed-Methods Analysis of Florida Home Birth

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Medicaid Pays for That?

An Exploratory, Mixed-Methods Analysis of Florida Home Birth

by

Nicole K. Demetriou

A dissertation submitted in partial fulfillment of the requirements for the degrees of
Doctor of Philosophy
Department of Anthropology
College of Arts and Sciences
University of South Florida

and

Master of Public Health
Department of Global Health
College of Public Health
University of South Florida

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Midwifery, Access to Care, Autonomy, Informed Choice, Empowerment

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DEDICATION

To midwives around the world preserving the sanctity of physiologic birth, policy makers recognizing its vital importance, and women and families honoring it in the warmth of their homes.
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I am grateful to all who provided support and encouragement on this journey, starting from those who helped me find my way to the University of South Florida and leading to those who helped me design and conduct this research. First off, Mavis Schorn midwifed me into the profession and for that I will be forever grateful. The National Health Service Corps not only financially supported my graduate nursing and midwifery education, but opened opportunities for me to provide health care in the “underserved” settings that would spark my desire to engage with the health system and policies through doctoral study. Big thanks go to Charles Mahan who recommended I consider the dual anthropology/public health program at the University of South Florida and who has spent many tireless years supporting midwifery. Aimee Eden spent many hours talking with me when I was just considering the program, and her infectious enthusiasm for maternal and child health helped steer me here and kept me on track with this research. Thanks as well to all of my fellow graduate students at USF.

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ABSTRACT

The overwhelming social norm for pregnant women in the U.S. is to receive prenatal care from an obstetrician and to give birth in a hospital setting. However, the incidence of midwifery care and out-of-hospital birth is increasing, particularly among White, non-Hispanic women. Florida has been considered a “model” state for home birth midwifery given legislative support that mandates coverage of all types of midwifery (e.g., Certified Professional Midwives and Certified Nurse-Midwives) care in all birth settings (e.g., hospital, home, birth center) and by all forms of insurance (e.g., commercial and Medicaid). Medicaid is the payer source for nearly half of the births in the United States and in Florida. However, Florida is one of only ten states where Certified Professional Midwives, who attend the vast majority of planned home births, are actively able to receive Medicaid reimbursement for home birth care. A key question then becomes, how is the system for Medicaid-funded home birth in Florida functioning?

The central aim of this research was to better understand how Medicaid impacts the practice of and access to planned home birth in Florida. This was examined through quantitative analysis of Florida birth certificates as well as through qualitative data collection and analysis that sought to describe the experiences of women who had planned home birth while on Medicaid as well as the experiences of midwives that cared for these women. Findings are presented through the lens of Critical Medical Anthropology, which helps to interpret how and why home birth is systematically supported or threatened by legislation, policy, and practice at the level of the State of Florida, the federal-state Medicaid program, and the professional organizations in the United States involved in maternity care.

Key findings demonstrate that the vast majority (87%) of planned home birth in Florida is attended by Certified Professional Midwives, and that while Florida Medicaid paid for 45% of all births between 2005 and 2010, only 31% of planned home births were paid for by Medicaid.
However, after controlling for multiple factors (e.g., race/ethnicity, age, parity), in fact women who completed home birth were much more likely to be self-pay (AOR 10.1) or on Medicaid (AOR 4.6) compared to private, commercial insurance. Women interviewed for this study who received Medicaid for their home births overwhelmingly appreciated the “safety net” that Medicaid provided to them and the “relief” of knowing that if a hospital transfer was necessary it would be covered. However, they nearly universally stated that they would have found a way to pay for a home birth if they had not received Medicaid. Women felt that home birth with midwives provided them the greatest chance of having a “natural” birth in the environment most likely to maintain autonomy over decisions related to their pregnancy and birth. Several women experienced significant delays in enrolling in Medicaid, and found that the only providers who would provide care during “presumptive eligibility” were Licensed, Certified Professional Midwives. Midwives appreciated the steady, reliable payments Medicaid provided, despite that these were at about 30 to 40% of their rates charged to privately insured or self-pay clients. They felt that providing care to Medicaid funded women served as a form of social justice. They strongly disliked interfacing with Medicaid HMOs. Some midwives felt that the Florida legislation supported their practice, while others felt that it constrained their practice.

Medicaid coverage of planned home birth in Florida now stands at a crossroads, given that Florida Medicaid has recently transitioned to a 100% managed care program (i.e., HMOs). These HMOs act as intermediaries between Medicaid providers and their reimbursements, as well as between Medicaid providers and recipients. The new relationships between providers, patients and the HMOs have shifted from that with a state agency to that with a private, for-profit industry. It remains to be seen whether home birth providers will enroll with Medicaid HMOs in order to continue providing care to pregnant women receiving Medicaid.

Key policy recommendations therefore are to monitor women’s access to pregnancy Medicaid, and specifically access to services mandated under Florida statute, including home
birth and midwifery care. Furthermore, the creation of an integrated maternity care system that better supports transfers of care from the home to hospital setting is needed
CHAPTER 1: BACKGROUND

Dissertation Overview

This dissertation grew out of multiple interests: in the topic of home birth as an expression of our innate biological reproductive capacity; in the topic of Medicaid as a policy experiment and a lived reality for recipients; and in the application of mixed methods to these topics to gain a deeper understanding of each and their interactions. The fields of anthropology and public health encourage a multi-faceted examination of human issues incorporating politics, culture, economics, biology, epidemiology, and so much more and allowed for this dissertation to view these topics from broad lenses.

The main goals of this research were to document the prevalence and socio-demographic characteristics of Medicaid-funded home birth in Florida; to examine the impact of Medicaid funding on home birth access; to examine the motivations for home birth among Medicaid-funded women; to document their experiences with prenatal care and birth; and to examine home birth providers’ experiences with the Medicaid system.

At its core, this dissertation sought to understand how the funding source for nearly half of America’s births, Medicaid, contributes to women’s access to a type of prenatal and delivery care that is far from mainstream and at times quite contentious: home birth. From a starting point of being situated in Florida, one of the few states that not only supports home birth among Medicaid recipients but one that is actually considered a “model” state for this practice, this dissertation sought to understand how Medicaid-funded home birth in Florida practically unfolds. How do women find out about their option for home birth? What motivates Medicaid recipients to pursue home birth? What is their experience with home birth midwives? Why do home birth midwives accept Medicaid clients and what rewards or challenges do they face working with this population or with the Medicaid system? Does Medicaid funding increase access to home birth
among minority women despite recent studies showing these women rarely seek out home birth?

This dissertation is structured to report in Chapter One on the topic of maternity care generally and home birth in particular in the United States (U.S.), as well as on the payment mechanisms for health care and maternity care in the U.S. and an overview of models of care. It concludes with an overview of the anthropology of reproduction. Chapter Two lays out the theoretical framework for the dissertation, which is rooted in a Critical Medical Anthropology approach and analyzes policy documents that relate to the topic of home birth. It also examines theories of risk, as risk is a paramount topic regarding birth, particularly when it occurs out-of-hospital. Chapter Three presents the methodological approaches to the research and the research objectives. Chapter Four reports on the quantitative analyses conducted on Florida birth certificates that help to both describe the Florida population that completed home birth, as well as to report on predictive factors and associations between payment sources and birth locations. Chapter Five reports on how the study participants felt that society viewed the concepts of midwifery, home birth, and Medicaid, and how the participants themselves experience them. Chapter Six specifically presents the experiences of being on Medicaid for recipients and for midwives as Medicaid providers. Chapter Seven presents results that relate to the topic of home birth, and reveals from both the perspectives of the Medicaid recipients and providers on the motivations for home birth, the pros and cons of home birth and hospital birth, and the best parts of prenatal care received from home birth midwives. Chapter Eight reports on issues related to access: making it through the Medicaid application process, the ways that Medicaid fosters or hinders access to other services during pregnancy, the ways that home birth and Medicaid constrain or promote access to Vaginal Birth After Cesarean (VBAC), and the potential shifts in access that Medicaid HMOs will have for both pregnant women and midwives. Chapter Nine reports on issues related to empowerment as an outgrowth of home birth and concludes with a discussion of how Florida policies either promote or constrict home birth
access. Chapter Ten reviews the key study findings and their implications, and makes recommendations for policy and future research.

**Chapter Overview**

The overwhelming social norm for pregnant women in the U.S. is to receive prenatal care from an obstetrician and to give birth in a hospital setting. However, a growing call for midwifery care and out-of-hospital birth exists. This chapter will begin with an overview of the current maternity care system in the U.S., followed by an overview of U.S. midwifery. Payment mechanisms for pregnancy and birth care will be reviewed, along with a brief overview of the Medicaid system and the Affordable Care Act. A review of home birth in the U.S. will include its history, current practice, and what is known about women’s motivations for home birth, as well as a review of the pros and cons of home birth, particularly in regards to maternal and newborn safety. This chapter will conclude with a comparison of the medical and midwifery models of care, followed by a brief overview of the anthropology of reproduction in order to frame this dissertation within the discipline.

**Maternity Care and Midwifery in the United States**

A discussion of home birth must be situated within an understanding of the U.S. maternity care system, as well as of the U.S. health care system and its payment mechanisms in general. The U.S. stands out as the sole industrialized, Western nation in which midwives, regarded as experts in normal birth, are not the primary providers of maternity care (Wagner 2006). However, despite a midwifery model and increased systematic support for home birth in nations such as England and Canada, home birth rates among these other industrialized western nations are only slightly higher than those in the U.S., hovering around 1 to 2%, potentially related to the social organization of the health models and midwifery systems in those nations (Benoit, et al. 2005). However, an exception to this pattern is The Netherlands, which has long been recognized for its support of home birth and has home birth rates at approximately 29% (Hendrix, et al. 2009b). What is unique to the U.S. is that very few births are
attended by midwives, regardless of the birth setting. In fact, U.S. midwives are considered “marginalized” despite evidence documenting their cost-effectiveness and high-quality care (Goodman 2007), and frequent closures of midwifery practices happen, often without any accountability (Rooks, et al. 2008).

The vast majority of U.S. births are attended in hospitals by physicians, (91.2% in 2009) (Martin, et al. 2011), generally by obstetricians who are experts in high-risk, surgical births. These physicians may have received degrees as medical doctors (MD) or doctors of osteopathy (DO), and may include physicians practicing as obstetricians or family physicians. In 2009, midwives attended 7.6% of all births, with Certified Nurse-Midwives (CNM) attending 93.5% of these and “Other” midwives attending 6.5% (Martin, et al. 2011) (a discussion of the types of midwives in the U.S. will be provided below and Table 1.1 outlines the types of maternity care providers and their common practice settings). Midwives attended 12.1% of vaginal births, with CNMs attending 11.3% of total vaginal births and “Other” midwives less than 1% (Martin, et al. 2011). The overall cesarean section rate in the U.S. in 2009 was 32.9%, representing a 60% increase from the mid-90s, and reflecting annual 2 to 7% rises in the same time period (Martin, et al. 2011). Therefore, one in three U.S. women experience a surgical birth. Figure 1.1 (Cyr 2006; Martin, et al. 2003; Menacker and Curtin 2001; Menacker and Hamilton 2010) highlights the shifts in total cesarean rates in the U.S. from 1989 to 2012, as well as rates of primary cesareans and vaginal births after cesarean. Reasons for the increase in cesarean births are multi-faceted, with primary drivers including providers’ fear of litigation (Cheng, et al. 2014-in press; Cox 2011), the American College of Obstetricians and Gynecologists (ACOG) 1999

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1 All Tables and Figures in this dissertation are reported at the conclusion of the chapter in which they are first discussed.
2 It is widely assumed that births attended by CNMs are underreported, and instead are credited to the physicians working in conjunction with CNMs (Walker et al 2004).
3 ACOG has changed its name from “College” to “Congress, but obtaining an accurate date for this name change has proven futile. Furthermore, Therefore, many of ACOGs own practice bulletins continue to utilize “College” although its formal name is referenced as “Congress”. Therefore, for simplicity, “College”
practice guidelines that included the recommendation for the “immediate availability” of a surgeon and anesthesia provider at attempted VBAC (American College of Obstetricians and Gynecologists 1999; Minkoff and Fridman 2010), other issues related to VBAC (National Instutes of Health 2010) particularly women’s lack of access to VBAC (Pratt 2013), and even maternal demand (Dexter, et al. 2014; Kukla, et al. 2009; National Instutes of Health 2006).

Some data suggest that cesareans are done for “convenience” (Tully and Ball 2013) or that economic incentives exist for physicians to perform cesareans (Lefevre 2014). However, the most recent examination concludes that the decision for a provider to perform a cesarean is ultimately multi-faceted (Cheng, et al. 2014).

As noted, births in hospitals are the dominant U.S. cultural norm, with 98.9% of all 2009 U.S. births occurring in that setting (Martin, et al. 2011). Since 1990, total out-of-hospital births in the U.S. have hovered in the 1% range, although a gradual decline from 1990 to 2004 (MacDorman, et al. 2010) converted to a 29% increase in home birth between 2004 and 2009 (MacDorman, et al. 2012a) and in 2012, 1.36% of all births occurred out-of-hospital (MacDorman, et al. 2014). This increase has been fueled mostly by a 36% rise among white, non-Hispanic women adopting the practice (MacDorman, et al. 2012a). Potential reasons for this race stratified increase include: the historical promotion of Lamaze classes and self-help groups (Jackson and Bailes 2013; Jackson and Bailes 1995) which primarily formed among white women; the speculation that Certified Nurse-Midwives who had attended most home births used a risk scoring system that could risk out minority women (Declercq, et al. 1995); or most recently through the popularity of films such as The Business of Being Born (Epstein 2008; Hans and Kimberly 2011). However, a more recent examination (MacDorman, et al. 2014) of the longer-term out-of-hospital birth trends from 2004 to 2012 demonstrate increased rates among all race/ethnicities. The largest out-of-hospital birth rate increase was among White-
non-Hispanic women (1.20% to 2.05%), with much more modest increases among Black-non-Hispanic (0.45% to 0.49%), Hispanic (0.38% to 0.46%), American-Indian (0.64% to 0.81%) and Asian/Pacific Island women (0.38% to 0.54%). White-non-Hispanic women contributed 89% toward the overall out-of-hospital rate increase from 0.87% in 2004 to 1.36% in 2012. In this same period, overall home birth rates increased from 0.56% to 0.89%, while birth center rates increased from 0.23% to 0.39%. Geographic variations in home birth rates exist, with northwestern states demonstrating home birth rates around 2% and southeastern states below 0.5% (MacDorman, et al. 2012a). Vital statistics reports published by the National Center for Health Statistics do not describe the payment source and/or insurance status for women or newborns, so from these reports it is difficult to assess the rates and trends of home birth mothers from various payment sources, or if home birth is primarily paid for out-of-pocket.

The World Health Organization (WHO) recognizes a woman’s right to choose a home birth, but recommends this only for women with low-risk pregnancies who receive skilled care and have plans for transfer to a facility for birth if complications arise (World Health Organization 1996). Furthermore, the WHO (World Health Organization 2004) recommends “that all women and newborns have skilled care during pregnancy, childbirth and the immediate postnatal period” and define a “skilled attendant” as:

An accredited health professional — such as a midwife, doctor or nurse — who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns (World Health Organization, 2004:1).

Therefore, a key component related to home birth in the U.S. is the presence or absence of a skilled attendant, which the WHO focuses on being trained in “normal” childbirth. However, obstetricians, considered specialists in high-risk births, attend most U.S. births. Many
obstetricians rarely attend or witness “normal” birth because the iatrogenic\(^4\) complications that arise during most hospital births make “normal” childbirth a rare event.

In addition, the International Confederation of Midwives (ICM) defines a midwife as:

A person who has successfully completed a midwifery education program that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery (International Confederation of Midwives 2011b).

This updated definition, along with ICM’s updated Essential Competencies of Basic Midwifery (International Confederation of Midwives 2013a) and Global Standards for Midwifery Education (International Confederation of Midwives 2013b), has challenged midwifery organizations worldwide to review their own standards for education and regulation. Within the U.S., these have created challenges partially because there are no uniform midwifery qualifications nationwide regarding midwifery education, licensure and regulation, as will be discussed below. In particular, these new ICM standards challenge certain routes to midwifery certification, such as an apprenticeship model that one type of U.S. midwives (Certified Professional Midwives, CPM) honors, but that another, Certified Nurse-Midwives (CNM), does not.

In order to address this and other issues that ultimately can strengthen U.S. midwifery as a whole, the U.S. Midwifery Education, Regulation and Association (U.S. MERA) work group was formed in 2011. U.S. MERA consists of members representing seven national midwifery organizations: American College of Nurse-Midwives (ACNM), Accreditation Commission for Midwifery Education (ACME), American Midwifery Certification Board (AMCB), Midwifery Education Accreditation Council (MEAC), Midwives Alliance of North America (MANA), National Association of Certified Professional Midwives (NACPM), and North American Registry of Midwives (NARM). The U.S. MERA focus has been to, “envision and work toward a more

\(^4\) Iatrogenic refers to problems that are caused by medical care itself. The concept is described in more depth in Chapter 2, in the Risk in Pregnancy and Childbirth section.
cohesive US midwifery presence inspired and informed by global midwifery standards and competencies adopted by the International Confederation of Midwives in 2011” (US MERA 2014). In reality, this group represents a historic shift among U.S. midwives towards working together to ultimately grow midwifery within the U.S. Indeed, a call has been made for unity among the types of U.S. midwives to support an effort at decreasing midwifery’s marginalization (Peterson 2010). It is notable that so many midwifery groups exist in the U.S., despite the fact that midwives collectively attend less than 10% of all U.S. births. This points to both the historic marginalization of midwives but also to the historic split between nurse-midwives and direct-entry (non-nurse) midwives.

In the U.S., there are no federally recognized licenses for health professions. Rather, states have the authority to license and regulate health care providers. However, the basis for these licenses is usually a national certification that most health professions use to determine state license eligibility. Furthermore, states determine many of the laws related to health professionals’ scope of practice, requirements for liability insurance, service coverage by health insurance plans, and criteria for Medicaid reimbursement. This creates a largely disparate picture of midwifery regulation and in particular home birth practice in the U.S., given that only twenty-eight states have some form of legal recognition and/or regulation of non-nurse-midwives (Big Push for Midwives 2013). Table 1.2 presents a current listing of the recognition of non-nurse-midwifery by state, and includes whether CPMs are recognized by Medicaid.

As briefly described above, midwives in the U.S. are not a homogenous group. Table 1.1 describes the different types of obstetrical providers in the U.S. Certified Nurse-Midwives (CNM) are nurses with post-graduate degrees who primarily attend births in hospital settings (although they can also attend births at home and in birth centers), and are legal and licensed in all states, territories and the District of Columbia. Certified Midwives (CM) are certified and regulated by the same accrediting body as CNMs (the American Midwifery Certification Board, AMCB) which is the only midwifery certifying body recognized by the American College of
Obstetricians and Gynecologists, the professional organization for U.S. obstetricians. However, CMs enter midwifery without nursing backgrounds. CMs can practice both in hospitals and in out-of-hospital settings, but only three states (NY, NJ, RI) license CMs, and two others (DE and MO) authorize CMs to practice (American Midwifery Certification Board 2014). Certified Professional Midwives (CPM) also enter midwifery without requisite backgrounds in nursing, and become eligible to sit for certification through a separate accrediting body, the North American Registry of Midwives (NARM), after completion of either an accredited educational institutional program, an apprenticeship, or a portfolio evaluation process. CPMs almost exclusively attend births at home or in birth centers, are regulated in twenty-eight states, and are eligible for licensure in twenty-six states (Big Push for Midwives 2013), as detailed in Table 1.2. In addition, there are people who call themselves midwives but who have not been certified in any of these manners. These types of midwives all differ from the growing presence of doulas, whose function is to support a woman and her family during the labor, birth and postpartum periods, but who rarely have specific technical training such as being nurses.

Regulation of midwifery practice varies per state laws and statutes. Some states regulate CNMs through a nursing board, some through a medical board, and a few through a midwifery board, or some a combination thereof. Due to the fact that CNMs are actively and legally practicing in all states, and because they attend so few home births in the U.S., a separate table delineating state-by-state governance is not provided. Certified Professional Midwives are not uniformly recognized, but in those twenty-eight states where they are, they are either regulated through licensure, certification, registration or permit (as outlined in Table 1.2). In those states without recognition, the practice of CPMs might be illegal or alegal (in other words, no laws or statutes regulate their practice so they exist in a “grey zone”) depending on statutes and judicial interpretations.

While midwives practice in different settings, certain principles of care are common to all types of midwives. Utmost to this is the emphasis on the normalcy of pregnancy and a woman's
autonomy to make decisions for herself and her baby. Table 1.3 highlights the differences between the midwifery and medical models of care. Thus, midwifery care in the U.S. is not of a singular type, although there is not a clear distinction among women or society at large regarding the differences between midwifery types.

Of the 1.36% of U.S. out-of-hospital births in 2012, 66% occurred at home and 29% in a freestanding birth center, with the remaining 5% occurring in a clinic, physician’s office, other, or unknown location (MacDorman, et al. 2014). Thus, home birth typically represents two-thirds of out-of-hospital birth, and can be classified as planned, unplanned, and/or unassisted. Planned home births are those where the intended birth site was in the woman’s home and in fact the birth occurred there. Unplanned home births are those where the birth site was not intended to be home, but birth did occur there. These can include cases of women who may have planned a birth center or hospital birth but were unable to reach the facility due to transportation issues, rapid labors, or various other reasons, or might even include women who were not aware of their pregnancies or those who might have been aiming to avoid detection of pregnancies and birth. The latter group includes groups such as women who abuse substances and who might fear their children would be removed from the home, or undocumented immigrants who might fear deportation, among others. Finally, unassisted home births are those where no skilled attendant was present. These may or may not have been planned. An increasing number of women are choosing this route for a variety of reasons, including religious convictions or desire to avoid repeat cesarean sections (Miller 2009). Despite the addition of the checkbox “Home birth: Planned to deliver at home (yes/no)” to the 2003 revised U.S. birth certificate (National Center for Health Statistics 2000; National Center for Health Statistics 2003), it remains difficult to assess the delivery planning status of births that occurred in the home or the hospital, partially because as of 2013, only 33 states had fully implemented the 2003 birth certificate revision. Home births that were planned, but were attended by non-licensed or even illegal practitioners, may not have appropriately selected the “planned” check box. Additionally, births
that occurred in the hospital but were intended to be home births are not required to utilize the “planned home birth” checkbox. Oregon is the only state that, as of 2012, has mandated the use of the check box for all births, regardless of final birth place, and thus represents the only state where birth certificates can be utilized for “intent-to-treat” analyses related to birth setting. Overall, there are currently no good mechanisms in the U.S. to accurately report or estimate planned home birth frequencies, although the Midwives Alliance of North America Statistics Project (MANAStats) might represent a way to assess planned home birth frequencies among CPMs in the future if NARM begins to mandate that its midwives report their enrolled clients’ data into this system.

However, based on the best statistics available from an analysis of birth certificates from the states that had implemented the planned home birth checkbox, it is evident that the vast majority of planned U.S. home births were attended by non-nurse midwives (Declercq, et al. 2010; MacDorman, et al. 2012a). In 2009, physicians (both MD and DO) attended 5% of all U.S. home births, with many of these actually representing unplanned, emergency situations (MacDorman, et al. 2012a). CNMs attended 19% of home births, “other” midwives 43%, and “other” attendants 33%. Notably, in the hospital setting where 92% of births are attended by physicians, less than 1% are listed as having an “other” attendant, and these could represent Registered Nurses who attended a birth prior to the arrival of a credentialed provider. Among home births, these 33% of “other” attendants could represent family members or emergency services personnel who attended an unplanned home birth, but could also include trained midwives practicing in states where licensure is illegal or undefined, or even self-proclaimed but “untrained” and “unregulated” midwives. “Other” attendants also include women who choose to birth at home without professional attendance, known as “freebirthing” (Freeze 2009; Miller 2009) or unassisted birth. “Other midwives” include Licensed Midwives (LM) in states where licensure is available, and/or Certified Professional Midwives (CPM), and/or non-professional midwives such as those who are called to attend births by a religious conviction (Klassen 2001).
Thus, it cannot be ascertained from birth certificates which of these “other” midwives are trained vs. untrained, licensed and/or regulated vs. unlicensed/unregulated. Again, Tables 1.1 and 1.2 provide descriptions of the types of obstetrical providers and of midwives’ state-by-state legal status. Thus, almost half (and potentially up to 75%) of the nation’s home births are attended by non-nurse-midwives. This is relevant because it suggests that women who desire home birth are often forced to choose an attendant that is not fully recognized and integrated into the health care system, which can lead to difficult transfers of care if a hospital birth becomes necessary (Cheyney, et al. 2014c; Davis-Floyd 2004; Fox, et al. 2014). In fact, the dominant U.S. societies of obstetrics (American College of Obstetricians and Gynecologists, ACOG) and pediatrics (American Academy of Pediatrics, AAP) only endorse midwives certified by the American Midwifery Certification Board (AMCB) (e.g., CNMs and CMs, not CPMs or “other” midwives) for planned out-of-hospital birth, which contributes to a lack of choice among women who desire home birth. When a “legal” midwifery or home birth option is not available to a woman, she is at times compelled to “freebirth” (Freeze 2009).

**Payment Mechanisms for Maternity Care in the United States**

Birthplace options in the U.S. are at least partially driven by payment mechanisms for maternity services, particularly when birth occurs out-of-hospital. One study of home birth primarily in the Southeast (Miller and Shriver 2012) suggests that economics, particularly a woman’s health insurance status, drives women’s choices for birth location. Little if any research on publicly-funded home birth in the U.S. has been conducted. However, research in Australia has specifically examined the increase in (often unattended) home birth as a form of resistance to the lack of public funding available for home birth (Catling-Paull, et al. 2012; Dahlen, et al. 2011). It is not known if women with Medicaid funding, particularly in states where Medicaid does not cover home birth provided by non-nurse-midwives, are choosing to remain at home and give birth unattended if they cannot find a provider recognized by Medicaid. In fact, even in Florida, where Medicaid does reimburse CPMs/LMs for home birth, rates of Medicaid-funded
planned home births are significantly lower than those of Medicaid-funded hospital births, even among women who meet risk criteria for planned home birth.

**Brief Overview of the U.S. Health Insurance System**

The United States does not have a universal health care or universal health insurance system. However, health insurance acts as a gatekeeper to health care in the U.S., and since World War II, health insurance has largely been obtained as a fringe benefit tied to employment (Klees, et al. 2010; McLaughlin and McLaughlin 2008). Some citizens are able to secure government-backed health insurance, either through Medicare, Medicaid or a military-based health plan that are outlined in Table 1.4, which describes the common types of health insurance in the United States. While individuals can purchase health insurance on the open market, individual plans are generally cost-prohibitive, as insurance companies price them in consideration of the principle of adverse selection (i.e., individuals who choose health insurance coverage are most likely to require health care).

In 2010, President Obama succeeded in passing the first national health reform since the 1965 advent of Medicare and Medicaid; however, the President’s program acts more like health insurance reform than health care reform. The Patient Protection and Affordable Care Act (ACA) (U.S. Congress 2010) and its “individual mandate” for all Americans to obtain and maintain health insurance is aimed to address and reduce the gap between those who have access to health insurance and those who do not. Health insurance as an employment benefit has declined, partially due to the increasing unemployment rate in the U.S., as well as to under-employment and the proliferation of part-time employment that does not carry health insurance benefits (Kaiser Family Foundation 2011). The ACA only mandates employers with more than fifty “full-time equivalent” employees to offer health insurance coverage to employees that work at least thirty hours per week, or the employer faces a fine. The ACA creation of health insurance exchanges, where both small employers and individuals can shop for health insurance coverage while at the same time determine if they are eligible for any federal
subsidies to help pay for the coverage, helps to bring Americans to the health insurance marketplace with greater buying power than on an individual market. These exchanges were mandated by the ACA, but states had the choice to either create their own, to defer to the federal exchange, or enter into a state-federal partnership. Since the implementation of the ACA on January 1, 2014, an estimated 20 million Americans gained health insurance coverage (Blumenthal and Collins 2014). However, states that demonstrated the steepest declines in their rate of uninsured adults either expanded their Medicaid program or set up state-based exchanges (Clemans-Cope, et al. 2014) (Florida did neither), with Arkansas (10.1%) and Kentucky (8.5%) showing the greatest reductions in uninsured adults (Wilters 2014). The long-term effects of the ACA and the exchanges on net reductions in uninsured Americans remains to be shown.

Medicare and Medicaid were enacted in 1965 to provide health coverage to the elderly, disabled, and low-income families with dependent children. Medicare recipients are by and large over 65 years of age or disabled. In 2010, among non-elderly adult Americans, 56% had employer-sponsored health insurance, 20% had Medicaid or other public sources, 5.5% had private/non-group coverage, and 18.5% were uninsured (Kaiser Family Foundation 2011), with large variation in rates of uninsured adults across states. These statistics have varied over time, with an increasing number of uninsured Americans who rely on the “health care safety net” (Institute of Medicine 2000), a patchwork of federally-funded community health centers, state health departments, free clinics, hospitals that provide a disproportionate share of uncompensated care, and even prisons and other non-mainstream sources of health care that provide care to uninsured and underinsured individuals and families, including those with Medicaid coverage that are unable to obtain health care elsewhere (Katz 2010). The irony is not lost in the fact that the very notion of a “safety net” implies the system itself is lacking, and care for “vulnerable” populations is left to institutions on the margins. Many women receive maternity care through the safety net, particularly because many private obstetricians do not
accept Medicaid as a payer source (American College of Obstetricians and Gynecologists 2008a; DiVenere 2012) or do not provide care to uninsured women. Care provided within community health centers, a vital part of the safety net, is comprehensive, coordinated, and focused on primary and preventive care. In addition, it offers ancillary services such as transportation and child care for health visits that in many ways exceed “standard” health care by addressing these additional, often complex, psycho-social needs (Maxwell, et al. 2014). Although very little federal oversight or analysis of the safety net occurs (Lewin and Baxter 2007), research has documented decreased racial disparities in rates of low birth weight among care recipients at community health centers (Shi, et al. 2004). However, this effect may be specific to this care model, as other research (Sparks 2009) utilizing a race-stratified model demonstrates that access to timely and appropriate prenatal care was the greatest predictor for pre-term birth reduction. This further suggests that the dominant paradigm of perinatal care delivery in the U.S. may not best serve women (particularly those who are low-income or on Medicaid) or produce the best perinatal outcomes, and points to the need for change. One such example is “Centering Pregnancy”, the increasingly utilized model of group prenatal care where about ten women with an estimated due date in the same month attend prenatal appointments together and ultimately receive increased amounts of education and social support during these group prenatal visits. This model has demonstrated improvements in low-birth weight, particularly among pre-term infants, and most notably among racial minorities (Ickovics, et al. 2007; Ickovics, et al. 2003).

**Medicaid and Pregnancy in the United States**

Medicaid is a federal/state entitlement program that offers health insurance to individuals who meet categorical and financial criteria. Categorical eligibility is afforded to low-income: seniors, non-elderly individuals with disabilities, children under eighteen, pregnant women, and adults with dependent children, when they also meet financial eligibility requirements (Centers for Medicare and Medicaid Services 2013). Each state sets its own limits regarding financial
need, or accepts limits set by the federal government. The minimum financial eligibility for pregnant women is 133% of the federal poverty level, based on household size. All but nine states have expanded eligibility for incomes above this threshold, with Florida using 185% of federal poverty as the eligibility threshold at the time of study interviews. However, in 2014, Florida raised the rate for pregnancy Medicaid to 191% of federal poverty. The pregnant woman’s unborn child is counted as a household member in the calculations, along with all other household members. Thus, for a family of three in Florida (e.g., the woman, her husband and unborn child) she would qualify for pregnancy Medicaid with an annual household income up to $37,800. Once a pregnant woman is approved for Medicaid, her coverage remains in effect until the last day of the month after sixty days from the day of delivery, regardless of any change in household income. Additionally, the newborn is automatically eligible for Medicaid at birth for a one-year period, regardless of the mother’s or father’s immigration status (Kaiser Family Foundation 2013a). Until 2009, states could deny any Medicaid coverage to non-citizens, including for up to five years after they obtained legal residency, except for emergency care or for labor and delivery per the Emergency Medical Treatment and Active Labor Act (EMTALA) statute. The 2009 Children’s Health Insurance Program Reauthorization Act (CHIPRA) regulations changed this so that states could now provide lawful residents coverage under Medicaid or CHIP without any waiting period. In 2008, roughly 19% of the Medicaid-paid deliveries in the U.S. were to undocumented women who received this “emergency” benefit (MACPAC 2013).

Undocumented women (i.e., women who do not have legal documentation for residency or work in the U.S.) also face state-by-state laws determining their access to prenatal and delivery care, particularly Medicaid. Some states provide full coverage to undocumented women during pregnancy (arguing that the baby will ultimately become a citizen of that state and the rationale exists for helping to ensure that baby’s optimal health at birth) while others deny coverage until the onset of labor, a condition required for treatment under the federal
EMTALA statute. For instance, undocumented women in Florida can only receive ten weeks of Medicaid coverage in pregnancy. Thus, many undocumented women wait until they have entered the third trimester of pregnancy to seek care so that it does not “run out” when they need it to cover the delivery, even though they would still receive labor and delivery care under EMTALA. This strategy, however, discourages women from seeking care in early pregnancy when education and counseling can be provided and when potentially high-risk conditions can be detected and treated or prevented. For instance, women with diabetes could receive nutritional and medical interventions to help prevent complications within the pregnancy. This serves as an example of a policy in which political-economic forces determine health care access and experience. In addition, the ACA specifically excluded undocumented residents, which could potentially lead states that do provide Medicaid coverage to undocumented women to stop this practice.

Various types of Medicaid exist in Florida, and are outlined in Table 1.5. States have the option to enroll pregnant women in full Medicaid coverage (i.e., to include the comprehensive services other Medicaid enrollees receive such as dental care) or to provide only certain services related to pregnancy. States can also contract with managed care companies to administer their Medicaid program, often referred to as a “Medicaid HMO” plan. Additionally, states can opt to include a “medically needy” or “share of cost” Medicaid program, which is similar to a “catastrophic coverage” plan, in which pregnant women become eligible for Medicaid if the amount that they pay in health care expenses (similar to a deductible, but reset monthly) exceeds an individually determined amount in any given month. Realistically, this grants some women coverage only for the birth itself, as they would likely not reach that spending maximum at any other time during the pregnancy. It also essentially contracts care providers to charge these “medically-needy” women only the Medicaid-approved reimbursement rates, which are significantly lower than rates charged to self-pay clients or reimbursements received from commercial insurers.
Florida Medicaid sets fee schedules based on provider type, and has not increased the rates paid to Licensed Midwives in over ten years. The allowable fee for a vaginal delivery is $640, and when all prenatal, intrapartum, postnatal, and newborn care are totaled (including the $640) the Medicaid reimbursement for the care of a pregnant woman is ~$1,800 (Florida Administrative Code 2013). In contrast, most Licensed Midwives charge self-pay clients between $4,000 and $6,000 for the comprehensive prenatal, delivery and postpartum care.

As part of the 1986 federal Omnibus Reconciliation Act, states were able to extend coverage to pregnant women for up to forty-five days while their Medicaid applications were in process, known as “presumptive eligibility.” This theoretically decreases women’s delays in accessing early (or any) prenatal care while their Medicaid application is pending, and ensures that providers would get reimbursed for care even if the Medicaid eligibility was denied. The presumptive eligibility period has been extended to 60 days, and 31 states including Florida currently allow for it (MACPAC 2013).

Various social safety net programs and entitlements often have similar eligibility criteria, and consequently, Medicaid eligibility helps pregnant women access additional services, such as supplemental nutrition programs including Women, Infants and Children (WIC) vouchers, food stamps, and Healthy Start counseling and referrals. Medicaid has become a key player in the provision and receipt of prenatal and delivery care. However, many health care providers are reluctant to participate as Medicaid providers because of Medicaid’s historically low reimbursement rates (Long 2013). Another chronic drawback of pregnancy Medicaid is what is known as “cycling” or “churning” when women lose eligibility and therefore health insurance coverage after pregnancy as they may no longer meet the categorical and financial requirements. These women can re-enroll in a subsequent pregnancy, but sometimes lack coverage even for contraception after their pregnancy Medicaid expires. The burden of this “cycling” on and off Medicaid is felt not only by the women, but also by health care providers and administrative systems (MACPAC 2013) given both the effort required to enroll these
women each time by the state Medicaid programs and by the medical offices who need to keep current on their patients’ insurance status. Health care providers might also have to find ways to ensure their patients continue to receive medications such as through pharmaceutical company’s “patient assistance programs” which require additional administrative processing time. Given the high burden Medicaid faces related to the coverage and cost of pregnancy and delivery in the U.S., it is crucial to gain an understanding of how home birth could save the Medicaid system money. This understanding partially serves as an aim of this dissertation.

Health Care Financing in the United States

In 2010, Medicaid, including the Children’s Health Insurance Program (CHIP), paid for nearly half of the four million live births in the U.S. at a cost of nearly $11 billion (not including the care of the newborn), of which $7.1 billion was spent on hospitalization costs related to the delivery (i.e., not antenatal admissions) (MACPAC 2013). In a separate estimate for 2006 that includes pregnancy-related costs beyond the delivery/hospitalization (Sonfield, et al. 2011), public expenditures were reported to total $21.8 billion, split between $12.7 billion in federal funds and $9.1 billion in state funds. From these numbers, it is clear that pregnancy and delivery care is a big business. Assuming half of the 4,265,555 U.S. births in 2006 were Medicaid-funded, that would translate to $10,221 per birth.

Financing is key to any health system, and in the profit-driven U.S. health system, it is important to acknowledge the amount of money and resources spent on health care, particularly when compared to other nations. In 2010, the U.S. spent nearly 17.6% of its GDP on health care, with costs about equally split between the private and public sectors and representing a 4.2% real annual-average increase from 2000 to 2010 (Organization for Economic Cooperation and Development 2012). This is compared with the 2010 average of 9.5% for all the member nations of the Organization for Economic Cooperation and Development (OECD), representing an increase from the average of 6.9% in 1990. Among virtually all other European and industrialized nations, less than one-third of all health care spending is from the private sector.
It is the presence and influence of the (mainly for-profit) private sector (both insurance companies and private medical practices) representing half of the U.S. health spending that thwarts attempts at reform to the nation’s health system. From a Critical Medical Anthropology perspective that will be further discussed in Chapter Two, this dichotomy contributes to the interest struggles between average citizens and the powerful health corporations.

The U.S. health system is structured hierarchically, with physicians historically at the top of an authoritative biomedical hegemony putting non-physician providers at a disadvantage (Beckett and Hoffman 2005). For instance, reimbursement rates through Medicare and Medicaid to nurse practitioners and nurse-midwives range from 65 to 85% of those to physicians (Chapman, et al. 2010; Naylor and Kurtzman 2010), although the Affordable Care Act (ACA) has made provisions for equalization to these providers’ payments. Non-nurse-midwives are rarely reimbursed by commercial insurance or Medicaid, with only ten states actually funding home birth care provided by CPMs (Lawlor 2012; Midwives Alliance of North America 2013), as is detailed in Table 1.2. Furthermore, in many states non-physician providers, particularly midwives, require physician oversight for licensing purposes, thus perpetuating physician hegemony. However, insurance companies, the pharmaceutical industry, durable medical equipment industry, hospital industry, and professional medical organizations now all exist within a “medical-industrial complex” (Singer and Baer 1995) structured upon the technocratic, reductionist, and profit-driven model (Davis-Floyd 2001) promoted by physicians, and which displaces physician’s authority to the hands of bureaucrats most interested in making profits.

Additionally, under the current, traditional health financing system (which is now undergoing mandated changes within the Affordable Care Act), physicians are financially compensated for each procedure they perform. A desire for increased income can potentially lead providers to support increased utilization of procedures and services, including the support of potentially unnecessary medical procedures (e.g., labor inductions, epidurals, cesareans,
etc.). While any of these procedures might be essential in any particular case, research documents their overuse, particularly among low-risk women (Tracy, et al. 2007). Additionally, research documents the escalating health costs associated with this “cascade of interventions” (Tracy and Tracy 2003). Women have come to believe that these procedures offer “safety” and ensure positive outcomes for them and their babies (Fenwick, et al. 2010), and the result is an increase in operative births and an increase in costs associated with birth, as well as increased cumulative costs per woman throughout her reproductive life (Allen, et al. 2006). The U.S. spends more on maternity care than any other Western nation, and yet demonstrates the worst perinatal outcomes (Amensty International 2010). In addition, some women do not have access to care or are relegated to utilizing the “safety net” to meet their pregnancy and delivery needs. As discussed earlier, to an extent, this is where Medicaid steps in.

**Federal Policies and States’ Rights**

The U.S. does not have a universal health care system that is accessible to all. Rather, a patchwork system exists that includes both private and public sources of health insurance and health care infrastructures. Common insurance types in the U.S. are outlined in Table 1.4. An estimated 49.1 million non-elderly adults were uninsured in 2011 (Kaiser Family Foundation 2011) (however, an estimated 8 million adults gained health coverage during the first six months of 2014 after full ACA implementation (Long, et al. 2014)). This impacts the ways in which women receive pregnancy-related care, as well as care prior to conception. Maternal and child health services have been included in federal health programs since they began in the early 20th century. The Social Security Act of 1935 included the Title V Maternal and Child Health Program, which helped guarantee access to care for mothers and children (Klees, et al. 2010). Title V was converted to a Block Grant program in 1981 (U.S. Dept of Health and Human Services), signaling a return to “states’ rights” under the “new federalism” of the Reagan era, and brought about a shift of control over health spending and social program administration from federal authorities to state agencies (Thompson 1986). The Affordable Care Act (ACA)
has further reinforced this “states’ rights” version of health care financing and regulation (Lee and Moncrieff 2011), partially evidenced by the patchwork of state choices regarding how to administer the ACA mandated health insurance exchanges and whether or not to expand their Medicaid programs. Thus, for women who receive publicly funded health care or health insurance (and to an extent for those women who are uninsured) state residency impacts access to care, partially via access to the insurance exchanges and Medicaid expansions created by the ACA. However, twenty-six states, including Florida, have refused to implement Medicaid expansions (Kaiser Family Foundation 2013b), a decision upheld by the U.S. Supreme Court in 2012. It is also important to note that among the five states (CA, FL, IL, NY, TX) that contribute 40% of all U.S. births, only three (CA, IL, NY) have opted for Medicaid expansion and Florida and Texas remain as the top two states for uninsured adults nationwide (Collins, et al. 2014). These Medicaid expansions have the potential to help women address health issues prior to becoming pregnant, when current categorical Medicaid eligibility (i.e., pregnancy) occurs. However, pregnancy Medicaid is not directly affected by the ACA or by states’ refusals to implement Medicaid expansions, as the expansions “expand” Medicaid beyond the current categorical eligibility criteria described earlier.

Policies enacted at the national level initially impact only Medicare and Medicaid recipients; however, the private insurance sector is known to set their standards based on federal regulations, and many hospital systems will use the most restrictive guidelines (e.g., Medicare) to set their own credentialing standards in order to ensure more of a universal policy regardless of provider or payer type. Thus, House Resolution 1054 (Pingree 2011), which calls for federal Medicaid recognition of the Certified Professional Midwife (CPM) credential, would not “legalize” CPMs in all states, but would provide strong evidence towards their legalization by recognizing, if not mandating, their ability to be covered under Medicaid. A similar situation occurred when the ACA amended a portion of Section 1905 of the Social Security Act to allow the addition of Medicaid payment for birth center based maternity care (U.S. Congress 2010).
Although the Centers for Medicare and Medicaid Services (CMS) had recognized freestanding birth centers as Medicaid providers since 1987, states were not required to pay for this care within their Medicaid programs until the ACA provision took effect on March 23, 2010. However, federal legislation recognizes states’ authority related to licensing and regulation of health professions. Thus, the ACA changes were only required in states with existing birth center legislation, and did not immediately increase access to birth centers for Medicaid enrollees in those states that did not have birth centers or birth center legislation. A similar situation would occur with passage of HR 1054, where states would not be forced to license CPMs, but those states with CPMs would be required to provide coverage for their services under Medicaid. The bill could also help to legitimize CPMs and therefore encourage states without legislation to adopt it.

While federal policies and programs impact women’s access to prenatal care and health services (and are routinely subject to budget cuts when political ideologies play out during annual federal appropriations), states are responsible for programmatic details, and wide variation exists between state laws that impact pregnancy care. Federal guidelines mandate certain basic covered services and criteria for eligibility under Medicaid, but states who administer Medicaid programs ultimately determine which services are covered, participant eligibility, and payment rates to providers (Klees, et al. 2010). Furthermore, states legislate medical and nursing practice acts that regulate health professions and requirements for practice. This leads to the inequity in access to Certified Professional Midwives nationwide, since CPMs are legal in only 28 states (Big Push for Midwives 2013), as detailed in Table 1.2. Furthermore, only thirteen states recognize Certified Professional Midwives, sometimes known as Licensed Midwives (LM), as Medicaid providers, of which eleven states (AK, AZ, CA, FL, ID, NH, NM, OR, SC, VA, VT, WA) actually allow LMs to bill Medicaid for home birth services (Lawlor 2012; Midwives Alliance of North America 2013) (also outlined in Table 1.2). However, Arizona Medicaid has essentially blocked access to home birth attended by LMs by setting
significant risk-assessment criteria that have precluded LMs in AZ from accepting Medicaid clients. California Medicaid recognizes LMs as providers but only if they have a supervising physician, a requirement that has proven impossible for any CA LM to meet due partly to malpractice concerns on the part of the physicians. As of January 1, 2013, Texas recognizes CPM/LMs but only for reimbursement at birth centers, which is likely an outgrowth of ACA legislation mandating Medicaid coverage of birth centers (Texas Department of State Health Services 2013). Thus, in reality, only ten states (AK, FL, ID, NH, NM, OR, SC, VA, VT, WA) offer a viable option for home birth to Medicaid recipients. Legislation introduced in the U.S. Congress (Pingree 2011) but that did not secure a Republican co-sponsor, proposed amending Title XIX of the Social Security Act to mandate, at the federal level, Medicaid enrollees to access CPMs (and therefore out-of-hospital birth). Thus, policies at the federal and state levels systematically open or close access to care (and types of care) without considering the true needs of those seeking care.

Home Birth Practice and Issues

Brief History of Home Birth in the United States

Childbirth in the formative years of the U.S. was largely considered a normal event for which “medical” assistance was not heavily relied upon (Rooks 1997). European midwives with varying amounts of training were among the immigrants to the U.S. and attended the births of most immigrant women through the 1800s. In the absence of any trained midwives, women began to attend each other’s births on the ever-expanding Western frontier. Midwives were also among the slaves that arrived from West Africa, and many southern plantations had elder black slave women that attended both white and black women in labor (Rooks 1997). By and large, all of these midwives worked independently and did not consider their work as a profession but more of a calling, and training was not formalized. In the late 19th century, male physicians began to define birth as a medical event that required “professional” assistance and due to their access to tools such as forceps and ether, women began to trust in the physicians’ techniques
to address issues of difficult labors and pain in childbirth. Detailed accounts of early American birth practices and the shifting roles of midwives are documented elsewhere (Leavitt 1986; Rooks 1997; Wertz and Wertz 1977).

Birth shifted from the home to the hospital at the turn of the 20th century as the profession of obstetrics developed and required increasing numbers of women patients to facilitate the training of additional doctors (Wertz and Wertz 1977). In 1900, physicians attended approximately half of all births, although most of these births still occurred at home. An increase in hospital births began in the 1930s, and by 1935, while less than 40% of total births occurred in hospitals, nearly 75% of urban women gave birth in hospitals, highlighting differences between race/ethnicities and rural/urban areas (Wertz and Wertz 1977). By 1955, 95% of births were in hospitals (Leavitt 1986) and women gave birth passively, ‘delivered’ by physicians utilizing twilight sleep and obstetrical forceps (Rooks 1997). At this point, maternal mortality had declined (likely due to improved nutrition, aseptic techniques, and antibiotics), and the shift from the mother’s health and safety to that of the fetus/newborn became paramount. However, as an outgrowth of the counter-culture movement of the 1960s and 1970s that included the natural birth movement, many women began to reclaim their active participation in giving birth and began to attend each other’s births, spawning a rebirth of traditional midwifery (Gaskin 2002; Rooks 1997). Women-centered, often feminist, organizations and health collectives formed around the country in response to the medicalization of childbirth, with notable groups including the Boston Women’s Health Collective; The Farm in Summertown, Tennessee; the Fremont Women’s Clinic Birth Collective in Seattle, WA; a Santa Cruz, California group including birth activist Robin Lang; and the Maternity Center in El Paso, Texas (Myers-Ciecko 1999). Many of these supported a home birth model and began to train midwives, and both nurse-midwifery and non-nurse-midwifery training programs grew. While the American College of Nurse-Midwives (ACNM) formed in 1955 to serve as a voice for midwives within nursing, the Midwives’ Alliance of North America (MANA) was established in
1982 to “honor diversity in midwifery educational background and practice styles while fostering unity among all midwives” (Myers-Ciecko, 1999: 385). MANA helped to spawn further organizations such as the North American Registry of Midwives (NARM) that helped professionalize non-nurse-midwives through certification (CPM) as well as through accreditation of midwifery schools. Thus, women’s desire for non-medicalized childbirth, and particularly for home birth, fostered the creation and organization of non-nurse-midwives. However, it is important to note that while the home birth movement has been described as an alternative model to the male-dominated medical model of childbirth, it has been primarily formed and accessed by white, middle-class, educated women (O’Connor 1993).

Current Practice of Home Birth in the United States

During a home birth, a woman remains in her home for the entire labor and delivery process. In fact, many home birth midwives also provide prenatal visits in the woman’s home. This is important to women who have transportation issues, or even childcare issues. For many women, going to the hospital to give birth can also mean time spent away from other children. Women choosing home birth participate more actively in the birth process, not only because of the type of care they receive, but also because they are asked to supply certain equipment that hospitals would normally provide. These include a basic birth kit that generally costs around $50 and includes items such as pads to cover the bed, cord clamps, sterile gloves, baby cap, perineal squirt bottle, bulb syringe, tape measure and a birth commemoration document. Some women might also choose to rent a birthing tub, usually available from the midwife. Whereas in the hospital any number of people unfamiliar to the laboring woman, including nurses, resident physicians, and ancillary support staff may enter a woman’s birthing room during labor and delivery, in the home this group is generally limited to the midwife and her assistant who are usually well known to the birthing woman. This creates a space of safety and intimacy that has been documented to be necessary for normal, physiologic birth to occur spontaneously (Odent 2001). Also important is the immediate and early bonding that occurs between a mother, her
newborn, and family that is critical to breastfeeding success and long-term relationships, but is often interrupted in the hospital setting. At home, women are also encouraged to take in adequate oral hydration and nutrition to maintain the strength needed for labor, whereas in the hospital, women are primarily kept “NPO” (literally “nil per os” or nothing by mouth) for fear of the potential need for general anesthesia and resultant aspiration of stomach contents, a rarely needed intervention as most cesarean sections are done using regional anesthesia (an epidural or spinal), and even the risk of aspiration with general anesthesia is low (Ranasinghe and Birnbach 2009).

As discussed earlier, home birth is primarily attended by non-nurse-midwives, whose roles and scope of practice are not well understood by the general public (DeJoy 2010; Johnson 1998). Many women in the U.S. are not aware of the option of home birth, and associate the word “midwife” with “babies born in the bathtub,” “hippies,” and “granny” midwives (Foley 2005). Thus, CPMs engage in “identity work” (Foley and Faircloth 2003), including a recent public education campaign launched by the Midwives Alliance of North America (MANA) (Simkins, et al. 2012) aimed at increasing the public’s awareness of midwives and of the normalcy of the birth process. These midwives further aim for legality and legitimacy in twenty-four states (Craven 2005; Midwives Alliance of North America 2013), facing felony or misdemeanor charges in the states where this type of home birth practice is illegal. Even among nurse-midwives, public perception of their role in the health care system is misunderstood, and the ACNM has also recently engaged in a marketing and public awareness campaign, “Our Moment of Truth” (American College of Nurse Midwives 2013). Call the Midwife, a widely popular Public Broadcasting Service television series that debuted in 2012, (Harris and Thomas 2012) documents midwifery practice among low-income families in London’s East End in the 1950s and has also increased awareness of midwifery among the U.S. public, but not necessarily in a “modern” light.
Little research to date has documented the demographic or practice characteristics of home birth midwives. Because of the disparate nature of legality from one state to the next, information can be difficult to extrapolate from existing data sources. However, the MANA Statistics Project (MANAStats) aims to collect prospective data related to CPM practice (Cheyney, et al. 2014a; Cheyney, et al. 2014b), and its database along with data from candidates certifying through NARM could be used to better describe the population of CPMs. This could include information important to CPM-specific and broader maternity workforce planning, such as midwife’s age, number of years practicing/number of years intending to remain in practice, average number of births attended and/or clients served per year, demographic data such as practice zip code or practice range, race/ethnicity information, liability coverage and claims statistics, and other pertinent data. Data can also be useful during legislative processes, such as during legislation introduction in the currently unregulated states as well as at the national level.

CPMs face additional issues related to their education and practice. Many academic training programs for CPMs do qualify for federal student loan assistance (based on the NARM accreditation of the schools), which helps to make midwifery education accessible. However, because CPMs are not a federally recognized provider under Medicare and Medicaid, unlike CNMs and physicians, CPMs are unable to receive loan repayment through programs such as the National Health Service Corps (Guzman 2012). Washington State attempted to enact a program for CPM loan repayment but has so far been unsuccessful. Additionally, because the type of personalized care associated with home birth midwifery tends to be time-intensive, income from such practices can be limited, despite the relative freedoms home birth midwives enjoy of acting essentially as small business owners.

Many CPMs practice home birth in isolation from each other, although certainly many practice collaboratively and many will provide back-up coverage to each other as needed, e.g., in the case of simultaneously laboring women or the need for personal time off. Midwives in
rural areas may be the only provider for a wide geographical range, and many home birth midwives limit their geographic radius to under ten to twenty miles so that they are never too far from their clients. This points to the fact that many U.S. women simply do not have access to home birth providers based solely on their geographical location, before even taking into consideration state laws which may restrict the legality or practice of CPMs. Additionally, women who live near state borders may request services from midwives that actually reside, practice, or have licensure in different states, where laws regarding the practice may be different. While this is certainly an issue for other types of health care providers, such as CNMs, there is additional burden for CPMs given their disparate legality across state lines, as well as the disparate insurance coverage for home birth.

Another practical yet key issue related to CPM practice revolves around medications. While CNMs and physicians enjoy prescriptive authority in all states, CPMs either have the ability to carry only limited “life-saving” medications such as injectable Pitocin for post-partum hemorrhage, or lack the ability to provide or utilize medications altogether. This can be particularly challenging when it comes to medications such as RhoGAM for mothers with Rh negative blood types, antibiotics for treating urinary tract infections, sexually transmitted infections or Group B strep, intravenous fluids, or even for prescribing contraceptives after the birth. Additionally, laboratory and diagnostic testing can be difficult for CPMs to order, as they may not be recognized by the facility, and therefore reimbursement by insurance can be compromised. In all states, regardless of whether they consider home birth midwifery legal or illegal, ordering blood tests or ultrasounds can be met with resistance, and mothers have anecdotally shared that staff in these diagnostic centers have shamed them when they find out of their intentions to have home births.

Another aspect of home birth practice revolves around collaboration with other health care professionals. In states that regulate their practice, CPMs usually require some form of physician collaboration and/or risk screening of women’s appropriateness for home birth. The
physicians that collaborate with CPMs may do so at risk to their own reputations, continuation of coverage with their malpractice carriers, or even their livelihoods. The opposition to home birth is so strong in the obstetrical community that physicians (be they obstetricians, pediatricians, or family practice physicians) are often ostracized by their colleagues when they support home birth. This occurred with the one obstetrician who provided consultation to most Tampa Bay Licensed Midwives and who ultimately came before the credentialing committee of her hospital and after having her privileges revoked, moved out of state (Catlett 2012). The American College of Obstetricians and Gynecologists (ACOG) opposes home birth and its supporters. If a newer obstetrician wanted to obtain board certification from ACOG, s/he might not consider providing supportive care to out-of-hospital practitioners, at least until after the completion of board certification, which can take up to six years after completion of residency.

However, despite all of these challenges, women are choosing midwife-attended births (Declercq 2012) and home birth in increasing numbers (MacDorman, et al. 2014; MacDorman, et al. 2012a). In 2008, actress Ricki Lake released The Business of Being Born (Epstein 2008), a film documenting the U.S. maternity care system and depicting home births in contrast to mechanized hospital births. The film highlighted the underlying economic drivers within the U.S. maternal health industry that often put evidence and the experience of women behind the convenience of the health care provider. This film not only spawned an interest in home birth in the general public (Hans and Kimberly 2011), but also drew a curt policy response from the medical (American Medical Association 2008) and obstetrical communities (American College of Obstetricians and Gynecologists 2008b) that highlighted the polarization between the out-of-hospital birth community and the obstetrics community. This polarization, which had long been brewing, was ultimately addressed by a national multi-stakeholder summit held in October, 2011, that “discussed the status of home birth within the greater context of maternity care in the United States” and resulted in nine “common ground” statements to guide further dialogue pertaining to the future of home birth in the U.S. (Home Birth Consensus Summit 2011). These
can be found on the Home Birth Consensus Summit website⁵, and are further discussed in Chapter Two. The Home Birth Summit reconvened in 2013, and a third summit occurred September 28-30, 2014. Both of these summits were intent on following up on research and advocacy work undertaken based on the original consensus statements, and also on furthering the integration of maternity services within the U.S.

State Jurisdiction Over Home Birth

As mentioned earlier, states oversee the licensure and regulation of health professionals. Certified Nurse-Midwives (CNM) may be regulated by a nursing board, a medical board, a midwifery board or a combination of these, and may require physician “collaboration,” “supervision,” or no formal relationship on file with any of the health boards. In the twenty-six states with regulated Certified Professional Midwife (CPM) practice, regulation is generally through a midwifery board, but some form of physician collaboration or participation in professional regulation is often required. In Florida, a main difference between CNMs and CPMs is that CPMs are independent practitioners who only need physician collaboration for “high-risk” cases and a generic physician “sign-off” on the CPMs’ practice guidelines, while CNMs require physician supervision in order to even be licensed. However, CPMs generally do not have the authority to prescribe medications, and depending on individual state laws may be allowed to carry certain medications that are necessary at birth (e.g., Pitocin) but not able to prescribe an antibiotic for a urinary tract infection. In these cases, they would need to consult or collaborate with a prescribing practitioner, such as a CNM or a physician who can prescribe such a medication. Nationwide, CNMs have the ability to prescribe “legend” drugs (e.g., antibiotics, medications for high blood pressure, diabetes, etc.) that require a prescription but do not require additional “controls” to regulate their prescribing and dispensing. Those drugs are thus referred to as “controlled substances” based on their potential for abuse or risk, and are further rated by a “schedule” to differentiate each based on the risk of abuse. For instance,

⁵ See: http://www.homebirthsummit.org/summits/vision/statements/
Schedule I drugs are substances like LSD and heroin that possess a high risk for abuse and have no known accepted medical use in the U.S., while Schedule II drugs also possess a high risk for abuse or dependence, but have recognized medical indications, such as morphine for acute pain or Ritalin for attention-deficit disorder. These Scheduled II medications can be prescribed by health care providers that have controlled prescribing authority based on state laws. Schedule III drugs possess lower risks of abuse, and generally include less potent pain medications, anabolic steroids, and some lower potency anesthetics. Schedule IV drugs have even lower potential for abuse and the most notable are benzodiazepines, used as anti-anxiety medications. Schedule V medications have the lowest abuse potential and include codeine and medications for neuropathic pain like Lyrica. Any prescriber of controlled substances must register with the federal Drug Enforcement Agency (DEA) and obtain, at a significant cost, a “DEA number” that can be monitored and regulated nationwide. CNMs in all 50 states have prescriptive authority for “legend” drugs (with Georgia being the final state to pass this in 2006), while CNMs in all states except Florida have some scheduled drug prescriptive authority (after Alabama passed this in early 2013), mostly to prescribe limited quantities of Schedule III to V drugs and with significant physician oversight. Washington State is among the most progressive of states regarding physician oversight with essentially complete independent practice for CNMs including the prescriptive authority for controlled substances in Schedules II to V (of note, Washington also has quite liberal laws regarding LMs, which points to the fact that where CPMs flourish, midwifery in general flourishes).

The need for physician collaboration and/or supervision can instantly impact a CNM’s (or LM’s) ability to practice, depending on state collaborative practice laws and statutes. For example, in North Carolina, where there is no licensure process for CPMs and where CNMs are perhaps the most tightly regulated through the Midwifery Joint Committee of both the Boards of Medical Examiners and Nursing, CNMs practice under the supervision of a physician actively practicing obstetrics. On May 30, 2012, the North Carolina Obstetrical and Gynecological
Society sent a letter to its members (Skipper 2012) requesting to receive information on any known home births with “tragic” or “adverse” outcomes in order to prepare for potential testimony to the North Carolina General Assembly regarding House Bill 522, the “Midwifery Licensing Act.” Although this bill is meant to license “professional” (i.e., non-nurse) midwives (CPMs), repercussions were felt in the CNM community. Shortly after the letter was received by members, seven of the eleven CNMs providing home birth care in the state were informed by the Midwifery Joint Committee that their supervising physicians had withdrawn support and they had forty-five days to obtain a new physician supervisor’s signature to remain in legal practice (Elliott 2012). While some of these CNMs did find a new supervising physician, other CNMs were forced out of practice, which meant they lost their livelihood and that the women they cared for had to seek new providers (who likely did not offer home birth, or were “illegal” CPMs). Additionally, physician and/or hospital owned practices that employ CNMs often place these CNMs at risk of swift job loss if a policy or decision is made to discontinue its midwifery practice. Practice closures (either for CNMs or LMs) have immediate impact on pregnant women, especially on those who are close to their due date and are left to face finding a practice that will accept a late-term transfer. A recent example occurred in Orlando, Florida, when a hospital decided to eliminate delivery care provided by CNMs because their Medicaid reimbursement rates were lower (80%) than those of physicians (The Kaiser Family Foundation State Health Facts 2012). Another immediate practice closure occurred in North Carolina in 2009, spawning the creation of a consumer advocacy group (Where’s my midwife? 2012) that has since embraced a wider, national, focus and held an inaugural “Birth Activists Retreat” at The Farm in Tennessee, from June 22 to 24, 2012 and a second retreat in Utah from July 26 to 28, 2013. A growing movement of such consumer birth activist groups includes ImprovingBirth.org, Uzazi Village, Birth on Labor Day (BOLD), Evidence Based Birth, multiple states with “Friends of Midwives” groups, and many others. Clearly, “consumers” are important agents promoting the availability of and access to midwives (Craven 2007), and it is recognized in the midwifery
community that these “consumers” represent strong lobbying power. Additionally, arguments of “job loss” and “job creation” go over well in the political-economic climate that exists in the U.S. today, particularly among “Tea Partiers” who espouse a return to Conservative, Constitutional principles and value the reduction of big government as well as the promotion of domestic job creation (Tea Party 2014). Thus, if the debate was framed around “free market choice” and “small business job creation,” legislation and policy supporting CPM (and CNM) autonomy could gain momentum and help increase access to midwifery care.

**Florida-Specific Home Birth Legislation**

Given this national backdrop, but recognizing that many health policies and statutes are enacted, governed, and implemented at the state level, how, then, does Florida fare in regards to home birth policies? Florida Licensed Midwives (LM) (by law CPMs) are licensed and regulated by state laws and practice acts, and do not require “physician supervision” or “oversight.” Under Florida Statutes section 467.015(2) “Responsibilities of the midwife,” LMs must maintain a written protocol with a Florida licensed physician with hospital privileges for the collaborative care of women deemed not to be at low-risk as defined by conditions specified in the Midwifery Practice Act (State of Florida 2011a). One direct example of how physicians “sanction” other physicians that are not in line with the promulgated policies of their professional organization ACOG and act to maintain their hegemony is as follows. The “collaborating” physician for most of the LMs in the Tampa Bay area had her hospital privileges suspended under suspicious circumstances relating to her support of home birth and Vaginal Birth After Cesarean (VBAC) in both home and hospital settings. As a result, she chose to relocate to another state, resulting in a potential loss of practice rights and livelihoods for these LMs, and loss of care for their clients while these midwives sought an alternative collaborating physician.

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6 Available at: http://www.flsenate.gov/Laws/Statutes/2014/Chapter467/All
7 Available at: https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64B24-7
for patients developing “high-risk” conditions as outlined in Statute 467\(^8\) (State of Florida 2011a), and provided in adapted format in Table 1.6. These LMs would be the first to say that the current arrangements for “high-risk” transfers is far from ideal and points to the true need for an integrated, seamless system for care coordination and transfer between the various maternity providers, as documented through qualitative research (Cheyney, et al. 2014c; Davis-Floyd 2004; Fox, et al. 2014). In fact, home birth transfer guidelines have recently been developed, although no organization in Florida has adopted similar guidelines. The Midwives’ Association of Washington State released guidelines in 2011 (Midwives’ Association of Washington State 2011) that became the subject of a quality improvement project by their state perinatal collaborative (Washington State Perinatal Collaborative 2013). At the national level, the Home Birth Summit Collaboration Task Force released a best practices document regarding home birth transfers in 2014 (Home Birth Consensus Summit 2014) that has received multiple organizational endorsements, including from the ACNM.

Aside from the example described above, Florida has a long history of supportive practice and insurance reimbursement laws related to home birth care by LMs and midwifery care in general\(^9\) (State of Florida 2011a; State of Florida 2011b). Anecdotally, among CPMs, Florida is regarded as a “model” state for legislation related to professional midwifery and state-mandated payment for midwifery services (with Washington State also regarded as a model state). Although Florida was the fifteenth state to license and regulate LMs in 1995 (Big Push for Midwives 2013), it did so with the rare “governor’s full support” after forming the Midwives Association of Florida and engaging lobbyists (Denmark 2006). Aside from the historical regulation of “granny midwives” dating to 1931, LMs in Florida attained initial recognition and licensure in 1982 with the passing of the Midwifery Practice Act (Florida Statute 467), revised in 1992. In 1988, LMs were included in state mandates requiring insurance reimbursement for

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\(^8\) Available at: https://www.flrules.org/gateway/RuleNo.asp?title=MIDWIFERY%20PRACTICE&id=64B24-7.004

\(^9\) Available at: http://www.flsenate.gov/Laws/Statutes/2014/627.6406
midwifery services, and in 1997, Florida mandated Medicaid reimbursement for homebirth, including for LMs. This was tied to a new provision requiring LMs to carry medical liability insurance (Clegg 2013).

Thus, in Florida, insurance (including Medicaid) reimbursement for midwifery care of all types is mandated, and CPM/LMs have legal rights to practice, assuming a physician is available for consults on high-risk cases as defined by the risk scoring system. On paper, LMs appear to be independent professionals who enjoy insurance reimbursement and practice policies backed by strong state legislation. However, in actual practice, a precarious balance and irony exist between this full autonomy and the need to function within the system. CNMs, however, have much less autonomy, being required to have a “supervising” physician for practice in any setting. Therefore, home birth provision by CNMs is rare (only 3 to 4 CNMs are known to be actively providing home birth in Florida, out of an estimated five-hundred currently licensed), and complicated by both physician supervision and medical liability insurance issues.

Medical Malpractice Issues in Florida

LMs in Florida are required to carry liability insurance, a requirement that was enacted in 1997 as part of legislation that granted LMs Medicaid reimbursement (Clegg 2013; Denmark 2006). At that time, the cost of this annual coverage was roughly equivalent to the Medicaid reimbursement for one to two home births; however, Medicaid reimbursements have decreased and liability costs have increased, making LMs bear a disproportionate share of this liability “excise” tax. Physicians in Florida can avoid these steep costs (arguably for which premiums are much higher for obstetricians than for LMs) and opt to go “dry” and not carry medical liability coverage as long as they either maintain a line of credit to cover the same malpractice minimums or an escrow account holding state claim minimums and post a sign in their practice relating that they do not carry liability coverage (State of Florida 2011b). CNMs are required to carry medical malpractice to renew their license in FL, which ultimately makes them the “deep pockets” in any liability claim. Additionally, the vast majority of physicians practicing obstetrics
in the West-Central Florida area (i.e., Tampa Bay to Orlando) are aligned under an umbrella organization known as Women’s Care Florida that in many ways serves as a monopoly for both women’s health care provision and for employment options in this field for obstetricians and CNMs. Prior to providing any care, these practices require patients to sign a form that waives their rights to a jury trial and stipulates that any claims will be heard by a binding arbitration panel of the Women’s Care Florida malpractice carrier (Women's Care Florida 2014). This policy/practice effectively limits their liability exposure, and in turn can lead to greater profits than independent physician practices. Furthermore, in Florida, physicians providing labor and delivery care in hospitals can participate in the Florida Birth-Related Neurological Injury Compensation Association (NICA), a program that provides similarly binding arbitration in lieu of jury trial for neurological injuries associated with newborns. These injuries often lead to the largest malpractice payouts, and this program, created by the Florida legislature in 1988, eliminates “costly legal proceedings, and through professional management of its disbursements, NICA ensures that birth-injured infants receive the care they need while reducing the financial burden on medical providers and families” (NICA 2006). While many would argue that NICA fails to appropriately provide monetary support for injured babies, this is one example of how physicians are protected from the most costly “risk” exposures, while other providers are required to carry liability insurance. CNMs are also required to carry liability coverage, and do not have any “opt-out” clauses in the way physicians do, unless they (like physicians can also be) are employed at practices that have state-immunity (e.g., CNMs employed by the University of South Florida or the University of Florida) or federal tort (e.g., CNMs employed in federally-qualified health centers). CNMs providing home birth must carry liability coverage, available through limited carriers, and demonstrate this coverage during their bi-annual licensure renewal. Florida CNMs are also required to have a “supervising” physician (similar to the type that California CPMs are required to have in order to be recognized as California Medicaid providers), whereas Florida CPM/LMs are not required to maintain any
relationship with a physician other than to refer high-risk consults. Thus, LMs maintain a level of professional autonomy that CNMs do not. From a Critical Medical Anthropology lens, this could be described as a means for the hegemony to control the practitioners most like them, i.e., the CNMs who deliver primarily in hospitals and who serve as the greatest competitive threat to the physicians.

**Motivations for Home Birth among Women in the United States**

When a woman in the U.S. seeks home birth she does so in a disjointed system. Given the precarious position of home birth, what motivates U.S. women to seek home birth? In the main study to date examining a cross-section of U.S. women's motivations to pursue home birth (Boucher, et al. 2009), five key reasons for giving birth at home were identified. Among the women who had planned a home birth and responded to the online research survey, 24% stated their desire for home birth represented their belief that their home was the safest place to give birth. Another 24% (responses were not mutually exclusive) described the desire for an “intervention-free” birth, and some tied this freedom from (presumably iatrogenic) interventions to the concept of safety at home. Another quarter of respondents described previous negative experiences, either their own or those they had observed, with hospital births. Twenty-two percent felt the home setting granted them greater control over their birth experience, and nearly 20% described a desire for a comfortable and calm environment. Additional responses cited included the desire for a drug-free birth, family involvement, avoidance of cesarean section, and a peaceful experience as well as concerns regarding cost, infection, and the “time limits” imposed by hospital birth.

In a broad study (Cheyney 2008) among women and their home birth midwives in two college towns, one in a state in the Pacific Northwest where the practice is fully legal, and the other in a Midwestern state where the practice is illegal, women choosing home birth described the process by which they overcame personal and societal fears related to “just in case something bad happens” in birth. In sum, the women noted going through a process of
“unlearning” the dominant cultural narratives of appropriate birth practices and “relearning” through acknowledging their own “embodied” knowledge which ultimately contributed to their increased participation in and informed consent towards their birth choices and experiences. This embodied knowledge contributed to the mothers’ increased agency, leading to an empowerment gained by birthing naturally. The concept of “embodiment” in anthropology relates to an understanding that social processes are embedded within the layers of our biological body: the individual body, the social body and the body politic (Scheper-Hughes and Lock 1987). Specifically these refer to: the individual body as a “phenomenally experienced body-self”, the social body as a “natural symbol for thinking about relationships among nature, society and culture”, and the body politic as “an artifact of social and political control” (Scheper-Hughes and Lock 1987: 6). In this way, the women in Cheyney’s study ultimately returned to their individual bodies after processing the embodied knowledge accessed in their social bodies and in the culture’s ‘body politic’. Finally, women were drawn to choose home birth out of a desire for intimacy, both in the birth setting and in the relationship with the midwife, as this intimacy allowed the mother to “let her guard down” in order to enter a safe space from which to give birth. The importance of promoting “physiologic birth” (one that is solely accomplished by the innate capacity of the mother and fetus, without intervention and resulting in the spontaneous expulsion of the fetus and placenta, and best described in the 2012 Consensus Statement (American College of Nurse Midwives, et al. 2012b)), along with the importance of suppressing the neocortex and its release of adrenaline in order to facilitate the release of oxytocin (the hormone of labor and love) to achieve a normal birth have been supported by research (Goer and Romano 2012; Lothian 2004; Odent 2001; Romano and Lothian 2008) and recently translated into care improvement modules (BirthTOOLS) for health care providers and systems (American College of Nurse Midwives 2014). Home birth, thus, aims to support the “natural” biological progression of labor, and women’s motivations for home birth seem to acknowledge this biological necessity for a safe and warm setting.
Additionally, it seems that some women are choosing home birth due to limited decision-making capacity they have in certain situations. The U.S. cesarean rate has steadily increased (see Figure 1.1) from 20.7% in 1990, to a peak of 32.9% in 2009 (Martin, et al. 2011) and has leveled to 32.8% from 2010 to 2012 (Martin, et al. 2013a). These rates far exceed the 10 to 15% rate the WHO deems appropriate (World Health Organization 1985). Rates of vaginal birth after cesarean (VBAC) decreased after a 1999 ACOG practice bulletin requiring “immediate availability” of both a physician-surgeon and anesthesiologist (American College of Obstetricians and Gynecologists 1999). These restrictions on in-hospital VBAC availability have resulted in some women choosing home birth after cesarean (MacDorman, et al. 2012b). Perhaps in response to this, but also in response to the dismal rates of VBAC, ACOG has amended its practice bulletin and proposed that women be offered a trial of labor after cesarean and asked to accept a “higher level of risk” (American College of Obstetricians and Gynecologists 2010). Women with other “high-risk” conditions in pregnancy also question the medical authority and seek alternative forms of care. Preliminary dissertation research among home birth midwives in Florida suggested that some women seek home birth care after the diagnosis of gestational diabetes by their obstetrician, who they felt lacked in the provision of follow up education to minimize complications, and thus sought the more personalized care provided by home birth midwives. Women with a history of Group B Strep (GBS) infection also reported seeking alternatives to hospital care and policies related to GBS management in labor. GBS is a relatively common bacteria found in women’s genital tracts that can (infrequently) lead to newborn sepsis and even death, and since 2002, the Centers for Disease Control and Prevention has recommended routine screening for GBS between 35 and 37 weeks of gestation and treatment of women with positive cultures with intrapartum, intravenous antibiotics (Centers for Disease Control and Prevention 2010). Some women seek to avoid the need for IV antibiotics by performing perineal washes to decolonize the GBS bacteria prior to being
screened, and these women find that out-of-hospital midwives are more likely to support them in this practice. Further results from this research are presented in subsequent chapters.

Some research has documented the motivations for home birth among women in developed nations outside of the United States. In a qualitative study among Finnish women, key reasons for seeking home birth revolved around maternal autonomy, previous unfavorable birth experiences, the desire for involvement of other children, and the viewing of birth as a natural process (Jouhki 2012). Results from a Canadian study related to women’s choice of birth setting among midwifery clients (Murray-Davis, et al. 2014) revealed that women wanted more control over the birth and decision-making, but that all midwifery clients viewed birth as a natural process. Finally, evidence exists that even among the same midwifery providers, site of birth does make a difference in regards to women receiving evidence-based care that promotes normal, physiologic birth, with women having home births receiving the most evidence-based care (Miller and Skinner 2012).

**Known Characteristics of Women who Seek Home Birth in the United States**

Some statistical data is available regarding which segments of the U.S. population are seeking home birth. A recent evaluation of U.S. birth certificates demonstrated a 23% increase in home birth among white, non-Hispanic women from 1990 to 2006, while in the same time period a 37% decrease was noted among American Indian women, a nearly 50% decrease among non-Hispanic black women, and a nearly 66% decrease for both Asian/Pacific Islanders and Hispanics (MacDorman, et al. 2011). Similar figures were reported among white, non-Hispanic women in an updated study including out-of-hospital births from 2004 to 2012 (MacDorman, et al. 2014); however, rates of out-of-hospital births actually increased among all race/ethnicities in this time period. In the 2011 evaluation of birth certificates from 1990 to 2006, home birth women also tended to be older, multigravidas, and married. Geographic variation was also noted. In a separate study examining the characteristics of planned and unplanned home births in the nineteen states where birth certificate data on planning status was available,
mothers with planned home births were 90% non-Hispanic white, and compared to mothers that had unplanned home births or hospital births were more likely to be older than thirty, U.S. born, non-smokers, married, have at least some college education, and have full-term pregnancies (Declercq, et al. 2010). Most of the outcomes studies on home birth also describe the demographic characteristics of the women in the study, and these studies reported similar demographic trends. A study reporting on analyses of Missouri birth certificates from 1989 to 2005 (Chang and Macones 2011) demonstrated that women who had planned home birth with non-physician and non-CNM attendants were more likely than home birth women attended by physicians and CNMs and non-home birth women to be older, white, married, overweight, of a higher parity, non-Medicaid recipients, and non-smokers. In a prospective study that looked at CPM outcomes in both the U.S. and Canada, (Johnson and Daviss 2005) women planning home birth were also more likely to be non-Hispanic white, older, non-smokers of higher parity and higher educational attainment than the comparison group of full-term women in the U.S., although notably in this study the home birth women were more likely to be of lower socioeconomic status. Finally, in a study examining outcomes of planned home births in Washington State from 1989 to 1996 (Pang, et al. 2002), compared to women choosing hospital birth, those choosing home birth were again found to be older, married, white, non-smokers of higher parity and higher educational status, and less likely to be “indigent.”

Little interpretation of these results was provided in the studies in which they were reported, and previous studies have documented the limitations of birth certificates. Therefore, at this point, it is only possible to speculate as to their meaning and interpretation. For instance, are there cultural differences between these women and those who choose hospital birth? Does socio-economic status play into access to home birth care, or access to knowledge about home birth as an option? It is difficult to assess from these statistics alone if “older, white, multigravid” women are more likely to be able to afford home birth, i.e., a type of care that is generally not covered by insurance and thus paid out-of-pocket, or if there are cultural or other
issues at play. It is also difficult to ascertain if the race/ethnicity of the midwives themselves impacts the rates of non-white home birth, as no data exists regarding the race/ethnicity of birth providers. There is increasing publicity of celebrity home births, and these may or may not contribute to overall awareness of or desire for home birth, particularly since there are much greater structural issues and barriers at play. Of course, there are also vocal critics of home birth (e.g., Teuter 2012), and thus, an overview of the arguments of home birth supporters and opponents is warranted.

Arguments For and Against Home Birth

Groups of home birth supporters and opponents vary. Generally speaking, obstetricians, pediatricians, and most medical doctors oppose home birth, although they are also more likely to view all birth as “safe only in retrospect” (Declercq 2010). Home birth supporters include CNMs (though not all CNMs support home birth) (Vedam, et al. 2009), non-nurse midwives, consumers of home birth, and to an extent public health professionals (American Public Health Association 2001). It is difficult to assess where maternity payers stand, despite likely cost savings to them of home birth. Primarily, opponents of home birth adhere to the “medical” model while supporters adhere to the “midwifery” model of childbirth, which will be described here briefly and are outlined in Table 1.3. Briefly, the “medical model” utilizes a high-tech approach to birth that is rooted in the philosophy that birth is pathological and that physicians are “experts” in a hierarchical relationship with the laboring woman and her family. Alternatively, the “midwifery model” views birth as a physiological process that is directed by the birthing woman and supported by an equal partnership with the midwife. Home birth supporters and opponents often use similar categories to make their arguments for and against home birth, which will be addressed separately below. Generally, these fall into safety for the mother and baby, post-birth outcomes, perceptions of risk, autonomy for the mother and family, and the experience of birth. A common criticism of women who choose home birth is that they place their own desires for a natural birth experience over the safety of their baby
(American College of Obstetricians and Gynecologists 2011a; Teuter 2012); however home birth mothers counter this by citing iatrogenic injuries to themselves and their babies in typical hospital births (Boucher, et al. 2009).

Noting the growing movement for home birth, as well as the lack of consensus regarding evidence about home birth safety, the Institute of Medicine hosted a one-day workshop in March, 2013 addressing research issues related to birth settings (Institute of Medicine and National Research Council 2013), that served to update their first consensus report (Institute of Medicine and National Research Council 1982).

An overview of commonly cited home birth studies, some of which are not based in the U.S., is found in Table 1.7, and a brief review is reported here. The Farm Study (Durand 1992), an early, seminal study that set out to prove the safety of home birth, compared midwife-attended home birth outcomes from a well-known alternative community with representative physician-attended hospital birth outcomes from the national natality sample. The study concluded what remain as trends in future studies: that among appropriately selected, low-risk women, home birth attended by “lay” midwives is as safe as that attended in hospital by physicians, and demonstrates lower rates of intervention such as operative delivery. These findings have been consistently replicated in cohort (De Jonge, et al. 2009; Janssen, et al. 2009b), integrative review (Fullerton, et al. 2007), retrospective (Hutton, et al. 2009) and prospective studies (Birthplace in England Collaborative Group 2011; Johnson and Daviss 2005). Of course, randomized control trials are regarded as providing the “best scientific evidence;” however, in regards to home birth, such studies are both ethically and practically unrealistic (Dowswell, et al. 1996; Hendrix, et al. 2009a). Finally, while not published in a peer-reviewed journal, a study which examined planned home birth outcomes among Medicaid recipients in Oregon (Cawthon 1996) found no significantly different mortality rates between a matched cohort of home and hospital birthers.
Alternatively, several key studies have aimed to discredit these findings by presenting “scientific” evidence demonstrating the relative risks of home birth. Primarily, these risks were to the newborn and are discussed below. However, these studies are widely critiqued for errors in study design, data analysis or reporting of outcomes. It is interesting to note that when studies with findings that are favorable to home birth are released, they receive little media attention or reaction from professional medical organizations, but when studies demonstrating “increased risk” during home birth, press releases, policy statements, television appearances, etc. are quickly deployed by the organizations that oppose home birth.

**Newborn Safety**

Home birth opponents use neonatal outcome measures most frequently to make their arguments against home birth, despite their own admission that rigorous scientific studies regarding newborn safety are lacking (American College of Obstetricians and Gynecologists 2007). However, because neonatal morbidity and mortality are captured statistically with relative ease, these outcomes become the easiest to cite and report in studies opposed to home birth. An early study (Burnett, et al. 1980) attempted to link decreasing maternal and neonatal mortality rates from 1940 to 1975 to the shift of birth from home to hospital, although it did not account for advances in medicine including the development of antibiotics. Another early study (Schramm, et al. 1987) did find excess neonatal mortality for planned home birth, that disappeared when planned home birth was restricted to that attended by physicians, CNMs or recognized midwives. A study often cited by home birth opponents (Pang, et al. 2002) examined birth certificate data from Washington State to compare outcomes from “planned” home births against hospital births. However, the study definition of “planned” included any singleton birth that occurred at home with an estimated gestational age greater than 34-weeks and that was attended by a “midwife, nurse, or physician,” as well as babies under 34-weeks that delivered in the hospital but were “initially attempted” to birth at home. Strong reaction to this methodology (Vedam 2003) challenged the study’s findings that “planned home births” were associated with
a two-fold risk of neonatal death that increased to three-fold for nulliparous women. A widely cited (Wax, et al. 2010) systematic review that has been widely criticized (Gyte, et al. 2011; Michal, et al. 2011) for methodological flaws resulting in improper conclusions, claims that “less medical intervention during planned home birth is associated with a tripling of the neonatal mortality rate” (Wax, et al 2010: 243) although the absolute neonatal mortality percentages of home vs. hospital birth resulting in this 2.87 odds ratio were 0.15% to 0.04% respectively. Studies such as these are reported in the mainstream media simply in sound-bite form with claims such as ‘home birth babies three times more likely to die’ further fueling fears associated with childbirth. The most recent outcomes study (Birthplace in England Collaborative Group 2011) essentially found that among low-risk women, giving birth in any setting is “generally safe” and that home birth carries no “additional risk” for multiparous women, but that nulliparous women who give birth at home are statistically more likely to have a baby who experiences adverse perinatal events. However, while these events are statistically significant, they still represent very small actual numbers, and to be fair, are from within a country and health system that does have an integrated and regulated system for out-of-hospital birth.

Therefore, in fact, perinatal injury (including fetal/newborn complications such as sepsis, respiratory distress, brachial plexus injury, cerebral palsy, etc.) and mortality can occur in any birth setting, and most methodologically rigorous studies show no significant difference in rates of these complications. On the flip side, births in the hospital subject neonates to pathogens not found in their homes and risk separation from their mothers at a critical time of life. Thus, it is important to remember that definitions of “risk” are not static and that “risk” can exist in any setting.

**Maternal Safety**

Most home birth safety data relates to infant mortality and morbidity. Maternal safety data generally revolves around rates of medical interventions that are more common in hospital settings and can pose maternal health risks (e.g., labor induction and/or augmentation, epidural
anesthesia, episiotomy, operative vaginal birth, and cesarean section) (Olsen 1997) or perinatal complications that can occur in any setting such as third or fourth degree perineal tears, postpartum hemorrhage or intrapartum infection (Janssen, et al. 2009b). Maternal mortality, though on the rise in the U.S., occurs so infrequently in any setting that it is difficult to cite as a home birth complication, and in fact no maternal deaths were cited in the Cochrane meta-analysis (Olsen 1997), or in any of the home birth safety studies in the U.S. (Durand 1992; Pang, et al. 2002; Wax, et al. 2010). Interestingly, the most significant link to the increasing maternal mortality rate is cesarean delivery (Deneux-Tharaux, et al. 2006), a procedure with a consistently negative association with home birth.

Noting these maternal outcomes associated with hospital birth, many home birth mothers cite their own safety as a key motivation for seeking home birth (Boucher, et al. 2009). They perceive the iatrogenic risks in the hospital, and the interventions mentioned above, as far more substantial and likely than the small risk that exists in home birth to them and to their newborns. Home birth mothers and their care providers also take a wider definition of “safety,” and unlike the medical authorities that oppose home birth who look merely at short term, major mortality and morbidity in both mothers and newborns, home birth supporters incorporate long-term emotional and physical well-being into their risk calculations. They “place a high value on [care that] prevents complications, protects breastfeeding, and fosters early mother-infant attachment” (Freeze 2010:292) and that builds relationships between mothers and their care providers that foster mother’s active participation in decision-making (Freeze 2010).

Maternal Autonomy

The concepts of maternal decision-making and informed consent are at the heart of midwifery practice, as documented in the ACNM “Hallmarks of Midwifery Care” (American College of Nurse Midwives 2002; American College of Nurse Midwives 2012) and MANA “Childbirth Choices” (Midwives Alliance of North America 2014), both of which detail the process that midwives take to ensure women are empowered to make informed choices regarding their
pregnancies and births. ACOG also recognizes the importance of informed consent (American College of Obstetricians and Gynecologists 2009), but in their own position paper on home birth, suggest that women put their own desire for autonomy over the safety of their fetus. Informed consent and expression of autonomy are cited as key reasons for women to seek home birth (Boucher, et al. 2009) and take on heightened significance in situations where women may have less choices, such as in the case of vaginal birth after cesarean (Cox 2014; Shorten, et al. 2014). However, a study (Miller and Shriver 2012) that analyzed the birth stories of 135 women from Bourdieu’s framework of “habitus” concluded that while women may make initial birth choices from the backdrop of societal expectations, economic constraints ultimately determine a woman’s choices in childbirth, such as her birth location. Such a finding is key to this examination of home birth among publicly funded pregnant women in Florida.

**Medical versus Midwifery Models of Childbirth**

Anthropologists (McBride 1982) have long recognized that no “one” way of birth in the U.S. can exist. Birth is clearly a biological, physiological, and socio-cultural event. Models of maternity care have arisen, but within them wide individual, societal, and even biological variations and consequences exist. Two maternity care paradigms (described in Table 1.3) broadly categorized as the medical model and the midwifery model, emerged in the 1980s and remain as the two dominant approaches in the U.S. These care paradigms stand in addition to the model of technocratic, humanistic and holistic models proposed by Davis-Floyd (Davis-Floyd 2001). The present author would like to suggest a comparison of these two separate paradigms as referring to the medical model as akin to the technocratic model, the nurse-midwifery model as akin to the humanistic model, while the non-nurse-midwifery model as akin to the holistic model, because the nursing aspects within nurse-midwifery somehow limit the ability of nurse-midwives to practice in a truly holistic model.

A desire for autonomous decision-making related to birthing women’s own bodies fueled the midwifery model, which took shape primarily in response to the status-quo medical model.
The medical model focuses on risk and holds an inherent belief in the pathology of pregnancy and childbirth. The central actor is the birth attendant, not the birthing woman, and decision-making is more coerced than shared, supported by a cultural view of the righteousness and hegemony of physician decision-making. Even the early structure of prenatal care visits, which remains today, was established by medical authorities to detect “toxemia” (Tew 1990), as opposed to providing prenatal care to help promote a woman’s health and educational needs regarding pregnancy and child-bearing/rearing. The medical model prompted a shift to technological birth that encouraged maternal yielding of agency and control to (primarily male) obstetricians who (primarily in hospitals) “delivered” the baby from the passive mother. This further encouraged a “technocratic” birth model that reduced childbirth to a mechanized process that shifted the focus of care from the mother to the fetus (Davis-Floyd and Dumit 1998). In an attempt to “save the baby,” technology such as electronic fetal monitoring was embraced without thorough evaluation of its effectiveness (Wendland 2007). In fact, of all medical practices, obstetrics is cited as the least “evidence based” (Cochrane 1979; Enkin, et al. 2006; Goer 1995). The main provider in the medical model is the surgically-trained obstetrician, who is supported by nursing staff that help to document and measure labor’s progress, not to help facilitate a woman’s labor process or to support her emotional or physical needs. Indeed, in modern obstetrics as practiced in American hospitals, nurses support the doctors more than they do the mothers. With the focus being on monitoring pregnancies and labors for potential problems, adages such as “a normal birth is a retrospective diagnosis” and “when in doubt, cut it out” dominate the hospital birth culture. This medicalization of birth not only shifted the focus of care from the pregnant mother to the health system and attendant, it also transformed a normal, biological process into a pathological, medical event, a process known as medicalization. Medicalization contributed to the increased costs now associated with birth (Conrad, et al. 2010), partially given the increased economic inputs required to provide surveillance over this new medical event.
In contrast to this technological birth paradigm, the midwifery model of care partially grew out of feminist and consumer movements that challenged biomedical hegemony and sought to preserve women’s control over their birth experiences (McBride 1982). This “natural” birth movement grew out of the counter-culture of the 1960s and 1970s and spawned an increased interest in midwifery (vs. obstetric) care (Gaskin 2002; Rooks 1997). The midwifery model of care believes that pregnancy and birth are normal life events for which minimal intervention should be applied unless complications develop, and which should incorporate attending not only to the physical, but also the emotional and social needs and well-being of the mother in a collaborative process that values the mother’s autonomy and decision-making capacity. The congruence between the model of birth that a pregnant woman holds and that which her birth attendant holds can result in improved satisfaction with care and birth outcomes (Gibson 2013).

The Anthropology of Reproduction and Birth

The sociocultural study of birth has been well established, starting perhaps with the work of sociologist Barbara Katz Rothman (Katz Rothman 1978) and anthropologist Brigitte Jordan (Jordan 1978). Katz Rothman focused on the ways in which medicine as a discipline exerted control over the birthing process by shifting control of birth from laboring mothers to attendant obstetricians. For instance, shifting the nomenclature to the term “delivery” instead of the term “birth” changed the focus of the event from the birth mother to the birth attendant, thereby forcing the mother to assume a more passive role. Jordan focused more on understanding birth as a biosocial event that may physiologically have universal features, but culturally held different meanings that were embodied within its related social practices, thus creating wide diversity in the practice of birth across cultures. These early inquiries coincided with social movements in which American women began to reclaim their innate abilities to birth after years of medical subjugation that included the combined use of scopolamine and morphine (a concoction designed to induce amnesia and pain relief injected into laboring women and commonly referred
to as “twilight sleep”) with the use of forceps to extract babies without the need of maternal pushing efforts. Jordan and Katz Rothman’s work initiated a discourse related to who could claim authority over women’s bodies and biological processes (Jordan 1977). This “authoritative knowledge” has served as a major theme within the anthropology of reproduction (Davis-Floyd and Davis 1996; Davis-Floyd and Sargent 1996; Davis-Floyd and Sargent 1997; Gaskin 1996; Hays 1996), and has focused mostly on the notion that women’s intrinsic and intuitive knowledge of their bodies and biological processes was discounted within medical practices that shifted the ownership of knowledge to “authorities” such as medical doctors, particularly as technologies developed to overcome commonly encountered birth situations, such as obstructed labors assisted with obstetrical forceps. Early bio-cultural investigations (Kay 1982; McBride 1982) further contributed to an anthropological understanding of the interaction between the evolutionary adaptations of the human pelvis and the socio-culturally bound practices of birth, as discussed below.

In her seminal work examining the biosocial aspects of childbirth (Jordan 1978; Jordan 1993), Jordan reports that birth is not universally regarded as a mere physiological function but as a life changing, even a life crisis, event that is socially patterned in order to make sense of the event within the cultural contexts and frameworks particular to that society. This contributes to very small variation of birth practices within a particular society or community but to a rather wide variation when viewing birth practices across societies. Turning more to an examination specific to the United States, further inquiry highlighted the role of midwifery in resistance to mainstream birth culture (Davis-Floyd and Johnson 2006; Katz Rothman 1983; Katz Rothman 1984; Weitz and Sullivan 1986), as well as the role of feminist inquiry in childbirth (Ginsburg and Rapp 1991; Rapp 2001; Sargent and Gulbas 2011). The medicalization of birth has also been well documented (Dalton 2009; Sargent and Gulbas 2011; Van Teijlingen, et al. 2004), and is critical to both an understanding of the anthropology of reproduction from a Critical Medical
Anthropology lens, as well as an understanding of home birth within a cultural milieu of the “medical-industrial complex” (Singer and Baer 1995).

Biological anthropologists have made important contributions to our understanding of the human necessity (compared to other primates) to have assistance at birth (Trevathan 1987). While concepts of pelvic typologies have been debated (Walrath 2003), most biological anthropologists agree that the upright positioning necessitated by bipedalism led to shifts in pelvic shape. Furthermore, the freeing of our hands from ambulation promoted an increased brain size and capacity as the hands were used for more fine and complex motor tasks. As human brain capacity increased, so did its size, resulting in both a larger head size at birth and a continued rapid brain growth and development in the first few months after birth, a growth that continues for the first few years of life but at a somewhat slower pace. Thus, the length of human gestation was limited by the fit between the shape of the pelvis and the increased newborn cranial size, resulting in the altricial newborn state (Davis-Floyd and Cheyney 2009) wherein newborns remain helpless while significant physiological growth occurs in the “fourth trimester” or the first three months of life. This “obstetrical dilemma” describes the balance between the constraints of the narrowed human pelvis required for bipedalism with the need for a more rounded and open passage to accommodate the larger brain sizes of offspring (Wittman and Wall 2007). To overcome this “dilemma,” humans pass through a series of “cardinal” movements during birth not required by other primates. While humans are capable of birth in a number of positions, these cardinal movements of labor (Oxorn-Foote 1986; Posner, et al. 2013) that came to define “normal” birth (although many variations of “normal” and “possible” human birth exist) support the birth of a fetus in an occiput-anterior position (i.e., the back of the

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10 The most widely cited source documenting these cardinal movements is Oxorn Foote (1986, updated in 2013). Additional resources include a YouTube video at: http://www.youtube.com/watch?v=66jMER1Savq, or handouts found at either: http://www.birthsource.com/pdffiles/CardinalMovements.pdf or: http://www.open.edu/openlearnworks/mod/oucontent/view.php?id=269&printable=1&extra=thumbnail_idp156128
baby’s head is against the maternal pubic bone, not the maternal sacrum, which is occiput-posterior). Earlier primates birthed in occiput-posterior positions, which allowed the mother to reach down, greet the baby’s eyes, and lift the baby by its head and neck upwards towards her own chest, with the baby’s neck in forward flexion. Alternatively, in the occiput-anterior position, if a human mother were to reach down to lift the baby toward her chest, the baby’s neck would hyper-extend, potentially leading to spinal injury. Thus, modern humans require the assistance of an attendant who can guide the baby’s head further downward from the maternal outlet and bring the baby to the mother’s chest after full expulsion of the baby’s body, a condition termed “obligate midwifery” (Trevathan 1987).

Of course, this attended birth refers more to a biological than a cultural need. However, “obligate midwifery” is important to a discussion of home birth because the human “need” for a birth attendant brought about a shift of power and autonomy at birth from that of the woman to that of the attendant, as women now “required” assistance. However, it seems that historically, women were able to support each other in the birth process, thereby maintaining an active maternal role in birth until the increased use of male doctors and their technologies that were developed to assist with this dilemma, such as forceps, diminished maternal roles to that of passive player. Home birth can represent an attempt to reclaim this autonomy (Jackson, et al. 2012), with the most extreme form of home birth, “free birth” or the choice to birth “unassisted” succeeding in reclaiming complete autonomy. Furthermore, many of the arguments for increased technology in birth and the “safety” of a hospital setting relate to the concepts of risk that surround human birth, further discussed in Chapter Two, which relate to this obstetrical dilemma. Relevant literature suggests that preference for home birth can result from women’s dissatisfaction with the medical dominance at birth (Dahlen, et al. 2011) which arose as a byproduct of risk mitigation against this very “obstetrical dilemma.”
Conclusions and Implications

The practice of home birth in the U.S. is highly contested, and research consensus is lacking, as noted by the IOM’s recent workshop (Institute of Medicine and National Research Council 2013). Medical “authorities” continuously try to prove the “risks” particularly to the newborn, while home birth supporters and mothers fight for autonomy. In this Occupy Wall Street era of the “99%,” here the 1% who chooses out-of-hospital birth are not the elite, power-wielding minority, but rather a “small group of thoughtful, committed citizens” fighting for autonomy to break away from the powerful control of the big business of medicine. Research on home birth safety has been “spun” (Goer 2003) to prove and disprove various view-points. What is ignored in many of these debates is the impact of the disjointed system. Safety could be greatly improved if, as the WHO recommends (World Health Organization 2004), a seamless system of care amenable to transfers of planned home birth clients to a hospital was in place (Davis-Floyd 2004). A woman’s right to choose a home birth in the U.S. is protected under her fundamental Constitutional right to privacy (Young 2008), yet her choice is restricted through many policies discussed in Chapter Two.

Home birth is accessed by a relatively privileged sector of the U.S. population. Whereas in the past, segregation barred some minority women from hospital access and poor, primarily Black, southern women were relegated to the home setting for birth, now home birth is somewhat “segregated” and accessed primarily by middle-class, non-Hispanic White women. In light of recent U.S. Census data indicating the U.S. is becoming a “majority-minority” culture (U.S. Census Bureau 2012), with greater than 50% of children born identified as minority (i.e., not “single race” and not “White, non-Hispanic”), it is important that all birth options be made available to all women. State Medicaid policies that allow for CPM billing of home birth services may serve to increase access to a more diverse population of women.

Thus, key issues that relate to the practice of home birth in the U.S. that warrant attention include: the lack of standards for home birth, and the lack of uniform legality across the
states for CPMs providing home birth; the lack of an integrated and regulated system that supports transfers of home birth clients to other levels of care within the health system; the antagonism that exists between providers within the system that prevents collegiality, communication and collaboration; and finally, issues related to payment for home birth as well as "competition" that might exist between provider types.
Table 1.1: Maternity Care Provider Types in the United States

<table>
<thead>
<tr>
<th>Type</th>
<th>Credentials / Training</th>
<th>% of U.S. Births (2012-NCHS)*</th>
<th>% of Births by Site</th>
<th>Legality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetricians (OB)</td>
<td>Medical Doctor (MD) or Doctor of Osteopathy (DO)</td>
<td>90.6%</td>
<td>~100% hospital</td>
<td>50 states + D.C. and Territories</td>
</tr>
<tr>
<td>Family Physicians</td>
<td>Medical Doctor (MD) or Doctor of Osteopathy (DO)</td>
<td>Unable to distinguish from “Physicians” on NCHS report, included in 90.6% above</td>
<td>~100% hospital</td>
<td>50 states + D.C. and Territories</td>
</tr>
<tr>
<td>Certified Nurse-Midwives (CMN)</td>
<td>Registered Nurse (RN) with minimum of Masters Degree in Nursing (MSN, MN), may hold Doctorate of Nursing Practice (DNP)</td>
<td>7.9% (significant underreporting known to occur)</td>
<td>~95% hospital, remaining birth center and home</td>
<td>50 states + D.C. and Territories</td>
</tr>
<tr>
<td>Certified Midwives (CM)</td>
<td>Masters Degree Not RNs</td>
<td>Unable to distinguish from “Other Midwife” on NCHS report</td>
<td>Unknown</td>
<td>Licensed in NY, NJ, RI Practice Authorized in DE, MO</td>
</tr>
<tr>
<td>Other Midwives (CPM) (DEM) (LM)</td>
<td>Certified Professional Midwives (CPM) Direct-Entry Midwives (DEM) Licensed Midwives (LM) Non-Certified Midwives</td>
<td>0.7%</td>
<td>~100% out-of-hospital</td>
<td>Regulated in 26 states Unregulated in 24 states and DC, Illegal in 11 states and DC (See Appendix X)</td>
</tr>
<tr>
<td>Others</td>
<td>Family Members, Emergency Services Personnel, Intentional Unassisted</td>
<td>0.7%</td>
<td>~100% out-of-hospital, mostly accidental births</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Table 1.2: State-by-State Comparison of Direct-Entry\textsuperscript{11} Midwifery Status (as of 9/25/14)

<table>
<thead>
<tr>
<th>State</th>
<th>Legal Status</th>
<th>Type of Regulation or Status of Recent Legislative Efforts</th>
<th>Year of Legislation</th>
<th>Medicaid Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL</td>
<td>Illegal</td>
<td>Current efforts towards regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AK</td>
<td>Legal</td>
<td>Licensure</td>
<td>1999</td>
<td>Yes</td>
</tr>
<tr>
<td>AR</td>
<td>Legal</td>
<td>Licensure</td>
<td>1983</td>
<td></td>
</tr>
<tr>
<td>AZ</td>
<td>Legal</td>
<td>Licensure</td>
<td>1978</td>
<td>Yes\textsuperscript{12}</td>
</tr>
<tr>
<td>CA</td>
<td>Legal</td>
<td>Licensure</td>
<td>1993</td>
<td>Yes\textsuperscript{13}</td>
</tr>
<tr>
<td>CO</td>
<td>Legal</td>
<td>Registration</td>
<td>1993</td>
<td></td>
</tr>
<tr>
<td>CT</td>
<td>Alegal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DC</td>
<td>Illegal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DE</td>
<td>Legal</td>
<td>Permit</td>
<td>1978</td>
<td></td>
</tr>
<tr>
<td>FL</td>
<td>Legal</td>
<td>Licensure</td>
<td>1995</td>
<td>Yes</td>
</tr>
<tr>
<td>GA</td>
<td>Alegal</td>
<td>Statute, Licensure unavailable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HI</td>
<td>Illegal</td>
<td>Statute, Licensure unavailable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IA</td>
<td>Illegal</td>
<td>Current efforts towards regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>Legal</td>
<td>Licensure</td>
<td>2009</td>
<td>Yes</td>
</tr>
<tr>
<td>IL</td>
<td>Illegal</td>
<td>Current efforts towards regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IN</td>
<td>Alegal</td>
<td></td>
<td>2013</td>
<td></td>
</tr>
<tr>
<td>KS</td>
<td>Alegal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KY</td>
<td>Illegal</td>
<td>Current efforts towards regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LA</td>
<td>Legal</td>
<td>Licensure</td>
<td>1985</td>
<td></td>
</tr>
<tr>
<td>MA</td>
<td>Alegal</td>
<td>Current efforts towards regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD</td>
<td>Illegal</td>
<td>Current efforts towards regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ME</td>
<td>Legal</td>
<td>Unregulated, No licensure available but can administer medications</td>
<td>2008</td>
<td></td>
</tr>
<tr>
<td>MI</td>
<td>Alegal</td>
<td>Recent (2012) efforts towards regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MN</td>
<td>Legal</td>
<td>Licensure</td>
<td>1999</td>
<td></td>
</tr>
<tr>
<td>MO</td>
<td>Legal</td>
<td>Statute, Licensure unavailable</td>
<td>2007</td>
<td></td>
</tr>
<tr>
<td>MS</td>
<td>Alegal</td>
<td>Unregulated, midwives practicing Current efforts towards regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td>Legal</td>
<td>Licensure</td>
<td>1991</td>
<td></td>
</tr>
<tr>
<td>NC</td>
<td>Illegal</td>
<td>Current efforts towards regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NE</td>
<td>Alegal</td>
<td>Current efforts towards regulation Note: Illegal for CNM to attend home birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NH</td>
<td>Legal</td>
<td>Certification</td>
<td>1979</td>
<td>Yes</td>
</tr>
<tr>
<td>NJ</td>
<td>Legal</td>
<td>Licensure</td>
<td>2002</td>
<td></td>
</tr>
<tr>
<td>NM</td>
<td>Legal</td>
<td>Licensure</td>
<td>1978</td>
<td>Yes</td>
</tr>
<tr>
<td>NV</td>
<td>Alegal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NY</td>
<td>Legal</td>
<td>Certification</td>
<td>1992</td>
<td></td>
</tr>
<tr>
<td>ND</td>
<td>Alegal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OH</td>
<td>Alegal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OK</td>
<td>Alegal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td>Legal</td>
<td>Voluntary Licensure</td>
<td>1993</td>
<td>Yes</td>
</tr>
<tr>
<td>PA</td>
<td>Illegal</td>
<td>Legislative efforts for licensure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{11} The term “direct-entry” is used to describe non-nurse-midwives, since Certified Professional Midwives (CPM) are not recognized in every state.

\textsuperscript{12} Arizona Medicaid (AHCCCS) recognizes CPM/LM home birth but has significant risk-assessment criteria that must be met.

\textsuperscript{13} California Medicaid (MediCal) will only allow CPM/LMs to become providers if they have a supervising physician, but physicians are unwilling to “supervise” LMs due to malpractice concerns.
<table>
<thead>
<tr>
<th>RI</th>
<th>Legal</th>
<th>Certification</th>
<th>Legislative efforts for licensure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>Legal</td>
<td>Licensure</td>
<td>1976</td>
<td>Yes</td>
</tr>
<tr>
<td>SD</td>
<td>Illegal</td>
<td>Recent (2013) efforts towards regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TN</td>
<td>Legal</td>
<td>Certification</td>
<td>2000</td>
<td></td>
</tr>
<tr>
<td>TX</td>
<td>Legal</td>
<td>Licensure</td>
<td>1983</td>
<td>Partial¹⁵</td>
</tr>
<tr>
<td>UT</td>
<td>Legal</td>
<td>Voluntary Licensure</td>
<td>2005</td>
<td></td>
</tr>
<tr>
<td>VA</td>
<td>Legal</td>
<td>Licensure</td>
<td>2005</td>
<td>Yes¹⁰</td>
</tr>
<tr>
<td>VT</td>
<td>Legal</td>
<td>Licensure</td>
<td>2000</td>
<td>Yes</td>
</tr>
<tr>
<td>WA</td>
<td>Legal</td>
<td>Licensure</td>
<td>1991</td>
<td>Yes</td>
</tr>
<tr>
<td>WI</td>
<td>Legal</td>
<td>Licensure</td>
<td>2006</td>
<td></td>
</tr>
<tr>
<td>WV</td>
<td>Illegal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WY</td>
<td>Legal</td>
<td>Licensure</td>
<td>2010</td>
<td></td>
</tr>
</tbody>
</table>

Data obtained from the following sources:

Midwives Alliance of North America, State-by-State Regulations:
[http://mana.org/about-midwives/state-by-state#top](http://mana.org/about-midwives/state-by-state#top)

Midwives Alliance of North America, Direct Entry Midwifery State-by-State Legal Status (last updated 5/11/11):

Big Push for Midwives, Push States in Action:

Big Push for Midwives, Push Chart: (last updated 9/1/13)

Additional clarifying details were obtained via websites referenced in the pages above, and listed here by state; all were accessed on August 7, 2014


IA: [http://www.friendsofiowamidwives.org/get-involved.html](http://www.friendsofiowamidwives.org/get-involved.html)

IL: [http://www.illinoismidwifery.org/blog/home](http://www.illinoismidwifery.org/blog/home)


MS: [http://www.msfriendsofmidwives.org/midwifery-in-ms.html](http://www.msfriendsofmidwives.org/midwifery-in-ms.html)

NC: [http://www.ncfom.org/page-1434350](http://www.ncfom.org/page-1434350)

NE: [http://nefriendsofmidwives.weebly.com/history-of-legislative-efforts.html](http://nefriendsofmidwives.weebly.com/history-of-legislative-efforts.html)

VA: [http://webcache.googleusercontent.com/search?q=cached:Lz_wlAmCCUoJ:www.commonwealthmidwives.org/files/10.11.07%2520Medicaid%2520Coverage%2520of%2520the%2520Services%2520of%2520Certified%2520Professional%2520Midwives%2520Final%2520.pdf&cd=1&hl=en&ct=clnk&gl=us&client=safari](http://webcache.googleusercontent.com/search?q=cached:Lz_wlAmCCUoJ:www.commonwealthmidwives.org/files/10.11.07%2520Medicaid%2520Coverage%2520of%2520the%2520Services%2520of%2520Certified%2520Professional%2520Midwives%2520Final%2520.pdf&cd=1&hl=en&ct=clnk&gl=us&client=safari)

14 The term “direct-entry” is used to describe non-nurse-midwives, since Certified Professional Midwives (CPM) are not recognized in every state.

15 Texas only reimburses CPMs in birth centers, not for home births.

16 Virginia CPMs are reimbursed at 75% of the rate to physicians and CNMs.
<table>
<thead>
<tr>
<th></th>
<th>Midwifery Model</th>
<th>Medical Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Birth Setting</strong></td>
<td>Home, or home-like</td>
<td>Hospital, sterile, unfamiliar</td>
</tr>
<tr>
<td>High-touch, low-tech</td>
<td>Fewer providers, little division of labor</td>
<td>High-tech, low touch</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technology and bureaucracy, division of labor</td>
</tr>
<tr>
<td><strong>Philosophy of Birth</strong></td>
<td>Normal event in woman’s life, physiological process</td>
<td>Pathological process</td>
</tr>
<tr>
<td>Assume birth will work, but ready for any possible complications</td>
<td>Assume birth is fraught with problems, normal only in retrospect</td>
<td></td>
</tr>
<tr>
<td>Laboring woman and her family are the actors, the ones working</td>
<td>Doctors, nurses, midwives and other “experts” are at work</td>
<td></td>
</tr>
<tr>
<td>Woman is the center of the experience</td>
<td></td>
<td>Woman is the patient</td>
</tr>
<tr>
<td>Birth is holistic</td>
<td></td>
<td>Birth is divisible into parts</td>
</tr>
<tr>
<td>Shared decision making</td>
<td></td>
<td>Authoritative decision making</td>
</tr>
<tr>
<td>Equal relationship between woman and caregivers</td>
<td>Hierarchical and authoritative relationship between woman and caregivers</td>
<td></td>
</tr>
<tr>
<td>True informed consent</td>
<td></td>
<td>Glossed over informed consent, at times biased</td>
</tr>
<tr>
<td>Birth as bio-psycho-social and spiritual event</td>
<td>Birth as a biological event only, no emphasis on psycho-social or spiritual aspects</td>
<td></td>
</tr>
<tr>
<td>Personalized care</td>
<td></td>
<td>Depersonalized, objective care</td>
</tr>
<tr>
<td>Extended time during prenatal visits</td>
<td></td>
<td>Brief prenatal visits</td>
</tr>
</tbody>
</table>

Adapted from Katz Rothman (1978) and Davis-Floyd (2001)
<table>
<thead>
<tr>
<th>Type</th>
<th>Eligibility</th>
<th>Details</th>
</tr>
</thead>
</table>
| Medicare             | Adults over 65  
Disabled adults any age  
End-Stage Renal Disease | Federal health insurance program  
Working adults pay into system to receive benefits at age 65 (or when disabled)  
Part A: Hospital coverage (after deductible)  
Part B: Outpatient coverage (covers 80%)  
Part D: Drug Coverage (Private plans with additional premiums)  
Supplemental Plans: Private plans for optional coverage of the 20% not covered by Part B and/or for hospital deductible; additional premium required, without supplement, patient responsible for these charges |
| Medicaid             | Pre-ACA:  
Low-income:  
Children under 18, Pregnant Women, Adults with Dependent Children, Disabled adults & Seniors  
Post-ACA:  
For states that expanded coverage, also any adult <138% FPL | Federal-State (state administered) health insurance program for low-income citizens  
Covers some care beyond Medicare (i.e., nursing homes)  
Generally, patients have no premiums, no deductibles and if any co-pays they are very small (i.e., $2 per visit or prescription) which must be waived if patient unable to pay |
| TriCare              | Active duty uniformed service members and families  
Reservists and families  
Survivors and some former spouses of above  
Retirees of above have certain options within TriCare | Coverage details depend on duty status of eligible family member  
To an extent, plan works like a commercial health plan with deductibles and co-pays  
Providers available both in- and out-of network and different costs |
| Veterans’ Administration | Basically, any person who served on active duty for 24 consecutive months and had any type of discharge but dishonorable | Comprehensive coverage of all inpatient and outpatient services, including emergency care, preventive care, rehabilitative care and mental health care  
Generally all care provided by VA providers but sometimes care referred out of VA network |
| Employer-Sponsored Commercial Insurance* | Working (primarily) adults  
Coverage may be extended to worker’s family members  
Generally only provided by large employers (>50 employees) | Employer generally pays significant portion of premiums; employee also contributes to premiums (which are pre-tax dollars) |
| Commercial Insurance* available on Private Market | Individuals or Small Business Owners can purchase directly from insurance company/agent or via ACA Health Exchanges | Similar to the employer-sponsored plans except individuals purchase directly  
These plans have expanded under the ACA |
| Uninsured            | Anyone who either does not qualify for any of the other plans listed or who chooses not to enroll in a health insurance plan | Generally must pay 100% of all costs unless can either negotiate directly with providers or enroll in some form of “charity” or “assistance” program  
Sometimes hospitals will apply for emergency Medicaid benefits for uninsured patients presenting for care |
| Charity Care         | Anyone who does not meet other criteria and receives “charity” care | Generally provided by safety net providers, but may span from “free clinics” to tertiary hospitals |
Table 1.4: Common Health Insurance Types in the United States (Continued)

<table>
<thead>
<tr>
<th>Types of Commercial Insurance plans: (some Medicaid Programs use HMOs; Medicare enrollees can select an HMO for their supplemental plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Maintenance Organization (HMO)</td>
</tr>
<tr>
<td>Preferred Provider Organization (PPO)</td>
</tr>
<tr>
<td>Point of Service Plan (POS)</td>
</tr>
<tr>
<td>High-deductible Health Plan (HDHP)</td>
</tr>
</tbody>
</table>

Key information obtained from:
- http://www.medicare.gov
- http://www.medicaid.gov
- https://www.healthcare.gov
- http://www.tricare.mil
- http://kff.org
Table 1.5: Types of Florida Medicaid (prior to universal Medicaid HMO rollout 8/2014)

<table>
<thead>
<tr>
<th>Type</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Straight&quot; or &quot;Full&quot; Medicaid</td>
<td>Provides 100% coverage to those eligible by financial and categorical requirements. May have small co-pay when not pregnant (e.g., $2 prescription co-pay). Must be US citizens with a Social Security number.</td>
</tr>
<tr>
<td>Pregnancy Medicaid</td>
<td>100% coverage for all pregnancy-related care. Household &lt; 185% FPL. May be given “straight” Medicaid or assigned to an HMO. No copays applied.</td>
</tr>
<tr>
<td>Presumptive Eligibility for Pregnant Women</td>
<td>Temporary outpatient Medicaid coverage while pregnancy Medicaid application pending; allows access to prenatal care; income requirement same as pregnancy Medicaid (&lt;185% FPL), available to citizens and non-citizens; begins when eligibility determination completed and extends until Medicaid coverage approved or denied.</td>
</tr>
<tr>
<td>Presumptive Eligibility for Newborns</td>
<td>Children born to mothers on Medicaid are eligible at birth for one year of Medicaid.</td>
</tr>
<tr>
<td>Medically-Needy Medicaid “Share of Cost”</td>
<td>For those whose household income exceeds Medicaid eligibility, a form of Medicaid that &quot;kicks in&quot; after a household has paid a minimum amount of medical expenses (similar to an insurance deductible except amounts are re-set monthly) after which Medicaid covers the remaining.</td>
</tr>
<tr>
<td>Family Planning Waiver</td>
<td>Must be female, 14-55 years old and have been on Medicaid in past 24 months; not currently pregnant; no history of tubal ligation or hysterectomy. Covers: Pap smear, breast exam, STD testing, family planning, birth control supplies and related meds and labs.</td>
</tr>
<tr>
<td>Medicaid HMOs</td>
<td>Provides same ultimate care/coverage as “full” Medicaid but administered by third-party commercial insurer contracted with FL Medicaid (e.g., StayWell) that receives a capitated monthly amount for each Medicaid enrollee on their plan and then reimburses providers and hospitals for services at their negotiated rates.</td>
</tr>
<tr>
<td>Medicaid for Aged or Disabled</td>
<td>Any low-income senior or disabled person collecting Social Security Payments (known as Supplemental Security Income, SSI) is automatically eligible for Medicaid.</td>
</tr>
<tr>
<td>Emergency Medicaid for non-Citizens</td>
<td>Available in emergency medical situations to non-US-citizens, assuming same Medicaid eligibility income criteria met. Includes coverage the “emergency” labor and delivery of a child, but does not cover post-partum expenses.</td>
</tr>
</tbody>
</table>

FPL: Federal Poverty Level

For more information see:
http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf
or
http://www.myffamilies.com/service-programs/access-florida-food-medical-assistance-cash/medicaid
Table 1.6: Florida Midwifery Practice: Risk Assessment

Note: Any cumulative score of 3 or greater requires the midwife to consult a physician with obstetrical hospital privileges; if the patient is expected to have normal pregnancy, labor and delivery, the midwife can continue to care for the patient. If not, the midwife will transfer the patient out of her care.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Socio-demographic Factors</strong></td>
<td></td>
</tr>
<tr>
<td>Age &lt;16 or &gt;40</td>
<td>1</td>
</tr>
<tr>
<td>Residence of anticipated birth &gt; 30 minutes to emergency care</td>
<td>3</td>
</tr>
<tr>
<td><strong>Maternal Medical History-Documented Problems</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td></td>
</tr>
<tr>
<td>Chronic hypertension</td>
<td>3</td>
</tr>
<tr>
<td>Heart disease</td>
<td>3</td>
</tr>
<tr>
<td>Heart disease assessed by a cardiologist which places the mother or fetus at no risk</td>
<td>1</td>
</tr>
<tr>
<td>Pulmonary embolus</td>
<td>3</td>
</tr>
<tr>
<td>Congenital heart defects</td>
<td>3</td>
</tr>
<tr>
<td>Congenital heart defects assessed by a cardiologist which places the mother or fetus at no risk</td>
<td>1</td>
</tr>
<tr>
<td><strong>Urinary System</strong></td>
<td></td>
</tr>
<tr>
<td>Renal disease</td>
<td>3</td>
</tr>
<tr>
<td>History of pyelonephritis</td>
<td>1</td>
</tr>
<tr>
<td><strong>Psycho-Neurological</strong></td>
<td></td>
</tr>
<tr>
<td>History of psychotic episode which previously required medication management but not current medications</td>
<td>1</td>
</tr>
<tr>
<td>Current mental health problem requiring drug therapy</td>
<td>3</td>
</tr>
<tr>
<td>Epilepsy or seizures in the last two years</td>
<td>3</td>
</tr>
<tr>
<td>Required use of anticonvulsant drugs</td>
<td>3</td>
</tr>
<tr>
<td>Drug or alcohol addiction or use of addicting drugs in current pregnancy</td>
<td>3</td>
</tr>
<tr>
<td>Severe undiagnosed headache</td>
<td>3</td>
</tr>
<tr>
<td><strong>Endocrine System</strong></td>
<td></td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>3</td>
</tr>
<tr>
<td>History of gestational diabetes mellitus</td>
<td>1</td>
</tr>
<tr>
<td>Current thyroid disease: euthyroid</td>
<td>1</td>
</tr>
<tr>
<td>Current thyroid disease: Non-euthyroid</td>
<td>3</td>
</tr>
<tr>
<td><strong>Respiratory System</strong></td>
<td></td>
</tr>
<tr>
<td>Chronic bronchitis: Current or chronic with medication</td>
<td>3</td>
</tr>
<tr>
<td>Chronic bronchitis: Without medication or current problem</td>
<td>1</td>
</tr>
<tr>
<td>Smoking: &lt; 10 cigarettes a day</td>
<td>1</td>
</tr>
<tr>
<td>Smoking: &gt; 10 cigarettes a day</td>
<td>3</td>
</tr>
<tr>
<td><strong>Other Systems</strong></td>
<td></td>
</tr>
<tr>
<td>Bleeding disorder or hemolytic disease</td>
<td>3</td>
</tr>
<tr>
<td>Cancer of the breast in the past 5 years</td>
<td>3</td>
</tr>
<tr>
<td><strong>Documented Problems in the Obstetrical History</strong></td>
<td></td>
</tr>
<tr>
<td>Estimated Due Date &lt; 12 months from previous date of delivery</td>
<td>1</td>
</tr>
<tr>
<td>Previous Rh sensitization</td>
<td>3</td>
</tr>
<tr>
<td>5 or more term pregnancies</td>
<td>3</td>
</tr>
<tr>
<td>3 or more consecutive spontaneous abortions</td>
<td>3</td>
</tr>
<tr>
<td>2 consecutive spontaneous abortions or &gt; 3 consecutive spontaneous abortions</td>
<td>1</td>
</tr>
<tr>
<td>1 septic abortion</td>
<td>3</td>
</tr>
<tr>
<td>Incompetent cervix with related medical treatment</td>
<td>3</td>
</tr>
<tr>
<td>Prior uterine surgery</td>
<td>3</td>
</tr>
<tr>
<td>Prior uterine surgery followed by an uncomplicated vaginal birth</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 1.6: Florida Midwifery Practice: Risk Assessment (Continued)

<table>
<thead>
<tr>
<th>Previous placenta abruption</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous placenta previa</td>
<td>1</td>
</tr>
<tr>
<td>Severe pregnancy induced hypertension during the last pregnancy</td>
<td>2</td>
</tr>
<tr>
<td>Postpartum hemorrhage apparently unrelated to management</td>
<td>3</td>
</tr>
</tbody>
</table>

**Physical Findings of Previous Births**

<table>
<thead>
<tr>
<th>Event</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous placenta abruption</td>
<td>3</td>
</tr>
<tr>
<td>Previous placenta previa</td>
<td>1</td>
</tr>
<tr>
<td>Severe pregnancy induced hypertension during the last pregnancy</td>
<td>2</td>
</tr>
<tr>
<td>Postpartum hemorrhage apparently unrelated to management</td>
<td>3</td>
</tr>
</tbody>
</table>

**Maternal Physical Findings**

<table>
<thead>
<tr>
<th>Event</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestation of &gt; 22 weeks in a nullipara, unless patient provides medical records documenting care provided by a regular maternity provider</td>
<td>3</td>
</tr>
<tr>
<td>Gestation of &gt; 28 weeks in a multipara, unless patient provides medical records documenting care provided by a regular maternity provider</td>
<td>3</td>
</tr>
<tr>
<td>Pre-pregnant BMI is &lt;18 or &gt;30</td>
<td>2</td>
</tr>
<tr>
<td>Evidence of pathological uterine malformation, myoma, or abdominal or adnexal mass</td>
<td>3</td>
</tr>
<tr>
<td>Polyhydramnios or Oligohydramnios - Prior Pregnancy</td>
<td>2</td>
</tr>
<tr>
<td>Polyhydramnios or Oligohydramnios - Current Pregnancy</td>
<td>3</td>
</tr>
<tr>
<td>Cardiac diastolic murmur, Grade III or above systolic murmur, or cardiomegaly</td>
<td>3</td>
</tr>
</tbody>
</table>

**Current Laboratory Findings**

<table>
<thead>
<tr>
<th>Event</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb/Hct &lt; 10.3 / 31%</td>
<td>1</td>
</tr>
<tr>
<td>Hgb/Hct &lt; 9.2 / 28%</td>
<td>3</td>
</tr>
<tr>
<td>Sickle Cell Anemia</td>
<td>3</td>
</tr>
<tr>
<td>Pap smear suggestive of dysplasia</td>
<td>3</td>
</tr>
<tr>
<td>Evidence of active tuberculosis</td>
<td>3</td>
</tr>
<tr>
<td>Positive serologic test for syphilis confirmed active</td>
<td>3</td>
</tr>
<tr>
<td>HIV positive</td>
<td>3</td>
</tr>
</tbody>
</table>

Adapted from Florida Administrative Code and Administrative Register, Rule Chapter 64B24-7.004: Risk Assessment

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.015 FS. History–New 7-14-94, Formerly 61E8-7.004, 59DD-7.004, Amended 9-11-02, 2-2-06, 4-1-09.
Table 1.7: Commonly Cited Home Birth Outcomes Studies

<table>
<thead>
<tr>
<th>Author (Year) Journal</th>
<th>Study Design and/or Characteristics</th>
<th>Description and Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthplace in England Collab (2011) <em>BMJ</em></td>
<td>Prospective cohort n=64,538, all eligible women with singleton, term pregnancy across settings</td>
<td>Overall, no significant differences in perinatal mortality/morbidity, but for nulliparous women, AOR 1.75 for complications. Also, interventions substantially lower in “non-obstetric” settings</td>
</tr>
<tr>
<td>Cheng et al (2013) <em>AJOG</em></td>
<td>Retrospective cohort (n=2,081,751, PHB=12,039)</td>
<td>AOR 3.08 for newborn seizures at PHB vs. hospital birth; AOR 1.87 for Apgar &lt;4 at PHB vs. hospital these items not well-validated as measurable outcomes from birth certificates</td>
</tr>
<tr>
<td>Cheyney et al (2014) <em>JMWH</em></td>
<td>Prospective cohort (n=16,924) Planned home births</td>
<td>No comparison group, descriptive study 94% vaginal birth rate, 87% successful VBAC rate 11% intrapartum transfer rate; 0.76/1000 neonatal death rate. Conclusion: among low-risk women, planned home birth is safe</td>
</tr>
<tr>
<td>de Jonge et al (2014) <em>BJOG</em></td>
<td>Retrospective cohort of linked data sets(n=814,979) Low-risk midwifery care</td>
<td>No increased risk of adverse perinatal outcomes for planned home births among low-risk women</td>
</tr>
<tr>
<td>de Jonge et al (2009) <em>BJOG</em></td>
<td>Retrospective cohort (n=529,688) Low-risk midwifery care, planned home vs. hospital vs. unknown</td>
<td>No significant differences for any outcome measure (IP or NB death, NICU admit)</td>
</tr>
<tr>
<td>Durand (1992) <em>AJPH</em></td>
<td>Retrospective cohort n=1,707 (home) 14,033 (hospital)</td>
<td>Home birth with midwives can be accomplished as safely as hospital with physicians and with fewer interventions</td>
</tr>
<tr>
<td>Fullerton (2007) <em>JMWH</em></td>
<td>Integrative Review Planned home birth with CNMs</td>
<td>4 decades of home birth studies demonstrate generally favorable outcomes when compared with birth center or home birth outcomes</td>
</tr>
<tr>
<td>Grunebaum (2013) <em>AJOG</em></td>
<td>Retrospective cohort of US birth certificates</td>
<td>AOR increase for seizure and low Apgar for midwife-attended home and birth center births Major flaw: does not distinguish planned from unplanned home births</td>
</tr>
<tr>
<td>Janssen, et al (2009) <em>CMA Journal</em></td>
<td>Prospective cohort (n=14,771) Planned midwife home birth, hospital birth, MD hospital birth</td>
<td>No significant differences in perinatal mortality, home birth cohort had decreased interventions and babies less likely to have low Apgar or need resuscitation drugs</td>
</tr>
<tr>
<td>Johnson &amp; Daviss (2005) <em>BMJ</em></td>
<td>Prospective Cohort (n=5,418) All planned home births with CPMs in North America in 2000</td>
<td>Planned home birth for low-risk women was associated with similar perinatal mortality and lower rates of medical interventions</td>
</tr>
</tbody>
</table>
Table 1.7: Commonly Cited Home Birth Outcomes Studies (Continued)

<table>
<thead>
<tr>
<th>Reference</th>
<th>Study Design</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leslie &amp; Romano (2007)</td>
<td>Systematic Review of home birth safety studies</td>
<td>Out-of-hospital births have similar outcomes with fewer interventions to hospital births</td>
</tr>
<tr>
<td>Lindgren (2008)</td>
<td>Retrospective cohort n=897 (home), 11,341 (planned hospital)</td>
<td>RR of IP and neonatal mortality at home was 3.6, but not statistically significant, strong statistical significance for RR C/S (0.4) &amp; instrumental delivery (0.3)</td>
</tr>
<tr>
<td>Olsen (1997)</td>
<td>Meta-analysis of 6 controlled observational studies</td>
<td>Home birth is acceptable and demonstrates similar perinatal mortality with fewer medical intervention</td>
</tr>
<tr>
<td>Olsen (2012)</td>
<td>Cochrane Review</td>
<td>Only two RCTs, one included, therefore not enough and data exist to draw conclusions about home birth; Recommend updating review regularly as new studies emerge</td>
</tr>
<tr>
<td>Pang (2002)</td>
<td>Retrospective cohort n=5,854 (home), n=279 (PP transfer), n=10,593 (hosp)</td>
<td>Home birth showed increased risk of neonatal death (ARR 1.99) which increased to 3.0 among nulliparous women, who also had 2.76 RR for PP bleeding</td>
</tr>
<tr>
<td>Stapleton et al (2013)</td>
<td>Prospective cohort of U.S. midwifery-led birth centers (n=15,574)</td>
<td>No comparison group, descriptive study 93% vaginal birth rate, 0.40/1000 neonatal death rate (excluding anomalies) Conclusion: midwifery-led care in birth centers is safe for low-risk women</td>
</tr>
<tr>
<td>Wax et al (2010)</td>
<td>Meta-analysis *Flawed methodology</td>
<td>Planned HB showed OR 2.87 for neonatal death, tho less prematurity, LBW and assisted ventilation. HB women less likely to lacerate, hemorrhage or develop infection</td>
</tr>
</tbody>
</table>

Figure 1.1: Changes in U.S. Total and Primary Cesarean and VBAC Rates (1989-2012)


Note: Data for Primary Cesarean and VBAC after 2005 are based on inconsistent adoption of the 2003 Revised Birth Certificate across all U.S. states. Therefore, these rates after 2005 may not be fully accurate.
CHAPTER 2: THEORETICAL PERSPECTIVES

Theory serves as a framework of causality, allowing us to understand what causes what and why. Most relevant to a study about home birth among low-income women in Florida are theories related to risk as perceived from multiple perspectives, as well as to structural understandings of access to care, explicitly along the power differential of medical authority. This chapter provides an overview of risk theories in the social sciences, as well as of the Critical Medical Anthropology framework.

Theories of Risk and Risk Perceptions

Despite the significant reduction in maternal and infant mortality during the 20th century, contemporary American culture views birth as risky (Strong 2000; Weir 2006). Social scientists, most notably anthropologists and sociologists, have made important theoretical contributions to the conceptualization of risk, with three major relativist risk perspectives emerging in the 1980s (Lupton 1999b; Lupton 2013). The cultural anthropological approach, defined in “cultural-symbolic” terms (Douglas 1985; Douglas 1992; Douglas and Wildavsky 1982), embeds risk within cultural interpretations, and thereby defines it as variable and in a constant state of negotiation. Risks are navigated in order to maintain a social order, with varying degrees of individual responsibility for risk depending on the individualistic tendencies of the society. This perspective helps define the boundary between self and other, with the human body serving as a site for risk interpretation (Gephardt, et al. 2003). Alternatively, the “risk society” perspective views risk as a central, macro-social, organizing principle of modern society, and a “systematic way of dealing with hazards and insecurities induced and introduced by modernization itself” (Beck 1992:21). A key concept in this “risk society” perspective is that individuals must trust (Giddens 1991) expert knowledge in order to ultimately make decisions about their risk, although the burden of responsibility for risk becomes that of the individual through a process of
“reflexive modernization” (Lupton 2013) that stresses individual control over risk exposure. Finally, the “governmentality” perspective on risk promotes a neo-liberal self-management of risk that emphasizes personal responsibility but ultimately can be used as a means of social control (Foucault 1991; Lupton 1999b). The pregnant body thus becomes a prime site for risk discourse (Lupton 1999c).

Moving to more of a practical level from these macro-level risk discourses, additional risk rationalities have been defined in neo-liberal societies (Dean 1997; Ewald 1991; Lupton 2013). Insurantial risk strategy holds risk as a collective phenomenon, only calculable when distributed across a population, not at the individual level. The target of insurantial risk is capital. Epidemiological risk occurs when risk is assessed at an aggregate level, such as with large cohort studies that provide statistical analysis of risk predictors for outcomes of interest. This technological perspective of risk is found in medicine and epidemiology, and referenced as an objective phenomenon with a rationalistic focus that seeks to identify risk by mapping its causalities in order to develop predictive models that can ultimately minimize consequences (Lupton 1999a). While extracted from population-based studies, these predictive models lead to individualized case-management or clinical risk scores used to apply a qualitative assessment of risk towards an individual, thereby creating a “risk profile” and frequently utilized in clinical practice. However, this very strategy of “risk assessment” emphasizes pathology as opposed to physiology, particularly related to physiologic processes such as birth (Institute of Medicine and National Research Council 2013), and opens the door for an intrusion of medical surveillance that can ultimately obscure the line between what is normal and what is diseased (Armstrong 1995). However, risk can be ambiguous as well as dynamic (Smith, et al. 2012), and the major risk theorists highlight the known shift in risk perception over time.

**Risk in Pregnancy and Childbirth**

This overall conceptualization of risk and the “risk society” help us understand why American women fear birth. These concepts are emphasized in television shows such as A
Baby Story that are reportedly seen by over two-thirds of pregnant American women (Declercq, et al. 2006) and depict birth as chaotic, intense, painful and urgent, and ultimately contribute to women’s views that their bodies are flawed, technology can “fix” them, and physicians have the authority to “control” them (Fleming, et al. 2014; Hall 2012; Morris and McInerney 2010). A particular risk language is found within pregnancy and birth that focuses on both the “what if something goes wrong” and the “maternal vessel as fetal protection” narratives (Cheyney 2011; Davis-Floyd 2003; Lupton 1999c; Scamell 2011; Scamell and Alaszewski 2012). The pregnant body is often the target of interventions aimed to reduce harm and risk to the developing fetus, and a great deal of pressure is placed on women to assume the responsibility for ‘producing a normal infant’ (Lupton 1999c), further contextualizing pregnancy as perilous, challenging, and requiring intense scrutiny, primarily to ensure healthy offspring that can sustain the species. A main “risk” of this risk focus within obstetrics and midwifery is the potential to alienate practice from evidence or more importantly from a woman’s social contexts (Lyerly, et al. 2007). The risks of home birth therefore must be placed in the overall context of risk perceptions in childbirth more generally, and risk must be evaluated with an acknowledgement of what level or actor within the risk stratification is being addressed.

Iatrogenic risk is an important point related to the conceptualization of risk in childbirth and home birth. By definition, an iatrogenic complication is one that was caused by medical treatment or a medical provider. The term derives from the ancient Greek term for “physician” iatros. These ancient Greek physicians did not have any formal training, but were men who attended to all aspects sickness and healing from a philosophical and secular perspective. They left spiritual healing to the temples, and matters related to pregnancy and childbirth to midwives. They believed that the four “humors” (blood, yellow bile, black bile and phlegm) were responsible for health maintenance. A practice such as “blood-letting” could “cure” a patient of disease and serves as an early example of an iatrogenic practice that actually harmed patients. In the realm of obstetrics, a classic example of an iatrogenic complication is puerperal or
“childbed” fever that resulted from medical practitioners’ lack of knowledge of sanitary technique which contributed to their spreading infections from one pregnant or laboring woman to another, or indeed from a cadaver to a woman in labor (Pittet and Boyce 2001; Semmelweis 1861). Another example is that of immediate cord clamping, cited as early as 1801 by Erasmus Darwin (Darwin 1801) to be “injurious” to the child. While great attempts are made to promote home birth only among “low-risk” women, the inverse approach of near-universal provision of hospital care to “low-risk” women effectively exposes “low-risk” patients to the “high-risk” (i.e. iatrogenic risk) of a hospital setting (Institute of Medicine and National Research Council 2013). Iatrogenic risk is thus parallel to Beck’s “manufactured” risk (Beck 1992), as opposed to any “natural” risk that might occur simply from the biological reality of pregnancy. Iatrogenic risk within the realm of pregnancy and childbirth can include procedures such as episiotomy, side effects of medications such as Pitocin that can result in tetanic contractions resulting in fetal distress, anesthesia complications such as chronic back pain from epidural placement, bladder injury during a cesarean, or early cord clamping. In addition, complications from prematurity driven by early delivery due to either maternal demand or provider convenience (Joseph and D’Alton 2013) and future ectopic pregnancies or placental invasions after cesarean sections (Maymon, et al. 2004) also serve as examples of iatrogenic risks found in the hospital, but rarely if ever, the home birth setting.

Illich (1975) defined typologies of iatrogenic risk nearly forty years ago. Primarily, the iatrogenic risks described above fall into his category of “clinical iatrogenesis” (Illich 1975) i.e., factors caused directly by a medical encounter or treatment. He further divided clinical iatrogenesis into four types: negligence or malpractice, true accidents or human error, the iatrogenesis of treatment (e.g., due to cardiac stenting, one might survive a heart attack only to ultimately live long enough to develop prostate cancer), and finally the iatrogenesis resultant from practicing ‘defensive medicine’ (e.g., performing a cesarean section at the first deviation from a normal fetal heart rate tracing for fear of potential litigation and liability). Beyond this
clinical iatrogenesis, Illich described how social and symbolic iatrogenesis resulted from medicalization and allowed medicine to become an industry and health a commodity increasingly only available through a market. In turn, individuals no longer take responsibility for their health because it has become the role of the health care provider, and in fact, they can no longer interpret their own pain and suffering because this has also become the role of the medical system. It would seem that Illich’s perceptions hold true today, if not even more so (Biley 2010).

**Clinical Risk Contexts and Home Birth**

Concepts of risk permeate the debate about home birth, though much of the literature documenting women’s risk perceptions is from outside of the U.S. Weir (2006) refined the “risk society” and sociological risk concepts by describing similar yet distinctive “risk techniques”: epidemiological, clinical, actuarial and legal (Weir 2006:17). Epidemiological risk is in essence a statistical risk, wherein one outcome is “more likely” to occur over a reference “outcome” given a certain “exposure.” In contrast, clinical risk takes epidemiological risk and applies it to actual patients in clinical care, so as to transform what could be a “risk factor” into an objectively defined “sign of clinical disease” (Weir 2006:19). However, risk implies not the presence of a condition, but the future likelihood that a condition will be present, so applying “risk factors” to clinical care can contribute to iatrogenic injury and the obstetrical sense that ‘pregnancy is not safe until it’s over.’ This is particularly pertinent in “risk scoring” systems often used in obstetrical practice (including the “risk system” written into the Florida Midwifery Act) which tend to highlight the “abnormal” instead of focusing on pregnancy as “normal” (Weir 2006). Actuarial risk relates to insurance interactions with health care, and is founded on the concept of the “risk pool” in order to “spread risk” over members in a health plan (or health providers in a liability plan) and thus decrease potential losses while increasing financial gains (Weir 2006). Finally, legal risk relates to the interaction between statutes and clinical practice, where policies, guidelines, or even laws determine what is “safe” or “acceptable” (Weir 2006:19), again, such as
Florida Statute 467: Regulations of Professional and Occupations: Midwifery. Further concepts include absolute risk versus risk perception, risk assessment and risk management (Bryers and van Teijlingen 2010).

From a provider standpoint, "assessing, managing, and communicating" risk (Lyerly, et al. 2007) remains a challenging aspect of clinical practice. In the care of pregnant women, the “risks” to both the mother and the fetus, which at times compete or conflict, must be considered. This leads to the tendency “to consider probabilities out of the context of patient values…to consider elimination of fetal risk as paramount [i.e., to pursue a zero tolerance for risk to the fetus]” and the tendency to prioritize the risk of intervening to the exclusion of the risk of not intervening (Lyerly, et al. 2007:979). To balance these risks, clinicians rely on “evidence based practices” but must balance this with “patient-centered” care. Indeed, fear (mostly of litigation) determines clinicians’ practices during pregnancy care, and likely contributes to the opposition to home birth among obstetricians.

How, then, do pregnant women interpret risk as it relates to home birth? In a study of home birth parents in Finland (Viisainen 2000), the parents reported three types of risk: medical risks that were largely promoted by their society as the typical risks of childbirth, iatrogenic risks associated with the medical care provided in pregnancy and at birth, and the moral risk of betraying medical authority. Interestingly, they did not identify true risks related to home birth. In a Swedish study (Lindgren, et al. 2010) women who had given birth at home described risks they associated with hospital birth and with home birth. With hospital birth, risk related to loss of autonomy, specifically: being cared for by strangers, being subjected to routine procedures and interventions, and simply being in an unfamiliar environment with unfamiliar “pathogenic” exposures. With home birth, risks were associated with being “beyond help” either due to literal geographical distance or to “worst case scenarios” where the proper emergency services would not be available. But women who had birthed at home ultimately felt the risks at the hospital were greater than those they would encounter at home. Finally, in an Australian study
(Jackson, et al. 2012) among women who chose to give birth at home unattended, or who had high-risk conditions but still birthed at home attended, women described pregnancy and birth as having an expected element of risk, but to them the risks associated with being in the hospital to give birth were beyond the risks of giving birth at home, particularly because interventions and “interference” posed greater risks than allowing the natural process of birth to unfold, which they were able to do at home. This study nicely sums up the fact that “risk” is inherent in life, but that the right to determine the level of “acceptable” risk should remain in the hands of the women who will ultimately live with the consequences of their decisions.

**Critical Medical Anthropology as Theoretical Framework**

Throughout the social sciences, a “political economy of health” (PEH) perspective has been applied to describe the impacts that the worldwide capitalist system and national class structures have on local health and health care access (Baer 1982). By critiquing “health-related issues within the context of the class and imperialist relations inherent in the capitalist world system” (Baer, 1982:1), PEH represents a “missing link” to medical anthropology inquiries (Morsy 1979). Through this examination of the distribution of health resources, PEH describes how those marginalized society members “suffer” given the deleterious impacts of this disproportionate lack of access (Farmer 1996) while those in power and with more resources face few access issues.

Critical medical anthropology (CMA) further stresses the inherently politico-economic nature of health (Navarro 1984; Singer and Baer 1995), highlighting additional power differentials that impact health policy and implementation (Baer, et al. 1986). CMA takes a particularly Marxist lens suggesting that access to health and health care is ultimately a class struggle largely controlled by corporations, particularly insurance companies in the United States (U.S.) (Baer, et al. 1997), and arguably professional medical organizations. However, CMA represents an activist perspective wherein debating theory and drawing connections between these political power struggles and health outcomes are not sufficient, and instead the
use of CMA is meant to “change oppressive and exploitative patterns in the health arena and beyond” (Cheyney 2008: 255). Thus, CMA “emphasizes the importance of political and economic forces, including the exercise of power, in shaping health, disease, illness experience and health care” (Singer & Baer 1995:5), and it provides for an examination from the “macro-social” level (i.e., national and even global policies) to the “micro-social” level (i.e., individual level) (Singer & Baer, 1995:63), as well as an understanding of the interactions between levels. In the U.S., the physician-dominated medical system reflects the society's structural relationships defined by gender, class, and race/ethnicity (Baer, et al. 1997) in a pattern of “biomedical hegemony” that “attempts to control the production of health care specialists, define their knowledge base, dominate the medical division of labor, eliminate or narrowly restrict the practices of alternative practitioners, and deny laypeople and alternative healers access to medical technology” (Baer, et al. 1997: 215). From a CMA lens, it can be argued that the structure of biomedicine is supported by self-serving capitalist and neoliberal economic policies. More importantly, and key to CMA, this structure has caused members of the working classes to assume it is not only in their best interest, but indeed that it represents a natural social order (Singer and Baer 1995). Perhaps this is why attempts at health system reforms have been primarily met with resistance from ‘average’ Americans.

Medical anthropology recognizes that biology and culture both contribute to the experience of health and illness (Joralmen 2010). Human childbirth is a particularly “bio-cultural” phenomenon because while the physiology of birth is relatively static, the meanings attached to birth and the customs that surround it represent unique cultural value systems (Browner and Sargent 1996; Davis-Floyd and Sargent 1997; Jordan 1978; Jordan 1993; Kay 1982). Furthermore, each birthing system and its practitioners “tend to see [it] as the best way, the right way, indeed the way to bring a child into the world” (Jordan 1993:4). What constitutes a “healthy” pregnancy in one nation or even among social groups within one nation will depend on the social construction of “health” as well as the perceived positive outcomes to a pregnancy.
“Health” will also depend on the nation’s health system, as well as its economic system and the individual’s status within the economic structure. In this way, a nation’s political economy serves as an epidemiologic risk factor towards understanding the types of health conditions and available treatments its members will likely encounter (Joralmen 2010). The medicalization of childbirth within the United States over the past one hundred years coincides with a devaluing of midwifery care, the rise of a for-profit health care system, and the cultural acceptance of the superiority of technocratic solutions to natural processes (Davis-Floyd 2003; Denmark 2002). Thus, broadly, “a society’s medical system mirrors its core values in microcosm” (Davis-Floyd 2001:S21) and our childbirth practices reflect our society’s valuing of technocratic systems and medical authority over women’s intuition and autonomy (Davis-Floyd 2001). Here again the “risk society” perspective serves to define pregnancy as risky, and determines who can define risk, through “authoritative knowledge” (Jordan 1993).

Prenatal and delivery care in the U.S. is predominately provided by obstetricians who depend on multiple technologies to monitor and assess a very natural process. This medicalization of childbirth represents the culmination of biomedicine’s dominance, where technical professionals enjoy the privilege of structural support for their system of care and have come to claim authority over a natural process. Physician-attended childbirth in hospitals is the societal norm due to promulgated concepts of pain and fear in childbirth (Davis-Floyd 2003), and due to insurance companies deferential payment for this “standard” care as opposed to “alternative” care such as home or birth center birth (despite significant cost savings out-of-hospital). However, home birthers and home birth practitioners resist this control, and it is perhaps their growing success that has resulted in increasingly strong attempts at dominance by medical authorities. These include strategies such as releasing practice guidelines against home birth, pressuring the American Medical Association to resolve against the safety of home birth, and withdrawing needed collaborative or supervisory support for home birth midwives.
Specifically in reference to home birth within the U.S., CMA contextualizes women’s choices (or lack thereof) related to the place of birth, based on economic constraints, political realities, biomedical (i.e., obstetrical) hegemony, and concepts of risk. CMA further explains the roles of the U.S. maternity system’s structure, including payment sources, the dominance of hospitals as the site of obstetrical care, and the roles of and laws related to health care providers within the system and during patient interactions. Use of results from ethnographic inquiries grounded in a CMA perspective can give voice to marginalized women who choose to give birth at home (Grinager 2011) in an attempt to “change the oppressive patterns” (Cheyney 2008).

Thus, Critical Medical Anthropology provides insight into the constraints women face when choosing home birth, and a lens into who does and does not have access to home birth based primarily on policies and economics. These actually start from the very notion of choice itself, as the powerful cultural notions of birth in hospitals under the care of physician-obstetricians represent the American way to bring a child into the world (Jordan 1993), and obstetricians retain hegemony over other practitioners offering alternative birthing options, directly through “supervision” and “collaboration” requirements built into professional licensing procedures. For most women in the U.S., cultural and structural pressures to birth in this way are simply too strong for any other choice to exist. However, a growing birth activist movement exists (e.g., ImprovingBirth.org), largely fueled by “consumer” women who desire alternatives to the dominant biomedical/obstetrical paradigm. Yet, many structural barriers exist even for these women to access non-traditional care. Economics is a large driver, and insurance reimbursement for out-of-hospital birth varies from state to state but is generally lacking, particularly by Medicaid. Because insurance coverage is limited, many who choose home birth are forced to pay out-of-pocket, even when they are insured, or simply resolve to give birth in the hospital as that is what is “covered” by insurance. However, the actual cost of a home birth, both to insurers as well as to individuals, is significantly lower than a hospital birth (Anderson
and Anderson 1999; Health Management Associates 2007; Henderson and Petrou 2008; Truven Analytics 2013). Maternity charges fall into three basic categories/phases: prenatal care, delivery care, and postpartum care; newborn care is additional. Payments during the “hospitalization” phase account for 70 to 86% of all maternal-newborn care expenditures, with “facility fees” representing 59 to 66% of total payments and “professional fees” (i.e., for the physician or midwife in attendance) representing 20 to 25% (Truven Analytics 2013). Payment by commercial payers is generally double that of Medicaid, with the average 2010 U.S. payment for complete maternal-newborn care for a vaginal birth at $18,239 for commercial payers and $9,131 for Medicaid; cesarean births were $27,866 for commercial payers and $13,590 for Medicaid (Truven Analytics 2013). Contrast this with the average charges by midwives in Florida for global home birth care (maternal and newborn) of $4,000, of which Medicaid generally reimburses $1,600 (personal correspondence and data acquired during this research), and the cost-effectiveness of home birth care becomes obvious. A true cost-benefit analysis, even where home birth complications are included, that incorporates the unintended expenditures related to iatrogenic complications, would likely produce results highly favorable of home birth.

As significant as the strength of biomedical (as well as insurance) hegemony is the strength of its perpetuation of the belief that pregnancy is ‘risky until proven otherwise’ (Declercq, et al. 2010). Increasing perceptions of risk (more so than documented absolute risk) in childbirth coincided with its increasing medicalization (Bryers and van Teijlingen 2010), and risk arguments have become one of the greatest tools in the biomedical arsenal. Yet risk is not concrete and is in fact oppositional to the regard of pregnancy and childbirth as a “healthy, normal, physiologic state” (Weir 2006). Furthermore, “risk” implies “the likelihood of future illness, while diagnosis of the normal and pathological concerns present health/illness” (Weir 2006:107) and identifying and treating women based on “risk factors” can not only result in “abnormal” conditions but also iatrogenic injury (Weir 2006:91). Thus, the obstetrical focus on
risk in pregnancy serves to undermine women’s experience of pregnancy as normal. Instead of empowering women to develop confidence in their bodies and in their embodied knowledge of “what’s best” for their children, current obstetrical practice and its focus on risk scares women into making decisions based on the “in case something bad happens” (Cheyney 2008) argument and demonstrates an example of obstetrical hegemony.

Therefore, women in the U.S. who opt for home birth (and their providers) do so amidst a cultural backdrop of fear and have to face the questions posed by their family members, care providers, and at times legal authorities, all of which often label the mother as selfishly pursuing her own desires for a “natural” childbirth experience over her concerns for the safety of her newborn (American College of Obstetricians and Gynecologists 2008b). CMA would point to this as part of the “control of production” ultimately pitting the classes of pregnant women and their individual choices at the “micro-social” level against the medical establishment, including its payment mechanisms, at the “macro-level” and describe this interaction as antagonistic, and one in which the powerful, culturally-backed biomedical system ultimately prevails. The fact that these critiques of the U.S. childbirth system have remained the same for decades without much, if any, change speaks to the great power wielded by the medical establishment in its perpetuation of the status quo. However, it is perhaps at this juncture that increasing “consumer” (Craven 2007) activism may finally tip the scales.

CMA can also help to explain the persistent health disparities that exist along economic, racial, and ethnic lines. CMA contextualizes the U.S. health system, which supports an employment-based insurance structure that systematically excludes coverage to unemployed and under-employed individuals. This system led to the creation of government-backed health insurance in the form of Medicare and Medicaid for the growing numbers of citizens who lacked access to traditional, employment-based, private insurance coverage, but an outgrowth of that has been a tiered-system in which “private” practitioners can opt out of providing care to “public”
patients, and unequal care is received (Lazarus 1994). Home birth is differentially accessed along class lines, in part due to its low coverage by state Medicaid programs.

**Health Disparities**

Disparities exist in the U.S. both in terms of reproductive outcomes and reproductive care access. Infant mortality stands out as one of the greatest health care disparities (MacDorman and Mathews 2011), which is particularly telling because maternal and infant mortality are sensitive indicators of a nation’s health care system, as well as the socio-economic status of its citizens and residents, particularly women (Reidpath and Allotey 2003). In 2008, the U.S. ranked poorly, at 50th out of 172, in world-wide maternal mortality ratio (at 24/100,000 live births) and 44th for infant mortality rate (7/1,000 live births) (World Health Organization 2010), despite spending the largest share of GDP on health care. This can suggest that the U.S. health system is inadequate, that significant economic and access disparities exist, or both. U.S. infant mortality has demonstrated racial inequity for over one-hundred years (MacDorman and Mathews 2011). The “War on Poverty” and resultant social programs such as Medicaid helped to narrow this gap in the 1960s and 70s, but these declines turned to increases in the 1980s and beyond due to “welfare reform” programs (Krieger, et al. 2008).

Minorities are more likely to be uninsured, with 32% of Hispanics and 22% of non-Hispanic blacks uninsured in 2010, compared to 14% of non-Hispanic whites (Kaiser Family Foundation 2011). This can be particularly critical during the childbearing years because women with chronic medical conditions may not have health care access to adequately manage these conditions (such as thyroid disease, diabetes, hypertension, etc.) prior to pregnancy when Medicaid coverage “kicks in.” In 2007, non-Hispanic black women in the U.S. were 2.4 times more likely than non-Hispanic white women to experience infant mortality, with American Indian/Alaskan women and Puerto Rican women also having higher rates of infant mortality than non-Hispanic whites (MacDorman and Mathews 2011). A key factor in infant mortality is pre-term birth (birth before 36 completed weeks of pregnancy), with a 54% difference between
non-Hispanic white and black women where preterm birth was the cause of death in infant mortality (MacDorman 2011). Preterm birth rates among non-Hispanic black women in 2007 were 18.3%, compared to 11.5% among non-Hispanic whites and 12.7% in the total U.S. population (MacDorman and Mathews 2011). Risk factors for preterm birth and other poor birth outcomes include: age extremes (teens and women over 35), low socioeconomic status, not being married, tobacco use, and limited prenatal care (MacDorman 2011). Beyond these, it has been reported that non-Hispanic black women suffer disproportionately from the effects of racism and discrimination via a process known as “weathering” (Geronimus 1992; Geronimus 2001) in which chronic exposure to economic, social and political disadvantage results in biological responses that accelerate aging. Particularly, Geronimus proposed that due to this “premature aging” process, non-Hispanic black women were more likely to give birth at younger ages, such as during adolescence, which is a known risk factor for prematurity. From a life-course perspective (Lu and Halfon 2003), non-Hispanic Black women are also said to suffer from the cumulative effects of “allostatic load” (Geronimus, et al. 2006; Shannon, et al. 2007), defined as the chronic activation of the sympathetic nervous system and its resultant stress hormone release that leads to a “wear and tear” effect over time (Goldstein and McEwen 2002). These are important from the perspective of Critical Medical Anthropology that incorporates racism and discrimination into the factors that account for the disproportionate health care access among minority populations. Interestingly, however, when the theory of allostatic load is applied statistically, using adjusted regression models, allostatic load is not associated with preterm birth or low birth weight, or in some cases, it is not a factor among Black-non-Hispanic women during pregnancy, even though it had been prior to pregnancy (Morrison, et al. 2013; Wallace, et al. 2013; Wallace and Harville 2013). This might suggest that more robust models are needed to account for birth disparities.

Regardless, midwives care for a disproportionate share of women facing these risk factors (Raisler and Kennedy 2005), and midwifery care has been linked to decreased rates of
preterm birth (MacDorman and Singh 1998). Thus, midwifery care can serve as an important strategy to decrease infant mortality, but midwifery care is not always accessible to all U.S. women, given both the biomedical hegemony of obstetricians and state and federal policies. Thus, the care most appropriate to those who need it is often the very care least available.

Anthropologists have documented inequities in care access and provision between middle class and poor women since the early 1990s (Lazarus 1994; Lazarus 1990). CMA would explain these gaps as the perpetuation of the privileges of the dominant classes over the proletariat, being played out in medical encounters.

Racial disparities in home birth in the U.S. exist as well. Home birth rates for non-Hispanic whites are three to five times higher than all other racial and ethnic categories (MacDorman, et al. 2012a). Proposed reasons for the lower rates of minority women seeking home birth include economic disincentives, particularly lack of insurance or insurance coverage via Medicaid, decreased agency exhibited by minority women, as well as decreased access to quality care (Moore 2011). Total U.S. home births experienced a decline from 1990-2006, largely due to decreases among “minority” race and ethnic groups (declines of 37% for American Indians, 50% for non-Hispanic black, 63% for Asian/Pacific Islanders and 65% for Hispanics), despite a 23% increase among white, non-Hispanic women in this same time frame (MacDorman, et al. 2011). From 2004-09, U.S. home births increased 29%, largely fueled by a 36% increase among non-Hispanic whites, although rates among non-Hispanic black and American Indian women remained steady and very slight increases were noted among Hispanics and Asian Islanders (MacDorman, et al. 2012a). However, some evidence exists to demonstrate that home birth among “minority” women is more likely to represent unplanned, even emergency, home births than among non-Hispanic whites (MacDorman, et al. 2011), and therefore, a decrease among minorities might actually represent a “positive” finding to support that minority women are accessing prenatal and delivery care (vs. no care at all). However, that care is the standard biomedical care that consistently fails to address birth outcome disparities,
highlighting what CMA would term the “structural constraints” of this biomedical hegemony. Perhaps if more “minority” women were able to access care provided by home birth midwives that addresses a wider range of the bio-psycho-social as well as spiritual issues and concerns that women face during pregnancy, and values the relationship between the woman and caregiver, then birth outcomes could be improved. Policies that promote access to this care for all women are warranted.

**Medicalization of Childbirth and Critical Medical Anthropology**

CMA stresses the impact of hegemonic practices that serve to prevent access to health care, particularly to the care of an individual’s choice, as in access to home birth. Among these practices is the requirement for physician oversight of non-physician professionals’ practice, addressed later in this chapter. Medicalization refers to the process by which health-related but non-medical problems come to be defined as medical diagnoses and ultimately contribute to overall health spending (Conrad, et al. 2010). Anthropologists have contributed significantly to the examination of the medicalization and technocratization of birth (Davis-Floyd 2003; Davis-Floyd and Dumit 1998; Davis-Floyd and Sargent 1997; Sargent and Gulbas 2011). Sargent and Gulbas (2011:290) stress that, “reproduction reflects and shapes core societal values and structures” and anthropological research is key to understanding how childbirth “shapes and reshapes social, moral, and political landscapes.” Therefore, the dominant childbirth practices in the U.S., including a 98.6% hospital birth rate (MacDorman, et al. 2014), physician attendance at 92% of births (Martin, et al. 2011), a cesarean section rate of 32.8% (Martin, et al. 2013a), and 60% of laboring women receiving epidural anesthesia (Lancaster, et al. 2012; Osterman, et al. 2009) all point to the widespread cultural acceptance of the technocratic and medicalized birth culture. Furthermore, these birth practices are inherently more costly, but profits made from this care help perpetuate and reinforce the dominant medical paradigm. Thus, the “medical-industrial complex” (Singer and Baer 1995:66) controls birth, all the while women accept these practices as safer, and in fact, necessary.
**Professional Health Organizations Position Statements on Home Birth**

As public demand for and media exposure of home birth have increased, many of the major professional organizations involved in maternity care have released statements and practice guidelines related to home birth that fall along a medical/midwifery divide. These serve as a form of national policy regarding home birth, even though they are not binding. What they do represent is the power of the medical “authorities” to set “standards” and influence insurance companies, all of which reinforces their hegemony, even when the guidelines do not reflect best scientific evidence or impartiality (Grilli, et al. 2000). The following will summarize the general provisions of these statements and present relevant critiques.

**American College$^{17}$ of Obstetricians and Gynecologists (ACOG)**

By far, and representative of the medical hegemony referenced earlier when defining CMA, the American College of Obstetricians and Gynecologists (ACOG) sets the “standard” for maternity care practices in the U.S., despite studies demonstrating only one-third of ACOG practice bulletins are based on solid scientific evidence (Chauhan, et al. 2006; Wagner 2006; Wright, et al. 2011). In this way, ACOG exerts its power to “shape the health care experience” as cited by CMA theorists. ACOG first published recommendations against home birth in 1975, when the first wave of the home birth movement was cresting (and one year before the first edition of *Spiritual Midwifery* was released). Citing the “risks” of home birth (but notably without any documentation or evidence) it proposed: “Labor and delivery, while a physiological process, clearly presents potential hazards to both mother and fetus before and after birth. These hazards require standards of safety which are provided in the hospital setting and cannot be matched in the home situation” (American College of Obstetricians and Gynecologists 1975). ACOG reiterated these sentiments in the more comprehensive *Guidelines for Perinatal Care* published in conjunction with the American Academy of Pediatrics (AAP) and which exist as de

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$^{17}$ As described above, ACOG has changed its name from College to Congress but to maintain consistency throughout this dissertation, College is used in all references to ACOG.
facto standards for U.S. perinatal care. Now in its 7th edition (American Academy of Pediatrics and American College of Obstetricians and Gynecologists 2012), these guidelines demonstrate the hegemony of medical authorities over other health professions and even over women’s autonomy.

ACOG formally revised its out-of-hospital policy in 2006, reiterating its opinion that the hospital is the safest place for childbirth, and for the first time concluding that it not only “strongly opposes out-of-hospital birth” but further “does not support programs or individuals that advocate for or who provide home births” (American College of Obstetricians and Gynecologists 2006). Childbirth Connection, a national non-profit organization dedicated for nearly one hundred years to “helping women and health professionals make informed maternity care decisions” (Childbirth Connection 2012), led the critique of the new policy primarily because of a lack of evidence to support such opposition to out-of-hospital birth. In a joint letter submitted to the ACOG executive committee by the leaders of several national health care and consumer organizations (Corry, et al. 2006), concerns were expressed over the ACOG policy statement’s: lack of scientific evidence for its opposition to home birth; failure to cite strong scientific evidence supporting the safety of home birth; implications for women’s choices and legal rights to informed consent; and potentially dangerous consequences of the policy, such as jeopardizing the support of physicians who collaborate with home birth providers that could lead to increased systemic risk, and increasing low-risk women’s exposure to iatrogenic interventions in the hospital setting. The policy was further critiqued by the American College of Nurse Midwives, American Association of Birth Centers, Lamaze International, White Ribbon Alliance for Safe Motherhood and others, resulting (perhaps) in a 2007 revision that shifted ACOGs policy to include accredited birth centers as “acceptable” while continuing to “strongly oppose home births” (American College of Obstetricians and Gynecologists 2007).

Amidst these changes, increased media attention came to focus on the U.S. maternity care system and the viability of home birth. Primarily in a reactionary move against media
coverage of home birth (Lowe 2009), specifically the release of the Business of Being Born (Epstein 2008), ACOG issued a press release version of its "statement" on home birth in 2008. This “reiterate[d] its long-standing opposition to home births” (American College of Obstetricians and Gynecologists 2008b) and asserted its belief in the lurking risks of childbirth, even among low-risk women, that are best monitored in a “hospital or accredited birthing center.” The statement went on to “acknowledge a woman’s right to make informed decisions regarding her delivery and…choice of health care provider” but for the first time specifically denounced care provided by midwives other than CNM/CMs. This latest ACOG mandate was followed by American Medical Association (AMA) Resolution 205 that supported the hospital as the “safest” setting for birth and resolved to “support state legislation that helps ensure safe deliveries and healthy babies by acknowledging that the safest setting for labor, delivery, and the immediate postpartum period is the hospital or a birthing center within a hospital complex” (American Medical Association 2008). Thus, the medical establishment exerted is power and control in a move reminiscent of the class struggles CMA supporters often describe. Using their power as the dominant voice of physicians (and arguably health care) in the U.S., the AMA declared home birth as “unsafe” and established the hospital as the place for birth, which is of course the place that physicians have the most influence and dominance.

This action brought swift response by many “midwifery model” advocates and editors of professional journals focused on perinatal care. The editor of Birth: Issues in Perinatal Care provided a concise overview of the “action and reaction” to the issue, and questioned why the AMA and ACOG needed to spend such resources opposing the practice of so few U.S. women, in light of the much more prevalent and pressing maternity related health issues such as preterm birth, low birth weight, cesarean rates, ethnic and racial disparities, and VBAC (Young 2008). Midwives Alliance of North America (MANA) President Geraldine Simkins denounced AMA Resolution 205 as “anti-home birth, anti-midwife, anti-choice” and “unsupported by
scientific evidence” (Simkins 2008), and declared that midwifery care actually addressed the very issues highlighted by Young. Simkins asked (2008):

Why is the AMA not asking the real questions instead of trying to debunk existing research evidence on the safety and efficacy of home birth and attempting to corner the market on maternity care? For example, why are midwife-attended births far more likely to have fewer interventions, fewer postpartum infections, more successful breastfeeding rates, healthy infant weight gain and result in more satisfied, empowered mothers ready to embrace their newborns and parenting experiences? Why are so many women across the nation left emotionally traumatized by their childbirth experiences in hospitals and consequently why do rates of postpartum depression, anxiety, and post-traumatic stress continue to escalate?

This is a keen analysis from a CMA perspective (though likely not intentionally), as Simkins draws connections between the individual experience and the policies that influence choice in the name of “cornering the market.” She continues by asking for all maternal health providers to work together to collectively improve the poor U.S. perinatal statistics.

The International Cesarean Awareness Network (ICAN) publicly condemned ACOG for its statement that would “limit women’s choices” by declaring, “women and children should not bear the brunt of malpractice risks being conveyed into physical, mental, emotional and spiritual health risks in order to protect their physicians” (International Cesarean Awareness Network 2008). Thus, drawing on the CMA orientation, ICAN directly connects macro and intermediate level policies to individual experience, further recognizing and emphasizing the individual as more than a mere mechanistic body in need of medical assistance, but acknowledging the wider needs and realms of individuals and their lived experience. Medicine and medical authorities reduce health care to the evaluation of clinical outcomes, and do so under the pressure of the U.S. liability system (Wagner 2006), which supports their medical/technocratic model and renounces the potential for a humanistic or holistic model (Davis-Floyd 2001).

Citizens for Midwifery (CfM), a consumer-oriented group formed by mothers in 1996 and dedicated to promoting the Midwives Model of Care, published guidelines for rebuttal to the ACOG statements on their website that intended to help consumer activists write to local papers
or other press outlets (Citizens for Midwifery 2008). These rebuttals serve as excellent critiques of medical hegemony and serve to examine the issue from a CMA lens. Their key talking points include that:

- Midwifery and out-of-hospital maternity care is cost effective;
- Rigorous scientific studies support the safety of home birth;
- While ACOG claims complications can arise without warning even in low-risk women, many low-risk women in the hospital experience such complications as a result of the iatrogenic and often routine hospital practices;
- Cesarean rates for out-of-hospital CNMs and CPMs have been reported at 3-6% (Anderson and Murphy 1995; Johnson and Daviss 2005; Rooks, et al. 1989; Stapleton, et al. 2013), compared to the 19% among low-risk women attended by obstetricians in hospitals (Johnson and Daviss 2005);
- ACOG publicly promoted maternal cesarean by request, and cites maternal demand as a reason for the increase in cesarean rates. However, studies have demonstrated less than 1% of pregnant women request cesarean. Thus, “having actively worked to create a market for cesarean sections for no medical reason, based on lies and misinformation, ACOG is now blaming women for the increased cesarean rate” (2008:3);
- While ACOG recognizes only physicians and CNMs/CMs as appropriate home birth providers, these providers receive little to no training in home birth and in fact almost universally practice in the hospital setting. This ironically can increase the risk of out-of-hospital birth when attended by physicians or CNMs/CMs.

Thus, CfM concludes that women who choose home birth should be attended by a trained out-of-hospital birth provider, not by an expert in procedures associated with hospital birth. When the dominant childbirth and medical organizations in the U.S. demand for care to be provided by those realistically least competent (because at home they will not be supported by the technology they have come to rely on), a form of “structural violence” (Farmer 2004) occurs, both towards the women at home birth and against the trained and professional home birth providers. CfM is thus aware of the political-economic and hegemonic forces at work, which rely on playing on perceptions of risk and limit women’s reproductive choices related to place of birth.

The Big Push for Midwives, a lobbying organization with a mission to “educate state and national policymakers, and the public, about the reduced costs and improved outcomes associated with out-of-hospital maternity care and to advocate for expanding access to the services of CPMs” responded to ACOG’s 2008 press release by labeling ACOG as a “trade
union” that is “out of touch with the needs of childbearing families” (The Big Push for Midwives 2008). They particularly criticize ACOG for “adding insult to injury by claiming that women delivering outside of the hospital are bad mothers who value the childbirth ‘experience’ over the safety of their babies” and further cite the importance of trained out-of-hospital maternity providers as first-responders during natural disasters.

Nancy Lowe, a CNM and editor of the Association of Women’s Health, Obstetric and Neonatal Nurse’s (AWHONN) official Journal of Obstetric, Gynecologic and Newborn Nursing, decried, “This type of resolution by ‘authoritative’ bodies such as ACOG and AMA will certainly influence decisions made by third-party payers when women request home birth services and by liability insurance carriers when providers seek coverage for home birth services” (Lowe 2009:1). Indeed, citing the ACOG committee opinion, one major insurance carrier’s clinical policy bulletin on home births finds “planned deliveries at home and associated services not medically appropriate” although “coverage of home births will be considered when mandated by law under plans subject to state mandate” (Aetna 2011). Furthermore, she cited this as an example of how women in the U.S. must fight to uphold their choice to birth spontaneously, without medical intervention, in a system controlled by physicians and nurses that have minimal experience with “normal” birth (Lowe 2009).

Further response to the ACOG and AMA positions came from professional health, nursing, perinatal and midwifery organizations, again split largely along the medical vs. midwifery model of care. The National Perinatal Association adopted a position that “planned home birth should be attended by a qualified practitioner within a system that provides a smooth and rapid transition to hospital if necessary” (National Perinatal Association 2008). But this seamless transfer system does not exist (Davis-Floyd 2004), and “the point is that we have no system of maternity care in the United States that provides a healthy woman the choice of giving birth at home and if she needs to transfer to a different type of care during labor, the transfer is easy” (Lowe 2009:2).
Possibly, in knowing that this transport system does not exist, ACOG softened its opposition to home birth in its 2011 “Committee Opinion on Planned Home Birth” (American College of Obstetricians and Gynecologists 2011b) by accepting home birth among low-risk women when attended by physicians or CNM/CMs practicing within an “integrated and regulated health system” that provides “assurance of safe and timely transport to nearby hospitals.” This rhetoric implies acceptance because in reality, this integrated system with adequate hospital transport does not exist. Thus, this “standard” largely reiterates ACOG’s previous stance taken that “hospitals and birthing centers are the safest setting for birth” but bowing to consumer pressure, ACOG felt the need to affirm the “right of a woman to make a medically informed decision about delivery” (American College of Obstetricians and Gynecologists 2011b). This of course asserts “medical” knowledge as authoritative and fails to recognize the many other forms of information women are likely to utilize and negotiate in making a decision about such an important family-centered yet culturally-bound process as giving birth. ACOG manages to further reiterate its opinion that physicians or CNM/CMs are the only appropriate out-of-hospital attendants [and thus de facto attendants in any setting, given that CPMs and other midwives practice almost exclusively out-of-hospital]. By stating that “women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence” (American College of Obstetricians and Gynecologists 2011:3) but failing to cite the breadth of scientifically rigorous evidence and instead citing misleading and even refuted (see Chapter One) “evidence” (i.e. Wax, et al 2010), ACOG misleads its members and the women they care for with low-grade evidence, in order to maintain their monopoly on childbirth. As noted earlier, several studies published within ACOGs own journal (Chauhan, et al. 2006; Wright, et al. 2011) have demonstrated that less than one-third of their policy statements and clinical guidelines are based on Level A recommendations (i.e., “good and consistent scientific evidence”) per the U.S. Preventive Services Task Force, with only one-
quarter of obstetric, vs. gynecologic, recommendations Level A\textsuperscript{18} or the strongest type of recommendation.

The 2011 ACOG home birth guidelines further delineate selection criteria for planned home birth and specifically consider prior cesarean as an “absolute contraindication” to planned home birth. This leaves many women who desire VBAC without any choice, as the American Association of Birth Centers (AABC), in choosing to discontinue its “VBAC Study” (American Association of Birth Centers 2008) practically closed the door to VBACs at AABC centers. In Florida, the Birth Center Risk Status Criteria (Florida Administrative Code 59A-11.009) prohibits birth center birth for women with previous uterine surgery, although this law does not apply to home births (Florida Administrative Code 64B24-7.004). Therefore, many women who seek VBAC in Florida choose home birth because they have strong beliefs against going to a hospital and facing a likely repeat cesarean, and home birth with LMs is their only alternative. A review of the ICAN database for Tampa Bay area VBAC providers includes only home birth LMs, one CNM practice that delivers at Tampa General Hospital and the USF Obstetrics service that also delivers at Tampa General. Indeed, particularly in Hillsborough County, the remaining hospitals will not allow VBAC. Throughout the country, women have few options for VBAC and often pick home VBAC attended by CPMs/LMs, or even unattended birth at home, given this lack of other choices.

**American Academy of Pediatrics (AAP)**

The American Academy of Pediatrics (AAP) wields the same level of clinical prestige and “authoritative knowledge” for children’s health care that ACOG does for maternity care in the U.S. In a response to the ACOG statement, an AAP Fellow called for pediatric guidelines on both how to counsel women regarding home birth and how to care for infants born at home (Watterberg 2011). Accepting at face value the Wax and colleagues (2010) data reported in the

\textsuperscript{18} The U.S. Preventive Services Task Force uses a grading system to rank the strength of its recommendations, particularly after weighing any net risk against any benefits, with an A describing a strong recommendation. See: \url{http://www.uspreventiveservicestaskforce.org/3rduspstf/ratings.htm}
ACOG statements, the author concurs that home birth is associated with a significant increase in neonatal mortality. She applauds the ACOG committee as having “appropriately confine[d] its recommendations to the care of the woman choosing to have a home delivery and her right to make an informed decision about her birth plan” and recommends the pediatric community to similarly weigh the risks and benefits of home birth specifically related to the infant to create its own set of guidelines.

In 2013, AAP formally issued its own policy statement on “Planned Home Birth” (American Academy of Pediatrics 2013). Essentially “seconding” the ACOG statement, AAP reiterated the view that hospitals and birth centers are the safest sites for childbirth, but maintained respect for a woman’s right to make medically informed decisions about place of birth. They further reiterated that only physicians and CNMs/CMs are appropriate attendants (thereby dismissing the midwives not certified by the American Midwifery Certification Board (AMCB) who attend up to 90% of planned home births). Beyond the edicts put forth in ACOGs statement, the AAP statement laid specifications as to the capacity of birth attendants to provide immediate newborn care, as well as continuing neonatal care. They recommend that at least two attendants be present at birth, with one capable performing a “full neonatal resuscitation”, a skill reiterated and trained for in its own Neonatal Resuscitation Program, which by and large all midwives, regardless of setting, recertify in bi-annually. Emphasizing AAP’s power to set care standards, and using language describing the newborn as righteous, AAP stated “every infant newborn deserves health care that adheres to the standards highlighted in this statement and more completely in other AAP publications” referencing the joint ACOG/AAP Guidelines for Perinatal Care (American Academy of Pediatrics and American College of Obstetricians and Gynecologists 2012). Thus, AAP reinforces its position as the authority on newborn care, and while paying lip service to women’s right to informed choice, it uses questionable evidence or its own guidelines to both promote fear among the very women that choose home birth as well as to discredit out-of-hospital providers.
American College of Nurse-Midwives (ACNM)

The initial American College of Nurse-Midwives (ACNM) position statement on home birth was approved by its Board of Directors in December, 2005. Written in a very different tone than the ACOG bulletins, this statement upheld the right of “every family” (not just woman) to choose their birth setting and further to “experience childbirth within a context that respects cultural variations, human dignity, and self-determination” (American College of Nurse Midwives 2005). Thus, unlike ACOG and AAP statements that come as the proscriptions of an authoritative expert, ACNM clearly highlights the importance of a relationship between caregiver and care receiver and acknowledges the holistic experience of childbirth. ACNM references its separately published clinical guidelines (that are, however, only available through purchase) in its position statement that is used instead primarily to uphold evidence-based and ethical practices and principles. The majority of the statement is an annotated bibliography of studies on home birth, separated by evidence level, including studies they acknowledge to contain “methodological flaws.” In 2011, ACNM updated its position statement on home birth, switching the format to a bulleted list of positions and including a background statement on the issue, removing the annotated bibliography format, and notably not referencing ACOGs committee opinion. Furthermore, ACNM’s position statements do not delineate acceptable and unacceptable home birth providers, other than to acknowledge that CNMs/CMs are qualified to provide home birth care. In both statements, ACNM calls for research and evaluation of home birth, including looking beyond outcomes to client experience and development of quality assurance measures (American College of Nurse Midwives 2011). More recently, ACNM’s Journal of Midwifery and Women’s Health published a somewhat controversial article regarding the adoption of clinical guidelines for CNMs/CMs attending home births (Cook, et al. 2014), that suggested that home birth providers felt that their autonomy would be challenged if they were expected to uphold published guidelines.
Midwives Alliance of North America (MANA)

MANA is a voluntary membership organization representing midwives from the U.S., Canada and Mexico. While membership is open to midwives practicing in all birth settings, MANA has traditionally been a voice for out-of-hospital midwives, particularly those attending home births. Despite this, MANA did not release a formal home birth statement until September, 2012 (Midwives Alliance of North America 2012). Similar to the statement by ACNM, MANA’s statement does not put its focus immediately on the issue of home birth or even on the individual pregnant woman or her care provider. Instead, MANA opens its position paper by reaffirming its respect for birth as a natural, physiological process that is an “expression of wellness in a healthy woman” and a “transformative experience.” MANA acknowledges home birth as an “expression of a woman’s autonomy” and validates midwives’ support for women’s informed decision making related to their chosen place of birth. They attribute the privacy and comfort of home to a woman’s empowerment during birth, and view a woman’s home as the place where she can best experience cultural consonance. The language grants a sense of empowerment, gentleness, and appropriateness. The position paper references the safety and cost-effectiveness of home birth, as well as the health disparities that exist within the U.S. maternity care system, and upholds the value of midwifery care to promote healthy relationships not only within a care setting but societally. Nowhere does the statement reference or react to the ACOG or AAP home birth policy statements, though reference to ACOG is made in regards to maternity workforce shortages as well as its informed consent policy. Indeed, the true focus of this position statement deals more with a woman’s autonomy, informed consent, and empowerment, than simply with the issue of place of birth. It is written in a respectful manner that acknowledges the importance of collaborative care with other health providers as well as the need for integrated systems for transfer of care. The MANA home birth position paper highlights the excellent outcomes of planned home birth with skilled attendants, and the benefits of the trusting relationship, the familiar home setting, and the hands-on, individual care provided
by home birth midwives that contribute not only to these outcomes but to a woman’s empowerment. MANA concludes with a poignant statement of utmost relevance to this dissertation’s theoretical stance:

True support of a woman’s right to choose homebirth includes federal and state programs to eliminate disparities in underserved and marginalized communities, funding of multiple routes to homebirth midwifery education, legalization of homebirth midwives in all states, and public and private insurance coverage for homebirths and home birth midwives (MANA 2012: 4).

American Public Health Association (APHA)

APHA was among the first health organizations to support home birth, and to advocate for the advancement of CPMs through state licensure and regulation. In its 2001 policy statement, APHA recognized not only that women seek out-of-hospital birth experiences, but also that pregnancy and birth are generally normal events that can safely and cost-effectively occur in out-of-hospital settings (American Public Health Association 2001). Furthermore, it acknowledged the access issues faced by underserved women and families, and advocated for innovative education programs with multiple entry routes to prepare midwives to meet the needs of childbearing women. By far, APHA’s resolution offers the strongest language of support for out-of-hospital birth and for non-nurse midwives. However, APHA has little to lose by doing so, as it is not a direct, active player in the “maternity market”, but instead serves as an advocacy organization on health-related issues. For instance, APHA resolutions and policy statements can reiterate the ethical responsibilities of health practitioners, such as acknowledging the effects of racism, poverty or the environment on health, or indeed by carrying out the core functions of public health: assessment, assurance and policy development.

Home Birth Summit

In October 2011, the Home Birth Consensus Summit, a historic gathering of stakeholders representing all aspects of U.S. maternity care, convened to discuss home birth
and ultimately reach common ground for moving forward. Nine consensus statements were reached (Home Birth Consensus Summit 2011), addressing:

- Autonomy of childbearing women
- Collaboration within an “integrated maternity care system”
- Equity within the maternity care system, including education of providers
- Licensure and national certification for all maternity care providers, in all birth settings
- Consumer involvement
- Communication across all providers and disciplines
- Medical liability reforms
- Integrated data collection across birth systems to increase the evidence base
- Birth as a physiologic process

It appeared that finally some of the walls supporting biomedical hegemony in birth would be dismantled, and action against the oppressive dominant class would occur. However, to date, very little has actually changed, despite task forces that emerged out of each of the consensus statements.

**Joint Call to Action Statement**

Shortly after the Home Birth Consensus Summit, a “Quality Patient Care in Labor and Delivery: A Call to Action” statement (Joint Call 2012) was endorsed by members of ACOG, AAP, ACNM, American Academy of Family Physicians, AWHONN and the Society for Maternal-Fetal Medicine, clearly excluding representatives from MANA, CPMs, birth centers, or home birth organizations and therefore failing to act in a collaborative manner as had been called for at the Home Birth Consensus Summit. In this call, pregnancy and birth were recognized as physiological processes that “require minimal-to-no intervention” and the need for “an atmosphere of effective communication, shared decision-making, and teamwork” in optimal maternity outcomes is cited. No mention regarding place of birth is made, but an undertone exists assuming hospitals are the place where “labor and delivery” will occur, as evidenced by language such as, “organized board rounds, structured handoffs and bedside rounds” and “organizational priorities that guide decisions for organizational policies and practices” that

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19 Available at: [http://www.homebirthsummit.org/summits/vision/statements/](http://www.homebirthsummit.org/summits/vision/statements/)
obviously would not be part of birth in a woman’s home. These provisions nearly refuted the statement’s focus on “patient-centered” care, as the document appears to be primarily centered on making improvements to hospital-centered care in order to optimize maternity care. The fact that entering a facility is in fact an intervention unto itself contradicts the statements’ belief in birth as a “physiological” process. This statement in essence acts to affirm the control of the “medical-industrial complex” over birth while relegating the “patient” to the periphery of the true decisions made by organizations and providers, instead of advocating for patients truly at the core/center of their care. By stating, “patient-centered care requires the balance between maternal-child safety and well-being with the woman’s needs and desires” and claiming “patient-centered care is enhanced when women are provided supportive resources such as education and skilled attendants,” an underlying assumption prevails that providers and the care system are central to the process of a woman giving birth. A CMA perspective would recognize the inherent political-economic, biomedical dominance that reigns in this “Joint Call” which is in opposition to women receiving care that favors their inherent knowledge of their bodies and their natural abilities to give birth over the disembodied, structural knowledge and power wielded by “authorities” in birth.

**Joint Statement on Physiologic Birth**

While not directly related to home birth per se, in 2012 a significant joint statement (American College of Nurse Midwives, et al. 2012a) was released by the three key midwifery bodies in the U.S., the American College of Nurse-Midwives, the Midwives Alliance of North America, and the National Association of Certified Professional Midwives, that upheld the 1996 call by the World Health Organization for the support for and protection of “normal birth” which they define as:

…spontaneous in onset, low-risk at the start of labor and remaining so throughout labor and delivery. The infant is born spontaneously in a vertex position between 37 and 42 completed weeks of pregnancy. After birth, mother and newborn are in good condition (World Health Organization 1996).
The statement further defines and describes the characteristics of “normal physiologic birth” as well as factors that disrupt it, support it, and its expected outcomes. The statement does not endorse any particular birth setting, but does acknowledge the current high-intervention, technological maternity system and therefore promotes the introduction of policies within the hospital setting that will foster normal, physiological birth. In addition, the statement endorses access to midwifery care for all women, as well as culturally competent care that values shared decision-making and informed consent. It also makes recommendations for future education, research and policy to further promote physiologic birth. Significant unto itself is the fact that these three organizations, which have not historically been supportive of one another, came together to forge this common ground statement for the benefit of all maternity care in the U.S.

Organizational Policies: Discussion

Certainly, the hegemonic policies of ACOG and AMA have been met with resistance by other health professionals, consumers, and to an extent, lawmakers. The power wielded by these organizations and the resultant outcomes of their policies, such as iatrogenic injury, increased cesarean rates, etc., are a form of structural violence. Growing resistance by individuals and non-dominant organizations increasingly claims birth as within a woman’s realm. Home birth continues to rise, media coverage continues to highlight the issue, and ACOG continues to respond. On May 31, 2012, the ACOG President (Breedon 2012) drew further attention to the “home vs. hospital” debate in the general public when he cited a New York Times article (Shapiro 2012) about home birth and famed midwife Ina May Gaskin. In a blog post, Breedon upheld ACOG’s position that “it is important for any woman choosing home birth to have a certified nurse-midwife, certified midwife, or physician practicing within an integrated and regulated health system with ready access to consultation and plan for safe and quick transportation to a hospital in case of an emergency” (Breedon 2012). Again, such an integrated system with ready transportation does not exist, thus reinforcing ACOG’s true opposition to home birth as a feasible or plausible option in the U.S., at least not a profitable one.
for the “medical-industrial complex.” In fact, by promoting the attendance of home birth by the providers least experienced in it, it sets up home birth failures, and is another form of “structural violence.” As the Big Push for Midwives campaign suggests (2008) CPMs are the out-of-hospital birth specialists who are essential providers in times of disaster and in preventing cesarean, pre-term and low birth weight babies, and as such should be integrated into the health system.

This debate implies that as women feel their rights to choose how to give birth become severely constrained by policies enacted by the professional association representing over fifty thousand obstetricians, the professional organizations that represent these health consumers and non-medical health care organizations alike respond through policy statements and media outlets. As women have done since the 1960s, these modern birth activists exert their authority as the experts of their own bodies and fight back against policies that aim to perpetuate the biomedical hegemony. Meanwhile, midwifery-model organizations develop their own position statements, not just in reaction to ACOG but that demonstrate their own core values. However, to date, no systemic changes have brought about an “integrated and regulated system” because doing so would challenge the very “medical-industrial complex” that integrates all of the profit-making arms of health care through political legitimization and reduces “patients” to “consumers” who feed the profits. Of course, unlike the women who see their choices as constrained and equip themselves to resist the biomedical system, the vast majority of U.S. women are embedded in the cultural norms established and maintained through this system. They accept and choose biomedical birth in hospitals without question, and even argue for why it is best or “safer,” and in so doing demonstrate the true hegemony of the system by viewing it as the “natural social order” (Singer and Baer 1995). Thus, a discussion is presented in this dissertation of the overall health and maternity care systems in the U.S. and how Critical Medical Anthropology can be used to critique home birth policies within these systems, particularly as they relate to risk conceptualization.
Theoretical Perspectives: Discussion

Major federal policy issues that impact women’s access to home birth revolve mostly around the biomedical hegemony of obstetricians influencing culturally constructed norms of childbirth. Obstetrical guidelines are widely accepted and implemented by hospitals and insurers, ultimately binding women to their provisions. States have significant influence in home birth policies, as states license and regulate health professionals, health facilities and insurance (both liability coverage for providers and health insurance coverage, private or public). Florida overall has very supportive home birth policies, but these are far from ideal in clinical practice. Issues related to transport, low Medicaid provider reimbursement rates, physician collaboration, VBAC and others all impact women’s choices and access to care, ultimately impacting their individual economic costs, as well as costs to macro-structures.

The policies in the U.S. and Florida that impact the practice and legality of and payment for home birth bear partial responsibility for disparities in women’s access to home birth and providers’ ability to attend home birth. The U.S. health system, based on profits and medical hegemony, further impacts home birth practice and access. Professional medical organizations seek to maintain control of health care by issuing statements and practice guidelines that attempt to restrict and de-value home birth. Consumer movements related to maternity care and birthplace have grown and public media pressure has played a role in shifting policies and opinions among professional medical organizations, insurance companies, and even politicians. Home births remain a small percentage of total U.S. births, but a cresting wave of activism has brought multiple stakeholders into dialogue, such as that which occurred during the Home Birth Summit. Continued research is warranted to find a balance between the desires of women, the capacities of the health system and health care providers, and the concepts of risk and safety for mothers and newborns.

Maternal autonomy has often clashed with biomedical hegemony. Critical Medical Anthropology (CMA) offers a lens through which to critique home birth practice and biomedical,
technocratic birth and situate them within a larger national political and economic system. CMA stresses the relationship between macro-level structures and micro-level individual experiences, and begs for critical analyses of the interactions between the two. In this way, research studies utilizing a CMA perspective lend themselves to integrated, mixed-methods designs, so that macro structures can be described using population-based statistics, while local-level experiences can be explored using ethnography and in-depth interviews.

Theories of risk highlight the discrepant definitions and concepts of risk related to the perspective of an individual, a health care provider, a health profession, or more broadly from an epidemiological perspective. Many current risk conceptions place the individual patient at “blame” if “something goes wrong” which is ironic given the extensive medical liability system in the United States. The maternal-child health authorities, e.g., ACOG and AAP, are only too pleased to play into the “risk society” perspective that requires women to trust expert knowledge, although ACOG and AAP do perhaps understand that some modern women question this authority. This can perhaps result in lip service paid to this issue in their policy statements, i.e., as they state their respect of women’s rights to make “informed decisions”, by specifically referring to these decisions as “medically informed decisions” they in essence re-legitimize the authority of medical providers, not of women. “Risk assessment” and “risk criteria” are ultimately used to “risk out” some women from planned home-birth care by non-nurse-midwives without consideration of the woman’s own autonomy in terms of making decisions about her assessed “risk profile.” A disconnect exists between what clinicians and women view as “risk”. What clinicians’ derive as “high-risk” from epidemiological, population-based assessments may not always be applicable to an individual patient’s view of her own clinical risk, and a clinician might also bias an individual patient’s risk based on the clinician’s own personal experience. The interpretation of risk by the mother is also disconnected from the statistical risk, where a 1:4 risk might be totally unacceptable to a clinician from a medico-legal perspective, but entirely acceptable to a woman from her personal perspective.
These levels of risk understanding within clinical medicine and the social sciences are not unique to childbirth or to the maternity care system in the U.S. However, the extreme fervor of opinion that surrounds home birth begs for a multidimensional understanding of risk in the home birth setting that takes into account not only the divergence of risk perspectives between patients and clinicians, but also the power dynamics between provider types and the economic incentives threatened by any change to the existing power structure.

In summary, Critical Medical Anthropology provides an ideal framework from which to examine the topic of home birth funded by Medicaid in Florida as it highlights power differentials between health care providers, primarily between physicians and Licensed Midwives, as well as between providers and patients and even between Licensed Midwives and insurers. The keen desire for autonomy that acts as a primary driver for women to seek home birth directly clashes with the hegemonic medical system that promotes, if not forces, women to give birth in hospitals. Furthermore, the medical establishment has essentially mandated that women who desire home birth must do so with providers (Certified Professional Midwives) that are not universally recognized, credentialed and licensed throughout the fifty states, and must do so within a system that is not well integrated or prepared to handle transfers of care from the out-of-hospital to the hospital setting. Women face the stigma associated with going against the policies of the major obstetric and pediatric medical associations, and women who turn to home birth midwives to assist them in their natural childbirths rise above the power differential established by the medical experts who decry out-of-hospital birth, particularly that attended by non-nurse-midwives. Women desiring to tap into their own innate power to give birth in the comfort of their own home, free from the iatrogenic risks that they view as much more significant that any possible epidemiologic risk related to birth site, do so without support from the dominant medical system. Even in a state where laws support insurance reimbursement for home birth, women seek home birth amidst struggles with private insurance companies to recognize this option, or struggle with the Medicaid enrollment process, which will be
documented in this dissertation. Furthermore, the fact that women on Medicaid can only access planned home birth in ten U.S. states suggests systematic support for the biomedical birth paradigm, and restricts low-income women from accessing home birth. For those women that can afford to pay for home birth out-of-pocket, these payment barriers do not exist, but research has shown that a key driver to women’s choices of health care providers is payment status.

The rising tide of interest in home birth attended by providers not incorporated into the hegemonic medical paradigm, in fact, providers not even recognized by the “medical-industrial-complex”, forces the actors on top of the power differential (mainly physicians and insurance companies) to take actions that restrict the “control of production” and exert their own dominance over the “division of labor” in order to maintain their own power. Critical Medical Anthropology contextualizes this phenomenon within larger contexts, and as Illich (1975) would suggest, exposes the fact that the greatest iatrogenic risk is from the dominance of the “medical-industrial-complex” itself.
CHAPTER 3: METHODOLOGICAL APPROACHES

This chapter will begin with a theoretical justification for the choice of mixed methods for this research, including a literature review of the general process and science behind mixed methods research in anthropology and in health sciences, as well as a review of the concept of triangulation. It will then detail this study’s research questions and the methodological steps taken to conduct this research. It will conclude with a brief summary of the unique contribution this study makes to the literature.

Study Justification

Sparse anthropological literature documents the use of mixed methods within reproduction or childbirth research. Furthermore, few to no studies specifically address home birth within the Medicaid population, or utilize mixed methods to examine issues related to home birth and/or Medicaid funding of birth in general. Therefore, this study addresses a current gap in the literature, and the use of multiple methods of data collection and analysis provide a unique methodological approach to childbirth research within anthropology.

Research Objectives

This study utilizes quantitative and qualitative methods to address the following research objectives:

1. To document the prevalence and socio-demographic characteristics of Medicaid-funded home birth in Florida
2. To examine how Medicaid funding impacts access to home birth for Medicaid-funded women in Florida, particularly for minority women.
3. To examine the motivations for seeking home birth among Medicaid-funded women in Florida, and to document their barriers or facilitators to care.
4. To examine and document the experience of and satisfaction with prenatal care and birth among Medicaid-funded women in Florida who chose home birth.
5. To examine how home birth providers in Florida experience and navigate the Medicaid system.

Drawing on the best practice guidelines outlined by Creswell and colleagues (2011), the conduct of quantitative, multivariate analyses of Florida Vital Statistics assesses the scope and
frequency of Medicaid-funded home birth while the use of two sources of qualitative data serves to describe the underlying meaning of the phenomenon. A brief “Childbirth Satisfaction Scale” (Hollins-Martin and Martin 2014) is used as an objective measure of birth satisfaction that can potentially serve as a reference group in future research comparing the satisfaction with birth between women in home vs. hospital settings. Each of these data sources help to triangulate the findings, contributing to greater validity and credibility of the results.

**Overview of Mixed Methods and Triangulation**

Scholars in the social, behavioral, and health sciences utilize mixed methods research approaches to broaden and give depth to their inquiries. Early scholars (Campbell and Fiske 1959) promoted this dual approach as a means for the methods to complement each other, and to be able to draw on the strengths of each while making up for the weaknesses of the other, using a process of “triangulation” (Denzin 1970; Webb, et al. 1966). This convergence of findings using two or more methods (e.g., focus groups and participant observation) supports external validity through triangulation of the results “between” (or across) methods, while internal validity is attained by a process of triangulation “within” methods (e.g., using multiple scales within one study to measure a similar construct) (Denzin 1978; Jick 1979). These distinctive “triangulations” have also been referred to as conjunctive (“between”) and disjunctive (“within”) (Howe 2012).

The use of “mixed methods” has evolved since first described in the 1950s. The annual International Mixed Methods Conference began in 2005 and the introduction of the *Journal of Mixed Methods Research* in 2007 provided a platform for the continued development of the approach and theory building related to it. The Mixed Methods International Research Association (MMIRA 2013) recently formed and held its inaugural meeting in Boston June 27-29, 2014.

While a general characteristic of “mixed methods” research includes the use of both “qualitative” and “quantitative” methods, there is no one precise definition of what constitutes a
“mixed methods” approach (Denzin 2012). For that matter, there is not a clear delineation between what is considered “qualitative” versus “quantitative” research, data, and methodology (Small 2011). In a most general sense, “qualitative” data can be described as “narrative,” and more formally it can refer to the use of hermeneutic and interpretive methods rather than positivistic paradigms usually associated with quantitative methods, or simply it can imply the use of a small sample which lacks generalizability (and for which combining, or triangulating, with quantitative data can increase reliability and thus generalizability) (Small 2011).

“Quantitative” tends to refer to “numerical” data, or the application of statistical techniques to data, and generally requires or at least better supports large samples (Small 2011), although statistical techniques can be applied to small samples and non-normally distributed data primarily through the use of non-parametric tests. These qualitative and quantitative divisions are far from rigid, and their mixture results in no one obvious classification. Furthermore, some would argue that the divergent epistemologies driving qualitative (interpretive) versus quantitative (positivistic) methods result in “incommensurability” (Small 2011) because each approach supports a contradictory assumption relating to the nature of “truth” (Guba and Lincoln 2005). Thus, the argument exists that it is impossible to combine a quantitative/positivistic perspective that supports a known true existence of social realities with a qualitative/interpretive perspective that supports a subjective truth, but others have called this a “false dichotomy” (Doyle, et al. 2009). Therefore, a challenge to conducting mixed methods research lies in the integration of elements, something that triangulation can address, but that researchers must be willing to accept as a limitation.

There are ongoing debates over what constitutes “mixed methods” research and the typology of mixed methods research designs. These have been well documented in several journal articles and books (Johnson, et al. 2007; Tashakkori and Teddlie 1998; Tashakkori and Teddlie 2003; Tashakkori and Creswell 2007; Tashakkori and Teddlie 2010; Teddlie and Tashakkori 2006; Teddlie and Yu 2006). Tashakkori and Crewell (2007:4) offer the description
of mixed methods studies as employing the use of qualitative and quantitative approaches by utilizing:

- Two types of research questions (with qualitative and quantitative approaches),
- [A particular] manner in which the research questions are developed (participatory vs. preplanned),
- Two types of sampling procedures (e.g., probability and purposive),
- Two types of data collection procedures (e.g., focus groups and surveys),
- Two types of data (e.g., numerical and textual),
- Two types of data analysis (statistical and thematic), and
- Two types of conclusions (emic and etic representations, “objective” and “subjective,” etc.).

Another proposed definition of mixed methods research (Plano Clark, et al. 2008) promotes it “as a design for collecting, analyzing, and mixing both quantitative and qualitative data in a study in order to understand a research problem” (p. 364). Furthermore, the National Institutes of Health, Office of Behavioral and Social Sciences Research, recently commissioned a report of “best practices” (Creswell, et al. 2011) for mixed methods research that defined mixed methods as a research methodology (Creswell, et al. 2011:4):

- Focusing on research questions that call for real-life contextual understandings, multi-level perspectives, and cultural influences;
- Employing rigorous quantitative research assessing magnitude and frequency of constructs and rigorous qualitative research exploring the meaning and understandings of constructs;
- Utilizing multiple methods (e.g. intervention trials and in-depth interviews);
- Intentionally integrating or combining these methods to draw on the strengths of each; and
- Framing the investigation within philosophical and theoretical positions.

Thus, the mixing of the qualitative and quantitative methods can occur during research design, data collection, analysis or reporting, or may occur at different phases of a multi-phase research project. What becomes important then is to discuss the use of each type of data and the various methods to employ during data collection and analysis, as well as the mixing of multiple methods during each stage. Furthermore, a key component lies within the “integration” of the approaches (Tashakkori and Creswell 2007) which ultimately lead to “triangulation” of findings.

While triangulation in practice acts as a way to use multiple reference points (i.e., qualitative and
quantitative inquires) to situate a topic or phenomenon at hand, some scholars have suggested that “triangulation” is merely synonymous with “mixed methods” or alternatively that “mixed methods” is a subset of “triangulation” or vice versa (Bergman 2011). Debate exists whether a study employing either multiple qualitative or multiple quantitative components can be considered “mixed methods” and alternatively this has been termed “mixed model” research (Bergman 2011). Looking beyond the actual data collection and analysis to better describe mixed methods as a research process, Bergman (2011:273) suggests: “a good mixed methods research project includes an epistemology and ontology, a research question and theoretical framework, sampling strategies, and interpretations that are conducive to both qualitative and quantitative methods.”

Triangulation therefore serves as a form of cross-checking (or validating) the various data that are acquired during mixed methods research (Morse 1991). The concept of triangulation was extrapolated from the practice of surveyors who “locate an object in space by relying on two known points in order to ‘triangulate’ on an unknown fixed point in that same space” (Mertens and Hesse-Biber 2012:75), specifically by “fix[ing] the location of an observable point by using the baseline between the two known points and the angles made at each end of the baseline when viewing the distant point to construct the sides of a triangle. Each of the two sidelines so created will meet, and so they can now be measured and the location of the distant point fixed” (Bazeley and Kemp 2012: 61). Thus, triangulation has the intent of “fact checking” other data by approximating and/or locating it from other vantage points.

Several types of triangulation exist (Hussein 2009). Perhaps the most basic, data triangulation simply describes the impact of multiple data sources within a study on the ensuing data robustness, based on the timeframe in which the data are collected, the place they are collected from and the actual person collecting the data (Begley 1996; Denzin 1978; Hussein 2009). Theoretical triangulation involves the use of multiple theoretical perspectives within a study to examine and frame the research problem from multiple angles (Denzin 1970).
Investigator triangulation involves the use of multiple researchers within any one stage of the research, such as using multiple researchers in the process of interviews, survey development, data analysis, etc. to substantiate the findings of the other researchers (Thurmond 2001). An example of this would be inter-coder reliability during analysis of qualitative texts. Analysis triangulation refers to the process of using multiple analytic methods required of multiple data types (i.e. statistical analyses of quantitative data and thematic analysis of qualitative data). Methodological triangulation is the broadest form of triangulation and can be employed at either the research design or data collection phase. It refers to using multiple methods to study the same research problem, such as is demonstrated in the common approach of using qualitative pilot studies to generate hypotheses that can be tested using quantitative methodologies (Hussein 2009). Triangulation can thus “increase credibility of scientific knowledge by improving both internal consistency and generalizability through combining both quantitative and qualitative methods in the same study” (Hussein 2009:10). This study relies primarily on methodological and analysis triangulation.

The first special issue of the Journal of Mixed Methods Research (April 2012) focused on triangulation as a justification for the use of mixed methods, and explored concepts and issues related to triangulation praxis (Mertens and Hesse-Biber 2012). Among these is the use of qualitative data to validate quantitative statistical findings, although in this manner, triangulation merely allows one method to enhance rather than provide critique or conflicting reports to other methods. This concept becomes particularly important in feminist inquiries (Hesse-Biber 2012) that seek to uncover voices and data traditionally excluded from the research process. For instance, purely statistical quantitative studies are able only to examine data that was collected, elements of which might have been determined by the pre-existing structures that might have left out concepts or constructs important to the minority or under-studied sectors of the study population. Therefore, this study aimed to complement the
quantitative findings with qualitative interview data, in order to help identify data elements that will be important for collection in future quantitative studies and/or data sets.

Two major mixed methods design approaches have been classified as sequential and concurrent (Castro, et al. 2010; Creswell, et al. 2003). Sequential designs can follow exploratory, explanatory or transformative designs, while concurrent designs can be classified as concurrent triangulation, nested, and transformative. Within either type, designs can be based on the amount of emphasis (equal or unequal) given to the different types of data (i.e. quantitative or qualitative), the analysis and integration process applied to the data, and the underlying theoretical approach (Castro, et al. 2010). Studies that are sequentially designed can use results from one arm to guide the direction of other arms. As demonstrated in the following section, some studies are carried out in a more or less cross-sectional fashion where data collection is carried out simultaneously. In sequential studies, it can be useful to conduct pilot studies, often qualitative in nature and using a small sample of key informants to help better understand a topic or phenomenon from which further research questions and methods (such as quantitative surveys to be distributed to a larger study population) can be developed (LeCompte and Schensul 1999). In this way, the qualitative undertakings are considered exploratory, and the subsequent studies, often quantitative in nature, more confirmatory or conclusive (Salazar, et al. 2006). The data triangulate, but one form feeds into the next, and it becomes less possible for the various data sources to contradict and more likely for the data to complement. Alternatively, qualitative studies can be conducted after initial quantitative analyses to contextualize the quantitative findings, as described in the Spangler and Bloom (2010) study below. These studies can even be conducted sequentially to ensure probing during qualitative interviews regarding findings that arose from quantitative data. Thus, mixed data collection studies involve those with a minimum of two types of data (e.g., database available for secondary analysis and field notes) or two approaches for collecting data (e.g.,
newspaper clippings with individual interviews, or interviews with a controlled experiment) (Small 2011).

**Previous Mixed Methods Research Related to Childbirth**

Research related to home birth has primarily used quantitative methods to measure care outcomes. Qualitative research has examined women’s experiences with home birth in British Columbia (Janssen, et al. 2009a), but did not directly link to the quantitative research evaluating outcomes within the same cohort (Janssen, et al. 2009b).

By far, anthropological inquiry into childbirth has been primarily theoretical or qualitative, and few quantitative or mixed methods childbirth research studies within anthropology exist. Furthermore, most, if not all, of these studies were conducted outside of the United States. Interestingly, many of these studies are actually related to the setting/place of birth and will be discussed further below.

In a study conducted in Scotland (Pitchforth, et al. 2008), a combination of a survey questionnaire and focus groups was administered to women in rural areas related to their preferred location for childbirth, based on care model and proximity to facility. The authors stated the “purpose of using mixed methods in our study was to inform and improve the development of methodology and to gain a more comprehensive understanding of women’s preferences” (Pitchforth, et al 2008:561). A total of 877 surveys were included along with transcripts from eight focus groups with a total of forty-seven participants. Quantitative analyses were conducted using a conditional logit regression in STATA based on two independent variables of model of care and transport time. Qualitative focus group results were analyzed in an iterative coding process. Results from the combined analyses suggested that women prefer giving birth in facilities as opposed to at home, with a threshold of two hours proximity to the facility, and with physicians over midwives. Women perceived this type of care as safer than that at home with midwives, particularly when accounting for their rural/remote locations. The survey data were able to provide for regression analysis when taking into account factors such
as previous experience with childbirth, pregnancy risk status, family circumstances and geographic area, while the focus group data allowed for the expansion on these findings and description of meanings behind the preferences.

A British study (Kingdon, et al. 2009) examined women’s perceptions of decision-making related to mode of delivery (vaginal vs. cesarean). This longitudinal cohort study recruited 454 women and administered questionnaires at three time points (at initial prenatal care presentation, twenty-four weeks gestation, and thirty-six weeks gestation, with 90%, 72% and 65% response rates, respectively) and conducted 153 semi-structured, in-depth interviews at 24 weeks (n=55), 36 weeks (n=34) and twelve months post-partum (n=64). The longitudinal nature of the study allowed researchers to examine shifts in women’s perceptions over time as well as their knowledge acquisition, and also to compare the demographic characteristics of those who returned one vs. all survey instruments. It also allowed for an examination of the discrepancy between women’s choices regarding elective cesarean or vaginal birth and their actual autonomy to make decisions given care paradigms. This study claims to “offer strong evidence (by triangulating quantitative and qualitative data) that the final decision on mode of delivery develops as pregnancy progresses” (Kingdon, et al 2009: 894) and thus serves as an example of conducting longitudinal mixed-methods research in pregnancy.

A mixed methods study was conducted in Iran (Tabatabaie, et al. 2012) that aimed to examine the factors preventing women from delivering in hospitals. In Iran, the vast majority of births occur in facilities (99.2% in urban areas and 94.5% in rural areas), although regional differences exist. In this study, conducted in Zahedan, a regional capital city, 23% of births occurred in an out-of-hospital setting. The quantitative arm of the research used existing health-sector data to benchmark the region against the United Nations’ (U.N.) process indicators of emergency obstetrical services (including availability of services, percentage of births that occur in these facilities, and percentages of cesarean section). The study concluded that the availability of basic facilities was lacking, although comprehensive facilities were adequately
supplied. Cesarean sections occurred far lower than would be expected by the U.N. criteria. The qualitative arm of the study included in-depth interviews with seventeen informant midwives and skilled birth attendants and twenty-one interviews with mothers and their relatives. Grounded theory was used to code and analyze the transcripts. These data provided insights into the barriers that prevent midwives from initiating a referral to a facility and the barriers that mothers face in accepting the referral. Key reasons elicited included costs, lack of insurance, perceived poor quality hospital care, fear of disgracing the family or upsetting the traditional attendants, and poor collaboration between community midwives, traditional attendants, and hospital staff and physicians. Ultimately, these factors result in indecisiveness and a delay to transfer care to the hospital. This study combined the use of a quantitative evaluation to demonstrate poor attainment of benchmarked quality indicators in maternity care in this region in Iran, and qualitative analysis to offer socio-cultural, economic, professional and organizational explanations for care-seeking behaviors that the authors link to these poor quantitative indicators.

Finally, a study carried out in rural Tanzania (Spangler and Bloom 2010) also looked at obstetrical facility utilization in a population with 49% of home deliveries. The authors provided the following rationale for their choice of mixed methods design: “A concurrent triangulation design was employed for this study that assigns equal weight to quantitative and qualitative components. This design is used when a researcher conducts these methods simultaneously to triangulate the phenomenon of interest, to compare findings obtained from a single time frame from different vantage points” (Spangler and Bloom 2010: 762) as noted by Tashakkori and Teddlie (1998). Unlike previously cited longitudinal studies, this used more of a cross-sectional design looking at variables and observations at the same point in time. Logistic regression analysis was used to examine socio-demographic characteristics associated with the use of obstetrical services, while in-depth interviews and participant observation helped to contextualize its usage. Thus, factors in the logistic regression model which proved significant,
such as ethnicity, education, household assets, parity, and distance to care, are explained through the qualitative data as “multiple and overlapping processes that involve…mechanisms of affordability, risk perception, and more nuanced dynamics of social positioning, past experience, entitlement, shame, and self-identity” (p. 766).

**Current Study**

**Triangulation during Data Collection**

In the study that provides the basis for this dissertation, a secondary source of quantitative data (Florida Birth Certificates) was analyzed to assess frequencies and descriptive statistics related to the research objectives. These results set the sampling strategy for qualitative interviews with midwives and women who had completed planned home births. Bivariate and regression analyses from the secondary data sets were utilized to further contextualize themes that emerged from qualitative interviews, and are reported both within a separate statistical analyses chapter as well as within the “thematic” results chapters, as opposed to being used to script a survey or interview structure. Being mandatory, birth certificates capture all births, and provide for a comparison group of hospital births as well as the means to compare planned home births stratified by payer source. Statistical analyses included variables addressing either socio-demographics or outcomes as available within birth certificates. These were included in both basic descriptive and multivariate statistical analyses. Secondary data was further triangulated with existing research that reported on home birth outcomes and women’s motivations for home birth in order to determine if the present study found significance in these same factors. Further methodological detail related to this data source is described below, as well as in Chapter Four.

The two other data arms involved primary data collection among home birth midwives (Appendix A) as well as women who had planned home births with midwives that were funded by Medicaid. Open-ended questions such as, “Tell me about your birth experience,” were followed by probing questions from the semi-structured script (Appendix B) to elicit information
specifically related to the women’s interactions with the Medicaid system and opinions of how Medicaid funding impacted their experience with home birth. Data from pilot interviews conducted with home birth midwives in the Fall of 2010 were used to develop the list of semi-structured interview script used among the mothers who had given birth at home on Medicaid. In this way, the research design and the data collection were sequentially triangulated. Finally, a brief demographic questionnaire (Appendix C) was administered at the completion of the interviews in order to create comparison groups (i.e. primiparous vs. multiparous, race, and education categories) among the sample. A validated 10 item childbirth satisfaction scale (Hollins-Martin and Martin 2014) was mailed to participants (Appendix D) after the interview to provide an additional data stream related to satisfaction that can serve as a comparison group in future research comparing the experiences of women who had home vs. hospital births. Women were provided with a stamped, return envelope addressed both to and from the principal investigator. The scale contained a code so that the principal investigator could link the survey to the participant’s demographic survey in order to stratify the data by maternal age, time since the index birth, parity, previous birth experience, etc. The response rate was 75%, with nine of the twelve participants who received the survey returning it by mail.

In sum, data collection was triangulated by the use of multiple data sources, both quantitative and qualitative. Most studies that utilize either state or national natality data (e.g., birth certificates) do so without integrating qualitative data (e.g., interviews) to bring out individual meaning from the raw statistics; this study thus represents a unique form of data collection triangulation (as well as analysis and ultimately reporting). While the original intent was to further triangulate by conducting a novel comparison of two secondary data sources (Vital Statistics and MANAStats), concerns with reliability and true representation within the voluntary dataset MANAStats precluded its use in this study.
Triangulation during Data Analysis

Broadly speaking, mixed data-analysis studies, "regardless of the number of data sources, either employ more than one analytical technique or cross techniques and types of data (such as using regression to analyze interview transcripts)” (Small 2011: 60). Triangulation of the quantitative data in this study occurred by extrapolating “outlier” cases from the data sets to conduct case analysis to determine how these cases are unique or similar to each other or to the sample mean.

Qualitative triangulation followed a content analysis approach (Ryan and Bernard 2003). An iterative process was used to identify themes that were then triangulated between the interviews with women and midwives, with emergent themes then addressed through further statistical analyses on the quantitative data. Text codes were analyzed using frequency counts, frequencies of co-occurring terms and phrases, and an examination of proximity between concepts. Concise methodologies for these procedures have been described elsewhere (Annechino, et al. 2010; Bazeley 2006; Castro, et al. 2010; Fielding 2012).

An emerging form of analysis triangulation is participant or respondent validation (Torrance 2012). Commonly referred to as “member checking” (Creswell 2003; Lincoln and Guba 1985; Teddlie and Tashakkori 2009) respondent validation can contribute to the ethical considerations of a study (Torrance 2012), such that presenting results to research participants and allowing them to validate the conclusions that have been drawn enhances the subjective approach of qualitative research through a process of validating the more objective interpretations of the data by researchers. Practical considerations with this form of analysis triangulation include determining when to seek feedback from participants, the amount of text or other form of research product to share with participants, how to systematically incorporate the respondents’ feedback, and how to address any disaffirming feedback they may provide (Curry, et al. 2009). A copy of the initial paper written for the Fall 2011 Research Methods course was provided to the midwife participants that had been interviewed up to that point. In addition,
results from the statistical analyses were presented at the Midwives Association of Florida biennial meeting held September 20-21, 2013 (Demetriou 2013), and feedback was requested from these midwives. In addition to a reporting of the descriptive statistics gleaned from both the Florida Birth Certificates and the Midwives Alliance of North American Statistics Project (MANAStats), a voluntary data set that unfortunately only captured 12% of the planned home births in Florida in the same time period, and was thus determined to be unfit as a data source for this research, the presentation included a comparison of the results from these two data sources. Furthermore, comparisons were made to the publicly available birth certificate data on the Florida CHARTS website (Florida Birth Query System 2011) and presented this to the Midwives Association of Florida as well. Feedback from this was also used to further confirm the findings. The most striking fact that emerged during this presentation was that while the data that Licensed Midwives contribute to the Florida Birth Certificates appeared to be so complete, these Licensed Midwives shared that since they are almost exclusively filing paper birth certificates which are then entered electronically at the State Office for Vital Records (whereas most other birth attendants are directly filing electronically). Records that had missing data were sent back to the midwife to complete before being entered into the registry, which obviously contributed to the robustness and completeness of their birth certificate files. Furthermore, some midwives provided the rationale behind why they might list a family member as the attendant as opposed to themselves, which helped to contextualize the home births that had the attendant listed as “other”. Additionally, this presentation helped highlight that within the Florida CHARTS system, all home births are lumped together, so that planning status is not available from this data source. This helped the midwives to understand that while they may seek to glean statistics for their practices and for the overall practice of home birth midwifery among Licensed Midwives in Florida, this lack of planning status in the publicly available Florida CHARTS system precludes any meaningful data extraction. Unfortunately, the opportunity did not arise to present the research findings with the women who participated or
with another cohort of women who had completed Medicaid-funded home births. However, the final results presented in Chapters Five through Nine were presented to a Florida Licensed Midwife who has an additional background in anthropology, and she was able to confirm and validate these results based on her experiences and interactions with the Medicaid system and Medicaid clients.

**Triangulation during Results Reporting**

Dissemination of results is a key element of the research process. Reporting results from mixed methods studies can be complicated, however, by journal page or format restrictions (Creswell, et al. 2011; Strange, et al. 2006), journal methodological bias (Bryman 2007), or the fact that mixed methods are still emerging as “valid” science (Bergman 2011). However, journals such as the *Journal of Mixed Methods Research, International Journal of Multiple Research Approaches*, and *International Journal of Mixed Methods in Applied Business and Policy Research* are solely dedicated to mixed methods studies, and journals such as *Quality and Quantity, Field Methods*, and the *International Journal of Social Research Methodology* frequently publish mixed methods research (Plano Clark 2010), particularly regarding the methodological approaches themselves. Furthermore, mixed methods research is being increasingly utilized in doctoral dissertations, with an eight-fold increase from around 100 dissertations self-identified as mixed methods in the year 2000 to nearly 800 by 2007 (Plano Clark 2010). Finally, as mentioned earlier, the NIH recently recognized the increasing prevalence and value of mixed methods research and commissioned guidelines for their best practice (Creswell, et al. 2011).

An important component of presenting findings is to situate them within previous research findings and to demonstrate how the current findings represent new understandings (Curry, et al. 2009). These results are situated within the wider literature on home birth in the U.S. Furthermore, previous quantitative studies on home birth outcomes and demographics in general were used to help guide the statistical model development.
A common critique of mixed methods studies is the lack of integration found in the presentation of results (Bazeley and Kemp 2012; Bryman 2007). One strategy to prevent this involves integrating the findings before reaching conclusions about the results of the study so that the write-up is organized around the substantive issues that arose during analysis, and not on the intentions that arose based on the methods chosen. Another strategy is to avoid writing up integrated results in separate components or even articles (Bazeley and Kemp 2012). This dissertation reports thematic results based on all data collection arms, as opposed to the separate reporting of results that emerged from each arm of data collection and analysis, a strategy that served to integrate the data presentation. This triangulation of results represents more than a mere “summing of the parts” but rather a “forging [of] an overall or negotiated account of the findings that brings together both components of the conversation or debate” so that these qualitative and quantitative findings have become “mutually informative” (Bryman 2007:21).

**Mixed Methods in Current Study: Summary**

Mixed methods are increasingly utilized to answer research questions with both ‘numbers and narratives.’ Triangulation serves to cross-validate findings from multiple arms of research, and is needed during data collection, analysis and reporting. This study represents a novel combination of secondary analysis of Florida birth certificate data to examine home birth frequencies and outcomes by payer source and demographic characteristics, along with narratives from both health care providers/home birth midwives and home birth mothers that received Medicaid insurance in pregnancy that contextualize the “epidemiologic” findings. The perspectives of both women who sought and completed planned home birth that was paid for by Medicaid, as well as midwives providing this care and seeking reimbursement from Medicaid, are presented to give “narrative” depth to the “numbers” that emerge from analysis of birth certificates. Ultimately, several themes that emerged are reported by combining the results
from secondary data analyses with the stories of the women and midwives, and there are reported in Chapters Five through Nine.

Methodology

Quantitative Analyses

In addition to this brief section, Chapter Four presents additional detail and methodology regarding statistical analysis of Florida Birth Certificates. The specific research questions addressed in the secondary data set were:

1. What are the demographic and social characteristic differences (race/ethnicity, age, education, parity, pre-pregnancy BMI, marital status, WIC status, tobacco and alcohol use, previous cesarean, provider type and geographical location) between:
   a. Women who have home birth by payment source
   b. Medicaid-funded women by birth site (hospital vs. home)

2. What are the outcome differences (birth weight, gestational age, delivery presentation and mode, Apgar score, breastfeeding, Kotelchuck index, neonatal seizures, neonatal deaths, and maternal or newborn transfers) between:
   a. Women who have home birth by payment source
   b. Medicaid-funded women by birth site (hospital vs. home)

Data Set: Florida Vital Statistics/Birth Certificates

Initial Institutional Review Board (IRB) approval was sought in Fall 2011 from the University of South Florida (USF) IRB as part of an application to access and analyze both the Florida Birth Certificates and the Midwives Alliance of North America Statistics Project (MANAStats) during a Spring 2012 required Advanced Quantitative methods course in Applied Anthropology. Formal application to the USF IRB (Pro 6725) was submitted on December 16, 2011. On January 3, 2012, the USF IRB deemed that the research met Federal Exemption criteria given its focus on study of existing data (Appendix E). A subsequent formal application and research proposal was submitted, as required, to the Florida Department of Health (DOH) IRB on March 15, 2012. On March 21, 2012, FL DOH IRB further determined the research activity did not involve human subjects and was therefore exempt from DOH IRB review (Appendix F). To obtain the data files from the Florida Department of Health, Bureau of Vital Statistics, a Data Use Agreement was submitted on December 22, 2011 (Appendix G), pending
FL DOH IRB approval. Once the FL DOH IRB approved the study for non-review, the Data Use Agreement was approved, and has been renewed annually. Data was secured via an FTP file upload on March 22, 2012. Data integrity has been maintained behind the USF Health firewall. Key variables (Appendix H) were requested and received for years 2005 – 2010, as at the time of the data request, the 2010 data was the most current year of complete data, and 2005 represented the first full year that Florida had implemented the 2003 Revised Birth Certificate (National Center for Health Statistics 2003), which included the Planned Home Birth Check Box.

Annual data files were received in .txt file format, and were converted to data files within SPSS. These SPSS data files were then merged into a master file containing all six years, 2005-2010, representing 1,377,081 total live births. Substantial data cleansing was then completed, described in Chapter Four, to ensure data integrity, including removal of outliers (e.g., women older than 60) and scrutiny and cleansing of key analysis variables (e.g., planned home birth box checked but birth listed as unplanned home birth). Obviously, birth location was a key variable of interest. However, to keep the analyses straightforward, comparisons were made only between hospital births and planned home births (i.e., excluded from the analysis were unplanned or unknown planning status home births, birth center births and en route or other location births. These accounted for only 0.85% of the total births in the data set, prior to any further data cleaning.) Due to the disproportionate numbers of hospital births (98.77% of total) compared to planned home births (0.38% of total), once all data had been cleansed and major exclusions applied (non-singletons, maternal age <13 or >50, clinical estimate of gestation <36.6 weeks, birth state or maternal residence state not Florida), a random sample of hospital births equivalent to the exact number of planned home births included in the final analysis was generated within SPSS using its randomization functionality (described in Chapter Four). The final analysis sample included 5,138 planned home births and 5,138 hospital births for a total sample of 10,276 births that had occurred in the six-year period from 2005 to 2010. Chapter Four further describes this data cleansing process and contains detailed descriptive
statistics of the data set, and results of the bivariate and multivariate analyses/regression model. Where appropriate, descriptive statistics from the birth certificates are included in the thematic chapters to contextualize the qualitative data reported by the midwives and mothers.

**Qualitative Interviews: Licensed Florida Midwives**

This research project commenced during a Research Methods course taken Fall 2011 within the Applied Anthropology Ph.D. curriculum. As part of a course requirement, an engaged research project was undertaken that served as a pilot study for this dissertation. After IRB approval was granted (Appendix I), semi-structured interviews were conducted in person (n=4) or via telephone (n=2) with a purposive, convenience sample of Florida Licensed Midwives that attend home births and participate as Medicaid providers. Recruitment was informal, with midwives either known personally to the researcher and contacted via telephone or email, or for those unknown to the researcher, located via a search on the MANA “Find a Midwife” website (Mothers Naturally 2011) and contacted by email or telephone. Contacts were also made with Florida LMs at the Midwives Alliance of North America 2011 annual meeting in Niagara Falls, Canada. Each was provided a brief explanation of the project, and invited to participate. One semi-structured interview (Bernard 2011) was completed with each LM. Compensation was not provided. USF IRB review and approval was renewed annually to verify protection of human subjects. To further protect the confidentiality of the midwives, particularly because there are so few Licensed Midwives in Florida and even fewer Certified Nurse Midwives who attend home births, their demographic and practice characteristics have been condensed into categories, i.e., either Yes/No categories or for “number of years practicing: < 5, 5-10, >10.” A table of their pseudonyms used in this dissertation and their practice and demographic characteristics is found in Table 3.1.

All participants consented via a “waiver of documentation of consent” (Appendix J) procedure, with records maintained according to the IRB approved protocol. Unlike in states where non-nurse-midwife practice is either alegal or illegal, these midwives in Florida practice
transparently and legally. Therefore, study participants could theoretically speak openly to help document challenges and strengths within the current system of Medicaid-funded home birth, but to help ensure participant confidentiality, the waiver of documentation of consent prevented linkage between study participants’ names and consent forms. However, steps to safeguard their confidentiality were taken, including the use of pseudonyms and the avoidance of any specific reference to their geographic location or their educational background. Seven additional interviews with six Licensed Midwives and one Certified Nurse-Midwife who provide home births in Florida were completed by October, 2013. These midwives were recruited in a similar fashion as described above and interviews were conducted either in person at the midwife’s office or a location such as a coffee shop, or via telephone. The same interview script was utilized. No compensation was provided to midwife participants.

Appendix A contains the script for these semi-structured interviews with midwives providing home birth. The interviews lasted an average of 45 minutes, with a range from 36 to 84 minutes. Interviews were recorded with a digital audio recorder, with data files downloaded to a password-protected laptop, and audio files deleted from the recorder. The researcher transcribed each interview verbatim using Express Scribe and Microsoft Word. Responses were compiled to each question within a master file, mostly using brief summaries of interview statements, with some use of direct quotes. Tables were generated allowing for emergent themes to surface (LaPelle 2004). Content analysis (Bernard and Ryan 1999) began with level one coding using functionalities within Microsoft Word (Bernard 2011; Hahn 2008) followed by level two coding in Microsoft Excel. Levels three and four coding were completed using literal cut and paste techniques to draw ultimate themes and theoretical constructs, which are reported in the results chapters that follow.

Qualitative Interviews: Home Birth Medicaid Recipients in Florida

After approval of the dissertation research proposal from the dissertation committee, per the instructions from the USF IRB, an amendment was made to the previous IRB-approved
study of qualitative midwife interviews (PRO 5677) to encompass all three arms of data collection (interviews with midwives, interviews with women who had completed Medicaid-funded home births, and the secondary data analysis of Florida birth certificates). Essentially, the amendment combined the previous IRB approved studies related to midwife interviews and secondary data analysis, and added the interviews with the women who had given birth at home, as well as the Birth Satisfaction Scale and Demographic Questionnaire included in the interviews with the home birth women. IRB approval (Appendix K) was received on February 18, 2013, after which recruitment of women who had given birth at home began. IRB approval has been updated annually for this study (PRO 5677) that encompasses all arms of the dissertation research.

Semi-structured interviews (Appendix B) were conducted with a purposive sample of thirteen Floridian women who completed home births with midwives within the twelve months prior to the interview. This time frame was selected as previous research suggests a woman’s perception of her birth experience immediately after birth is clouded by the fact that the birth is completed, but that women’s memories of birth events remain intact for decades (Simkin 1992), with 60% of women having similar accounts of their birth at one year (Waldenström 2003). However, by two years, women have already placed their birth experience into a wider social context (Lundgren 2005; Waldenström 2004).

Inclusion criteria for these interviews were: women, ages 18 to 45, who within the past twelve months completed a planned home birth that was funded by Florida Medicaid and attended by a midwife licensed in the State of Florida (either a Certified Nurse Midwife (CNM) or Certified Professional Midwife (CPM)), and who met risk criteria for home birth as defined in Florida Statute 467 (State of Florida 2011a). Exclusion criteria were: women who do not meet the inclusion criteria, particularly any woman who had any contraindications to home birth, and women who had home births that were not funded by Medicaid, that were unplanned or unassisted, or that were attended by family members, physicians, or emergency personnel.
Due to confidentiality issues related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it is impossible to obtain a list from the Florida Medicaid Office detailing the women who have delivered at home in the past twelve months in order to generate a random sample. Therefore, midwives in Florida were contacted by email or in person and provided electronic and/or hard copy recruitment flyers (Appendix L) to distribute to their clients that met the eligibility criteria. Women interested in participating then contacted the researcher by phone or email, a further description of the study was reviewed, and women were provided an electronic copy of the informed consent document by email or a paper copy by U.S. postal service. Scheduling of interviews occurred either via telephone or email. Email communications were deleted from the researcher’s inbox and sent folder, and the trash folder was subsequently emptied as well. Informed consent documents, which did not contain the name of the interviewee, were stored according to protocol established during the IRB review and as done during the midwife interviews, employed a “waiver of documentation of consent” procedure (Appendix M). Participants were also asked to share information about the study within their social networks, in order to fulfill a respondent-driven sampling strategy (Heckathorn 1997; Heckathorn 2002). Participants were assigned pseudonyms (Table 3.2) that were used throughout the dissertation when quoting specific women.

Interviews lasted an average of 45 minutes (range 23 to 63 minutes) and followed a semi-structured script (Appendix B). All interviews were conducted by the primary researcher, and occurred via telephone. Telephone interviews were done at the request of the participants for convenience, and also because women were recruited from throughout Florida, which made in-person interviews a logistical challenge. Interviews were audio recorded on a digital recorder, after which digital recordings were downloaded to the PI’s password-protected laptop and deleted from the recorder. Audio files were transcribed verbatim using Express Scribe and Microsoft Word software.
A combined inductive, interpretive approach, and deductive content analysis approach using themes identified from prior home birth and childbirth research was used, similar to the description of the qualitative analysis of midwife interviews described above.

At the conclusion of the interview, participants were asked a series of questions (Appendix C) related to their insurance status prior to, during and after pregnancy, as well as demographic questions (age, parity, previous birth locations, educational attainment, employment status in pregnancy, and self-described race/ethnicity), responses to which were also transcribed and used for analysis and grouping.

Participants were mailed a $25 gift card to a major Florida grocery retailer (Publix) as compensation for their time and participation. No record of the participants’ addresses was maintained. Included in the envelope was a paper copy of the 10-item Birth Satisfaction Scale-Revised (BSS-R) (Appendix D), along with a stamped return envelope addressed to and from the researcher to ensure confidentiality when the document was in postal transit. The actual scale did contain a coded participant ID number so it could be linked with the participant’s interview and demographic questionnaire data. The first mother interviewed was not sent the scale as this portion of the research was still pending IRB approval at the time of her interview. Of the remaining twelve mothers interviewed, nine scales were returned, representing a 75% response rate. Further sample characteristics are reported in Chapters Four and Five. Additionally, Table 3.2 details respondent demographics, while Table 3.3 reports on their insurance status both before and after pregnancy.

**Birth Satisfaction Scale**

The purpose of including a scale in this study was primarily to objectively gauge whether women who had completed home births were in fact satisfied with this care and also to ultimately use these responses to compare satisfaction between women who gave birth at home vs. in the hospital in future studies. Several satisfaction scales related to childbirth, prenatal care, and health services in pregnancy have been developed and validated (Camacho, et al.)
2012; Goodman, et al. 2004; Gungor and Beji 2012; Hollins-Martin and Fleming 2011; Stevens, et al. 2010). The Birth Satisfaction Scale-Revised (Hollins-Martin and Martin 2014; Hollins-Martin and Fleming 2011; Hollins-Martin, et al. 2012) was chosen due to its short format, its ability for open-ended responses to its Likert scale measures, and its relative lack of specific questions that would pertain only to the hospital setting and therefore its ability to be used to assess satisfaction in multiple birth settings. The brief version has undergone validity testing by the original scale’s author (Hollins-Martin and Martin 2014). The principal investigator contacted the scale author by email to request permission to use the scale and its scoring system, with positive response (Appendix N). The scale author also gave permission to report scale results within the dissertation, and expressed interest in future collaboration to publish results (Appendix O).

**Positionality**

No research is undertaken in a vacuum. Researchers approach topics drawn not only from an identified research gap, but from personal interest. My interest in birth began as a first year student at Hampshire College in 1989, where I volunteered for “lamb watch” and stayed up through many nights with ewes as they labored and birthed (and I learned what a placenta is!). I didn’t think much about birth again until I served as an agroforestry volunteer in the U.S. Peace Corps in The Gambia from 1997 to 1999. It was there that I first witnessed a human birth and was mesmerized not only by the birth itself but also by how naturally and effectively women were able to birth without interventions. After returning to the United States, I gave birth to my own son, who was born with anencephaly and therefore passed away in my arms several hours after his birth. Even before the diagnosis, I was frankly appalled at the high-tech approach the U.S. health system took to the natural process of pregnancy and birth, particularly after spending two years in a remote African village without electricity, running water or any modern technology to speak of. Furthermore, I encountered many difficulties in accessing the U.S. maternity care system because I carried a rare type of insurance, and in the end paid out-of-
pocket after finally establishing care at 23 gestational weeks. That pregnancy experience sparked in me a calling to midwifery, so that I could provide education and care to other women as they navigated the pregnancy and birth process, both within the U.S. and abroad. During my first year of midwifery school, I gave birth to my daughter. As a graduate student married to a musician and with limited income, I received Medicaid insurance for the pregnancy and birth. I felt fortunate to live in Nashville, where a birth center staffed by nurse-midwives existed and accepted Medicaid for pregnancy. The pregnancy and birth were uncomplicated, gentle and amazing, and I gained an empowerment from giving birth naturally that I instantly knew would allow me to overcome any obstacle or pain I would face in the future. My daughter unexpectedly died at twelve hours of life, with the cause of death ultimately diagnosed as pneumonia. I completed my Master's degree and became a board-certified nurse-midwife as well as family nurse practitioner and went to work fulfilling a service obligation to the National Health Service Corps in medically underserved communities, including at state Health Departments and federally-designated Rural Health Centers. It was in these clinics where the true lack of health care access faced by many lower and middle income Americans sparked in me an interest to further my education in order to address the policy and practice environment of maternal-child health. I chose to pursue this Ph.D. and M.P.H. in Florida because I knew the laws existed here to support both midwifery practice and out-of-hospital birth. I figured it would be best to investigate these issues in a state that technically “had it right” and I wanted to include an investigation of Medicaid, not only because it is the payer for nearly half of the births in the U.S., but also because I had experienced it as an amazing safety net during my second pregnancy. Therefore, it is from this background that I undertook this research project. It is notable to mention this research was primarily carried out with non-nurse-midwives and home birth clients that primarily utilize non-nurse-midwives. I am a nurse-midwife, and am therefore perhaps both an insider and an outsider to this study population. A certain degree of historical distrust between nurse-midwives and non-nurse-midwives does exist, though I do not believe
this has directly impacted either my access to this study population or biased my approach to
the research. I became active within the Midwives Association of Florida, a group of primarily
CPMs in Florida, and I believe that they recognized that I was both supportive of their practice
as well as interested in promoting greater access to out-of-hospital birth, regardless of birth
attendant. The midwives I interviewed were eager to discuss the topic with me and actively
promoted my research by distributing the recruitment flyer to their clients. I am grateful for their
help with this project, as well as for their honesty and time.

Methods Summary

The overarching aims of this study are to apply quantitative and qualitative techniques to
investigate a relatively rare phenomenon, home birth, through the lens of the rather common
funding mechanism for maternity care, Medicaid. This study serves to make a unique
contribution to the existing literature, given that a) very little, if any, research exists relating to
the population of Medicaid-funded women who seek home birth or the practices related to
Medicaid-funded home birth; b) limited mixed-methods research exists related to home birth in
particular and childbirth more generally; and c) this study bridges a unique combination of a
secondary data source along with primary qualitative inquiry and survey data collection into this
novel topic.
Table 3.1: Midwife Respondents’ Pseudonyms and Characteristics

<table>
<thead>
<tr>
<th>Midwife Pseudonym</th>
<th>Number Years In Practice</th>
<th>Has Practiced Outside Florida</th>
<th>Has Other Health Training</th>
<th>Has Advanced Degree</th>
<th>Number of Home Births per Year</th>
<th>Attends Birth in Other Sites</th>
<th>Percent Medicaid Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nancy</td>
<td>&gt;10</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>15-20</td>
<td>Yes</td>
<td>30-40%</td>
</tr>
<tr>
<td>Olga</td>
<td>&lt;5</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>50</td>
<td>No</td>
<td>50-70%</td>
</tr>
<tr>
<td>Penny</td>
<td>&gt;10</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>&lt; 5</td>
<td>Yes</td>
<td>70%</td>
</tr>
<tr>
<td>Quincy</td>
<td>&lt;5</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>60</td>
<td>No</td>
<td>70%</td>
</tr>
<tr>
<td>Rose</td>
<td>&lt;5</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>40</td>
<td>No</td>
<td>33%</td>
</tr>
<tr>
<td>Susan</td>
<td>&gt;10</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>50</td>
<td>No</td>
<td>40%</td>
</tr>
<tr>
<td>Tammy</td>
<td>&lt;5</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>15</td>
<td>No</td>
<td>30%</td>
</tr>
<tr>
<td>Ursula</td>
<td>5-10</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>10</td>
<td>Yes</td>
<td>15%</td>
</tr>
<tr>
<td>Vera</td>
<td>5-10</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>15</td>
<td>Yes</td>
<td>30-40%</td>
</tr>
<tr>
<td>Wanda</td>
<td>&gt;10</td>
<td>Yes</td>
<td>Not asked</td>
<td>Not asked</td>
<td>50</td>
<td>No</td>
<td>0%</td>
</tr>
<tr>
<td>Xenia</td>
<td>&lt;5</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>40</td>
<td>No</td>
<td>75%</td>
</tr>
<tr>
<td>Yvette</td>
<td>&gt;10</td>
<td>Yes</td>
<td>Yes</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Zoe</td>
<td>5-10</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>100</td>
<td>Yes</td>
<td>30-40%</td>
</tr>
</tbody>
</table>

* Currently attending graduate school, not practicing midwifery

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20 Beyond that required to obtain midwifery certification
21 Other than that required to obtain midwifery certification
22 Includes Birth Centers and/or Hospitals
### Table 3.2: Maternal Respondents' Pseudonyms and Demographics

<table>
<thead>
<tr>
<th>Study Name</th>
<th>Age</th>
<th>Race</th>
<th>Marital status</th>
<th>Worked this Pregnancy?</th>
<th>Education</th>
<th>Gravida/Para &amp; Birth Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann</td>
<td>34</td>
<td>[not asked]</td>
<td>Married</td>
<td>Stay home mom</td>
<td>[not asked]</td>
<td>3/3 C/S (previa), HBAC, C/S</td>
</tr>
<tr>
<td>Becky</td>
<td>27</td>
<td>White</td>
<td>Single</td>
<td>Laid off (teacher)</td>
<td>Masters</td>
<td>1/1 Home</td>
</tr>
<tr>
<td>Chris</td>
<td>31</td>
<td>White</td>
<td>Married</td>
<td>2 days per month</td>
<td>Masters</td>
<td>2/2 Birth Center (not FL), Home</td>
</tr>
<tr>
<td>Debbie</td>
<td>28</td>
<td>White</td>
<td>Married</td>
<td>20-35 hours/wk property mgmt</td>
<td>Some college</td>
<td>4/4 C/S (presumed breech), Repeat C/S, HBAC x 2</td>
</tr>
<tr>
<td>Eve</td>
<td>28</td>
<td>American</td>
<td>Married</td>
<td>Stay home mom</td>
<td>Bachelor's</td>
<td>3/3 Hospital, Birth Center, Home</td>
</tr>
<tr>
<td>Faye</td>
<td>27</td>
<td>White</td>
<td>Married</td>
<td>Only 3\textsuperscript{rd} trimester - summer camp</td>
<td>Masters</td>
<td>1/1 Home</td>
</tr>
<tr>
<td>Gloria</td>
<td>25</td>
<td>White</td>
<td>Married</td>
<td>Nanny</td>
<td>1 year of College</td>
<td>2/2 Hospital, Home</td>
</tr>
<tr>
<td>Helen</td>
<td>27</td>
<td>White</td>
<td>Married</td>
<td>Self-employed as deaf interpreter</td>
<td>Some college</td>
<td>2/2 Birth Center, Home</td>
</tr>
<tr>
<td>Irene</td>
<td>21</td>
<td>White</td>
<td>Engaged</td>
<td>Stay home mom</td>
<td>High School Diploma</td>
<td>2/2 Hospital (w/ pre-eclampsia, out of state), Home</td>
</tr>
<tr>
<td>Jessica</td>
<td>24</td>
<td>Black</td>
<td>Married</td>
<td>Part-time paralegal until 36 weeks</td>
<td>Associates Degree</td>
<td>2/2 Hospital (induced), Home</td>
</tr>
<tr>
<td>Kate</td>
<td>28</td>
<td>White</td>
<td>Married</td>
<td>WIC educator until 16 weeks</td>
<td>Associates Degree</td>
<td>3/3 Hospital (induced), Birth Center, Home</td>
</tr>
<tr>
<td>Lauren</td>
<td>20</td>
<td>White</td>
<td>Married</td>
<td>Stay home mom</td>
<td>High School Diploma</td>
<td>2/2 Hospital (transfer from Birth Center), Home</td>
</tr>
<tr>
<td>Marie</td>
<td>26</td>
<td>American Indian</td>
<td>Married</td>
<td>Stay home mom</td>
<td>Some culinary college - culinary</td>
<td>2/2 Home x 2</td>
</tr>
</tbody>
</table>

**Key:**
- Gravida: # of pregnancies
- Para: # of deliveries
- C/S: Cesarean section
- HBAC: Home birth after cesarean
### Table 3.3: Maternal Respondents’ Insurance Status

<table>
<thead>
<tr>
<th>Study Name</th>
<th>Gestational Age When Medicaid Fully Activated</th>
<th>Insurance before pregnancy</th>
<th>Insurance after pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; trimester</td>
<td>Private</td>
<td>Private</td>
</tr>
<tr>
<td>Becky</td>
<td>7 months/ ~32 weeks</td>
<td>Private - but lost when laid off</td>
<td>None</td>
</tr>
<tr>
<td>Chris</td>
<td>16 weeks</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Debbie</td>
<td>Unknown</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Eve</td>
<td>~ 6 weeks</td>
<td>Private - HMO through husband’s job, not favorable coverage</td>
<td>None</td>
</tr>
<tr>
<td>Faye</td>
<td>6-7 months/ ~28-32 weeks</td>
<td>Private - Aetna - pregnancy exclusion</td>
<td>Private - Aetna</td>
</tr>
<tr>
<td>Gloria</td>
<td>Unknown</td>
<td>Private - High Deductible</td>
<td>None</td>
</tr>
<tr>
<td>Helen</td>
<td>10 weeks</td>
<td>Private - Major Medical only</td>
<td>Medicaid-Share of Cost</td>
</tr>
<tr>
<td>Irene</td>
<td>20 weeks</td>
<td>None</td>
<td>Medicaid-Family Planning Waiver</td>
</tr>
<tr>
<td>Jessica</td>
<td>Unknown</td>
<td>None (Had private when was working full-time, but was part-time when got pregnant)</td>
<td>None</td>
</tr>
<tr>
<td>Kate</td>
<td>14 weeks (27 weeks during 2&lt;sup&gt;nd&lt;/sup&gt; pregnancy)</td>
<td>Medicaid-Share of Cost</td>
<td>Medicaid-Share of Cost</td>
</tr>
<tr>
<td>Lauren</td>
<td>By 10 weeks</td>
<td>None</td>
<td>Private - Husband’s employer</td>
</tr>
<tr>
<td>Marie</td>
<td>Already on Medicaid</td>
<td>Full Medicaid</td>
<td>Full Medicaid</td>
</tr>
</tbody>
</table>
CHAPTER 4: QUANTITATIVE ANALYSIS OF FLORIDA BIRTH CERTIFICATES

Introduction

In the United States, the incidence of home birth has been rising, particularly among White-non-Hispanic women (MacDorman, et al. 2014; MacDorman, et al. 2012a; MacDorman, et al. 2011). Florida’s population is racially and ethnically diverse, and Florida state laws support out-of-hospital births, including to women who receive Medicaid during pregnancy. This study therefore aims to examine Florida home birth with a particular focus on how Medicaid funding impacts home birth rates among minority groups. The research objectives addressed are:

1. To document the prevalence and socio-demographic characteristics of Medicaid-funded home birth in Florida
2. To examine how Medicaid funding impacts access to home birth for Medicaid-funded women, particularly among minority women.

The key research questions for statistical modeling are:

What are the differences in demographic/social characteristics and birth outcomes as reported on birth certificates among:

a. Women who have planned home birth by payment source?
b. Medicaid-funded women by birth site (hospital vs. planned home birth)?

Materials and Methods

Ethics and Data Integrity

After the University of South Florida (USF) Institutional Review Board (IRB) determined the study met Federal Exemption criteria for review (Appendix E), the study was sent to the Florida Department of Health IRB for review. They also certified that the project did not involve human subjects and was thus exempt from their review (Appendix F). A data use agreement
(Appendix G) was then executed with the Florida Department of Health/Bureau of Vital Statistics and renewed annually. Data integrity has been ensured through a process of obtaining the data via a FTP transfer from the Bureau of Vital Statistics to a secured location behind the USF-Health firewall, where the data was maintained. All data files will be deleted once the final analyses have been completed, per the Data Use Agreement with the Bureau of Vital Statistics.

**Study Design / Study Population**

This cross-sectional, population based study uses Florida vital statistics, specifically birth certificates, from the years 2005 to 2010. Six files were retrieved as .txt files, one for each year. Each .txt file was converted into an SPSS file, after which the six SPSS files were merged into a master data set. All merging, data cleansing, variable recoding, and univariate analyses described below were done in SPSS versions 21 and 22 for Mac. The final data files used in the analysis were converted to .csv files and opened in SAS version 9.3, where bivariate analyses as well as logistic regression models were conducted.

The complete data set consisted of all Florida births issued a birth certificate for the six-year period of 2005 through 2010 (n=1,377,081), of which 1,371,956 (99.6%) listed Florida as the birth state. From this original data set, ten records were deleted: nine with nearly every variable containing "." or “missing” data values, and one listing an outlier maternal age (age 153), leaving an original sample data set of n=1,377,071. Yearly total births ranged from 215,677 to 240,280.

Appendix H lists the variables received, whether they were utilized in the analyses, and footnotes where further details are necessary. Most variables utilized within the analyses were recoded to more appropriately align with this study’s objectives or to narrow them into more clinically relevant categories. For example, the birth weight variable listed as the raw birth weight was recoded into a categorical variable with four categories that hold clinical significance: <2500 grams, 2500-3999 grams, 4000-4499 grams and >4500 grams. The maternal race variable was significantly recoded in order to collapse all Asians into one
category, Hispanics into another, and to separate Haitians out from within the Hispanics given
the relatively high prevalence of Haitians within Florida. The full documentation relating to how
these new variables were calculated from the reported race and ethnicity variables is located in
Appendix P. Paternal race was recoded in a similar fashion, and a new variable not included on
the birth certificate, child’s calculated race, was created; however, these were not utilized in this
study’s final analyses. The final maternal race categories used in these analyses were:

1 – White Non-Hispanic
2 – Black Non-Hispanic
3 – Hispanic
4 – Haitian
5 – Asian/Pacific Islander
99 – Other/Unknown/Mixed Race

Given that this study focuses on planned home births in Florida, steps were taken to
ensure data integrity particularly related to the planned home birth checkbox variable. The
FACILITY_TYPE_CODE variable (i.e., where the birth occurred) was cross-tabbed with the
HOME_BIRTH_PLANNED variable (i.e., the “Planned Home Birth Check Box”). This test
confirmed that records indicating a “Null” response to the home birth checkbox did not list
Planned Home Birth, Unplanned Home birth or Home Birth-Unknown Planning Status as the
facility type code, as well as confirmed that those records with a “Yes” “No” or “Unknown”
response to the planned home birth check box were appropriately categorized within the
FACILITY_TYPE_CODE variable as home births, and with the appropriate planning status.
Where there was disagreement, the FACILITY_TYPE_CODE was reclassified; specifically, nine
records were reclassified where disagreement between the facility code and planning status
existed. One record labeled as facility type “Planned Home Birth” had a “No” for the planning
check box and another record labeled as facility type “Planned Home Birth” had “Unknown” in
the planning check box. Both were reclassified to facility code “Home Birth-Unknown Planning
Status.” Finally, eight records labeled as facility type “Planned Home Birth” with “No” for the
planning check box were all recoded to “Unplanned Home Birth.” This highlights the fact that
some errors did occur within the original data entry period, although the overall false discovery rate for planned home births was 9/5253 or 0.17%. This also highlights a limitation of the “Planned Home Birth” check box, namely that those births that are planned at home but transfer to a hospital or other facility are not accurately captured in the current version of the U.S. Certificate of Live Birth, leaving no ability to conduct an “intent to treat” analysis related to birth site from the birth certificate data source. After this initial data cleansing, the breakdown of births by delivery site and planning status for the total sample are presented in Table 4.1. Table 4.2 presents the total population by payer source. Table 4.3 presents the total population by race/ethnicity. Finally, Table 4.4 presents the percentage of births per attendant type by delivery location.

**Sample Generation**

Prior to running bivariate and multivariate analyses, the data were restricted to exclude records of women that would likely not have been candidates for coverage by Medicaid based on their residence or for a planned home birth in Florida, as these were the primary dependent variables of interest in this study. Women with multiple gestation pregnancies were excluded by deleting those records where the variable “PLURALITY_CODE” was not equal to “1”. Among all birth records in the data set (n=1,377,071), 96.78% were singleton (n=1,332,795). Among the 5,243 Planned Home Births, 5,222 had Plurality = 1 (99.69%), with 20 records (i.e., 10 pregnancies since each child would have received its own birth certificate) listed as twins (plurality = 2) and one record listed as plurality = 0 (this birth occurred at 19 weeks, which indicates an error in filing, as technically this is too early for a certificate of live birth to have been filed).

Any births occurring outside of the State of Florida (total sample n=5,145 or 0.37%; among Planned Home Birth n=15, 0.29%) were excluded, since home birth statutes and regulations, particularly related to Medicaid, vary by state and this dissertation aims to analyze planned home births among Florida Medicaid recipients. Additionally, records listing a maternal
residence outside of Florida (total sample n=11,724 or 0.85%; among Planned Home Birth n=27 or 0.51%) were excluded because these would likely represent women who were not eligible for Florida Medicaid. For those non-Florida residents who had planned home birth in Florida, it could represent migration to Florida for the purpose of a home delivery that was illegal in their home state (or country) or for which the mother was unable to locate a trained home birth provider.

Finally, maternal age extremes (<13 and >50) were excluded along with clinical gestation estimates of < 37 weeks (and unknown/missing clinical estimate), again to conduct analyses on term births that would have met criteria for planned home birth. After deleting these records, given some overlap between the exclusion variables the Planned Home Birth sample was reduced by 105 records to n=5,138 or 97.99% of the original total. Hospital births decreased by 181,828 to n=1,178,374 (86.63% of the original sample of n=1,360,202 hospital births), with the largest deletion related to prematurity (n=152,363, or 11.20%).

In summary, after applying these exclusions, the final sample from which all remaining planned home births and a random sample of hospital births were extracted for analyses included birth certificates from 2005 to 2010 where:

1 – Plurality = 1 (singleton pregnancies only)
2 – Birth State = Florida
3 – Maternal Residence State = Florida
4 – Maternal Age = 13 through 50
5 – Clinical Estimation of Gestation = 37 weeks and up

From this remaining sample of 1,178,374 hospital births, a random sample of 5,138 records was generated utilizing the random sample generator within SPSS version 21, specifically requesting 5,138 records to create equal samples of hospital births and Planned Home Birth and Hospital Birth for the statistical analyses. This was done because the 5,138 Planned Home Births were equal to only 0.43% of the hospital births and with such unequal

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23 Specifically, the steps are: Data/Select Cases/Select Random Sample of Cases/Sample Size Exactly 5,138 cases/Copy Selected Cases to a New DataSet. This new data set was then merged with the 5,138 Planned Home Births to create the final data set of 10,276 cases, 50% of each per facility_type_code.
samples, any comparisons that resulted in statistical significance would likely result in a wide standard error. Because the random hospital births were estimated to approximate the total sample of hospital births, this study can therefore be considered population-based, as opposed to case-control. To ensure that the random hospital sample was representative of the total hospital sample, frequencies and t-tests were conducted comparing the random sample to the original hospital sample using variables that had not been used as exclusions (maternal education, maternal WIC status, principal payer source, maternal race, parity, and prior cesarean). These tests demonstrated that the random sample did not differ significantly from the original hospital sample. Figure 4.1 provides a visual representation of the final samples used in the analyses.

Table 4.5 reports the sample characteristics after exclusions were applied from the total hospital sample, the random hospital sample and the planned home births used in the analyses. Table 4.6 reports characteristics of the planned home birth sample stratified by payer source.

**Statistical Analysis: Bivariate Analyses**

To address the research objectives, the final sample for analysis consisted of 10,276 records (50% hospital and 50% planned home births). To ensure that the variables included in the regression model were robust to differences between the groups, bivariate analyses comparing the data by birth location were conducted in SAS 9.3 using PROC FREQ with Chi-square. Variables that were not found to demonstrate statistical significance at the p<0.05 level were excluded from further analyses, unless they were felt to be clinically significant enough to warrant inclusion in the model and therefore to be adjusted for. Crude odds were calculated in a model with birth location (planned home birth vs. hospital birth) as the dependent variable. Variables that were entered into the logistic regression model are reported as Crude Odds in Table 4.7.
Statistical Analysis: Logistic Regression

The logistic regression model continued with birth location as the dependent/outcome variable, and point estimates and 95% confidence intervals were calculated for the variables entered into and adjusted for within the model. These are reported in Table 4.8, except for year of birth, which was significant in the crude odds and included as an adjustment in the final model, but not reported. A paradoxical increase in planned home birth incidence continued each year while a decrease of hospital birth incidence occurred, likely a factor resultant from the 2008 economic downturn and the national trend toward lower birth rates. However, 2008 also signified the year that the *Business of Being Born* was released which prompted an increasing interest in out-of-hospital birth.

Significant differences were found between the crude and adjusted odds, thus warranting the use of interaction terms within the model to control for these variances. Specifically, interaction models between payer source and maternal race, payer source and maternal parity, and payer source and maternal age were applied to the logistic regression model. Race and parity demonstrated significance and therefore the adjusted odds ratios of these modification effects are reported in Tables 4.9 and 4.10. Maternal age did not show significance and therefore effect modifications are not reported.

RESULTS

Crude Odds

Crude odds are reported in Table 4.7. These demonstrated that relative to private insurance, Medicaid had a protective effect against home birth (OR 0.88) while self-pay mothers instead demonstrated four times the odds (OR 4.12) to have planned home birth compared to hospital birth. Additionally, relative to Black-non-Hispanic (BNH) women, White-non-Hispanic (WNH) women were 5.6 times more likely to have home birth, Hispanic women 1.3 times more likely and women from other/unknown or mixed races (Other) 2.9 times more likely. Haitian and Asian women did not significantly differ from BNH. U.S.-born women were 2.6 times more likely
than foreign-born women to have home birth, and married women were 4.4 times more likely than unmarried women. Compared to teens (ages 13-17) all maternal age categories were significantly more likely to have home birth, although this was only apparent in the crude odds model. Home birth seemed to demonstrate a protective effect in regards to increasing BMI and breech delivery. Home birth increased the likelihood of the following: mothers not receiving WIC benefits, mothers not smoking or quitting, increased maternal parity, increased gestational age, increased birth weight, and breastfeeding.

Additional variables that did not hold significance in the crude odds were: Apgar score, newborn seizures, and maternal alcohol use. Crude odds were calculated for several additional variables that were not included in the final adjusted model but were conducted to confirm that women in this sample having planned home births had been appropriately risk-stratified based on the Florida statutes. For instance, women whose births were at home were 2.1 times more likely than those in the hospital to have not had a previous poor pregnancy outcome, 19.6 times more likely to not be chronic diabetics, 17.7 times more likely to not be gestational diabetics, 9.9 times more likely to not have chronic hypertension, and 14.1 times more likely to not have developed pregnancy-related hypertension. While previous cesarean is not an absolute contraindication to planned home birth, compared to women who gave birth at the hospital, those with planned home birth were 2.8 times more likely to not have had a previous cesarean. Thus, it appears that women who completed a planned home birth had been appropriately risk-stratified.

**Adjusted Odds**

Adjusted odds are reported in Table 4.8. Compared to the crude odds, adjustment had little effect on maternal BMI, maternal education, foreign-born status, prior cesarean, tobacco use, WIC status, parity, gestational age, breech delivery or breastfeeding. The odds of home birth compared to hospital birth decreased significantly for married women, from 4.4 to 1.9. Where birth weight had been significant in the crude odds, it only became significant after
adjustment among births >4500 grams, and the odds decreased from 12.9 to 2.9. Most notably, compared to private insurance, adjustment shifted the protective factor of Medicaid (OR 0.88) to a 4.6 times likelihood of Medicaid having home births compared to hospital births. Adjustment also decreased the odds of WNH home birth from 5.6 to 2.8, while maintaining the odds of Hispanic and other races, and increasing the odds of Haitians from 0.98 to a statistically significant 1.48. All maternal age categories became non-significant after adjustment.

**Adjusted Odds with Modification Effect**

To understand if race/ethnicity, parity and age modified the effect of payer status on planned home birth, stratified analyses on each level of the effect modification were conducted, and adjusted odds were calculated for payer status by race and parity, as only these proved significant in the interaction model. Private insurance proved to be the least likely insurance status among planned home births, with WNH women who gave birth at home 4.2 times more likely to have Medicaid than private insurance, BNH women 2.4 times, and Hispanic women 5.1 times, as shown in Table 4.9. Self-pay, also shown in Table 4.9, was even more likely affected by race/ethnicity when comparing privately insured women to Medicaid and self-pay, across all race categories.

Parity also modified the effect of payer status on birth location, as shown in Table 4.10, but quite surprisingly in an opposite fashion than might have been predicted clinically. Among planned home birth, nulliparous women were 6.4 times more likely to have Medicaid than private insurance and 15.7 times more likely to be self-pay. These numbers remained positive as parity increased, but not as strong, where women with 1 to 3 prior births were 4.2 times more likely to have Medicaid and 8.2 times more likely to be self-pay than privately insured, and higher order parity (>3) were 2.3 times more likely to have Medicaid and 2.9 times more likely to be self-pay than privately insured. Increasing rates of Medicaid insured women would make real-life sense because household size is part of the calculation for Medicaid eligibility, but here it would appear that nulliparous women were the most likely to have Medicaid or be self-pay.
DISCUSSION

As an opening a word of caution, it is important to acknowledge that data quality among out-of-hospital birth certificates has not been previously investigated. This study operates under the assumption that birth certificate data quality among planned home birth is rigorous. One observation in conducting data cleansing among this data set is the relative lack of “missing” fields within the planned home birth certificates, which partially confirms the data rigor. However, one possible reason for this robust data completeness lies in the fact that most if not all out-of-hospital birth certificates are filed “by hand” as opposed to on a computer registry such as would be expected within the hospital setting. Anecdotally, the Licensed Midwives in Florida have shared that when the birth registrars at the State find missing data in their filed birth certificates, members of the State vital statistics staff call the midwives to clarify. This could possibly attest to the observation that out-of-hospital birth data is more complete, but not necessarily more robust. Out-of-hospital birth certificate accuracy is certainly an area for future research.

Having acknowledged that, several interesting observations emerge from these analyses. The breakdown of out-of-hospital birth in Florida differs from the rates published based on national data. Whereas in the national sample (MacDorman, et al. 2014; MacDorman, et al. 2010), 67% of out-of-hospital births occur at home (without mention of planning status) and 27% occur in birth centers, in Florida, the reverse is true. In this data from 2005 to 2010, among out-of-hospital births, the 54% birth center rate far exceeded the total home birth rate of 46% and the planned home birth rate of 35%. This could be due in part to the fact that Florida has a large number of birth centers, especially in comparison to the nation as a whole. Looking at the raw breakdown of payer status between all Florida births and planned home births in this sample also demonstrates a large difference, with all births showing payer status of 45% for Medicaid, 42% for private insurance and 10% self-pay while planned home births were more equally distributed between payer sources at 31% Medicaid, 34% private and 32% self-pay.
Differences also exist based on raw percentages of race and ethnicity, where a sample representing 19 states (including Florida) reporting known planning status of home births in 2006 (Declerq 2010) found that WNH women accounted for 90.1% of planned home birth, BNH 2.2%, Hispanic (which includes Haitian) 5.6% and Asian 1.6%. In the present study, from 2005 to 2010 77.6% of planned home births in Florida were to WNH mothers, 5.1% to BNH, 13.5% to Hispanics when Haitians are included, and 1.0% Asian. Of course, the racial and ethnic makeup of Florida is likely more diverse that the larger, multi-state sample, but from these raw data, it would appear that planned home birth in Florida is undertaken by a more diverse population than the sample drawing from nineteen states (which included Florida). A comparison of race/ethnicity rate changes between hospital births and planned home births in both the current sample and the Declerq (2010) sample, it appears that the rate change for WNH is not different but that higher percentage changes occur for all other race/ethnicities. Also notable from these raw data, and comparable to the Declerq (2010) study, is that compared to all Florida births, planned home birth mothers demonstrate more years of education, older ages, higher order of parity, higher rates of being US-born, and lower rates of smoking, lower BMI, fewer previous cesareans and lower WIC usage. Many of these variables maintained statistical significance in the adjusted models, with the notable exception of maternal age, and will be discussed below.

Also interesting is that certain variables that proved to be non-significant have been previously used by other researchers (Grunebaum, et al. 2013; Wax, et al. 2010) to support claims about the lack of safety of planned home births. Notably, the neonatal seizure and Apgar at 5 minutes variables were not significant, even in the initial model for crude odds ratios, and therefore were not included in the logistic regression models. Low birth weight might be thought of as a predictor variable among Medicaid funded women but it did not prove significant in any of the models, and instead birth weight showed significance only among large for gestational age (>4500 gram) infants, where Medicaid funded women were 7.87 times more likely to have a
baby >4500 grams than one of low birth weight (<2500 grams). Other variables appeared significant prior to adjustments, but their significance disappeared in the adjusted models, including maternal age.

Most notable to the research questions of interest are the results of the adjusted model for planned home birth and payer source. While in the crude odds, Medicaid appeared to be a protective factor against home birth (OR 0.88), in the adjusted odds women with Medicaid insurance, relative to private insurance, were 4.6 times more likely to have a home birth. The association among self-pay remained and grew from a crude odds of 4.1 to an adjusted odds of 10.1. Accounting for the differences between the crude and adjusted odds becomes a key point for discussion. Teasing out what factors seem to drive this shift is certainly speculative, but further research could be designed to better understand this shift and to better determine which of the model variables contributed most to the shift in Medicaid status and planned home birth between the crude and adjusted odds. Model variables that might likely help explain this shift include maternal age, maternal race/ethnicity, and marital status, but is there something about final birth weight or gestational age that contributes? Does a theoretical model such as the Weathering Hypothesis perhaps contribute to either social or biological contributions regarding when women of certain race/ethnicities enter childbearing and therefore whether they would be more likely to access Medicaid at those points in their life? Certainly, the adjusted model accounted for factors such as race and maternal age that could impact women’s likelihood of being a Medicaid recipient. For instance, with teens being the reference age group, were BNH more likely to be teenagers and therefore more likely to be on Medicaid, and did this contribute to the lower odds for home birth among Medicaid that fell out after adjusting for maternal age and race? Perhaps additional qualitative research might better inform the development of statistical models that could be applied to large data sets such as birth certificates to help tease out these answers.
Certain observations were aligned with what could have been predicted about the planned home birth population based on other studies. When looking at planned home birth and payer source, women with increasing education levels were more likely to have home births than hospital births, be non-smokers, and breastfeed. They were also more likely to have pregnancies extend into 40 weeks and even 41-42 weeks, and give birth to babies that were larger. Certain factors were more protective, such as women who had planned home birth were less likely to be on WIC and to be classified as obese.

Maternal age was statistically significant in the crude odds model but failed to hold significance in the adjusted models. Maternal education maintained significance throughout all of the models, and somewhat unexpectedly, Medicaid funded women had the greatest odds for having advanced degrees over high school diplomas compared to women with private insurance or self-pay status. For instance, Medicaid funded women were 5.15 times more likely to have a masters or doctorate compared to a high school diploma, while those privately insured were only 1.95 times as likely and among self-pay 1.96 times. Medicaid funded women were also more likely to have a bachelors degree compared to a high school diploma, at 2.74 times, while privately insured women had only a 1.58 times likelihood and self-pay a 1.85.

Therefore, in regards to the research questions posed within this study, it does appear that Medicaid increases access to home birth among minority women. This is particularly evident in the adjusted models that also apply the modification effect of payer source by race, where women of every race that birthed at home appear to be more likely to have Medicaid or self-pay insurance status compared to private insurance. Exactly how the interaction between race and payer status in regards to planned home birth cannot be definitively identified in a cross-sectional study. However, further qualitative research could attempt to better understand this interaction. It seems, however, that the assumption that the mandated Florida Statutes for all forms of insurance to cover births in all birth settings would likely lead to no significant difference in payer source for home birthers seems to be completely false.
Table 4.1: Total Data Set by Birth Location

<table>
<thead>
<tr>
<th>Birth Site</th>
<th>n</th>
<th>% total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Birth – Planned</td>
<td>5,243</td>
<td>0.381%</td>
</tr>
<tr>
<td>Home Birth – Unplanned</td>
<td>1,695</td>
<td>0.123%</td>
</tr>
<tr>
<td>Home Birth – Unknown Planning Status</td>
<td>35</td>
<td>0.003%</td>
</tr>
<tr>
<td>Birth Center</td>
<td>8,077</td>
<td>0.587%</td>
</tr>
<tr>
<td>Hospital Births</td>
<td>1,360,202</td>
<td>98.775%</td>
</tr>
<tr>
<td>Births en route, in clinic or unknown location</td>
<td>1,775</td>
<td>0.129%</td>
</tr>
<tr>
<td>Missing Birth Facility Code</td>
<td>44</td>
<td>0.003%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1,377,071</td>
<td>100.000%</td>
</tr>
</tbody>
</table>

Table 4.2: Total Data Set by Payer Source

<table>
<thead>
<tr>
<th>Payer Source</th>
<th>n</th>
<th>% total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>618,862</td>
<td>44.9%</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>575,451</td>
<td>41.8%</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>137,081</td>
<td>10.0%</td>
</tr>
<tr>
<td>Other *</td>
<td>45,677</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1,377,071</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

* Other includes those with Medicaid pending at time of delivery

Table 4.3: Total Data Set by Maternal Race/Ethnicity

<table>
<thead>
<tr>
<th>Maternal Race/Ethnicity</th>
<th>n</th>
<th>% total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White-non-Hispanic</td>
<td>612,149</td>
<td>44.5%</td>
</tr>
<tr>
<td>Black-non-Hispanic</td>
<td>245,052</td>
<td>17.8%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>392,031</td>
<td>28.5%</td>
</tr>
<tr>
<td>Haitian</td>
<td>46,915</td>
<td>3.4%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>37,682</td>
<td>2.7%</td>
</tr>
<tr>
<td>Other/Unknown/Multiple Race</td>
<td>43,212</td>
<td>3.1%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1,377,071</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 4.4: Total Data Set: Delivery Location by Attendant

<table>
<thead>
<tr>
<th>Delivery Location</th>
<th>MD/DO</th>
<th>CNM</th>
<th>LM</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>88.8%</td>
<td>10.9%</td>
<td>0.0%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Birth Center</td>
<td>3.8%</td>
<td>30.8%</td>
<td>63.5%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Planned Home</td>
<td>0.4%</td>
<td>3.6%</td>
<td>86.3%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Other*</td>
<td>35.2%</td>
<td>4.9%</td>
<td>2.1%</td>
<td>57.8%</td>
</tr>
<tr>
<td><strong>Attendant % of Total Births</strong></td>
<td>87.7%</td>
<td>11.0%</td>
<td>0.7%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

*Other includes: Unplanned home birth, Home birth planning unknown, En route, Clinic, Unknown location and missing data on birth certificate
Table 4.5: Sample Characteristics after Exclusions

<table>
<thead>
<tr>
<th></th>
<th>Hospital 1,178,374</th>
<th>Random Hospital 5,138</th>
<th>Planned Home Birth 5,138</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>529,385</td>
<td>44.9</td>
<td>2285</td>
</tr>
<tr>
<td>Private</td>
<td>495,461</td>
<td>42.0</td>
<td>2209</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>116,975</td>
<td>9.9</td>
<td>504</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>36,553</td>
<td>3.1</td>
<td>140</td>
</tr>
<tr>
<td><strong>Maternal Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WNH</td>
<td>522,692</td>
<td>44.4</td>
<td>2269</td>
</tr>
<tr>
<td>BNT</td>
<td>201,046</td>
<td>17.1</td>
<td>829</td>
</tr>
<tr>
<td>Hispanic</td>
<td>345,912</td>
<td>29.4</td>
<td>1553</td>
</tr>
<tr>
<td>Haitian</td>
<td>39,695</td>
<td>3.4</td>
<td>185</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>33,130</td>
<td>2.8</td>
<td>148</td>
</tr>
<tr>
<td>Other/Mixed/Unknown</td>
<td>35,899</td>
<td>3.0</td>
<td>154</td>
</tr>
<tr>
<td><strong>Maternal US-Born</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US-Born</td>
<td>794,057</td>
<td>67.4</td>
<td>3429</td>
</tr>
<tr>
<td>Foreign-Born</td>
<td>384,317</td>
<td>32.6</td>
<td>1709</td>
</tr>
<tr>
<td><strong>Maternal Age</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>13-17</td>
<td>37,914</td>
<td>3.2</td>
<td>158</td>
</tr>
<tr>
<td>18-24</td>
<td>389,047</td>
<td>33.0</td>
<td>1679</td>
</tr>
<tr>
<td>25-34</td>
<td>581,715</td>
<td>49.4</td>
<td>2527</td>
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<tr>
<td>35-50</td>
<td>169,698</td>
<td>14.4</td>
<td>774</td>
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<tr>
<td><strong>Marital Status</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Married</td>
<td>646,689</td>
<td>54.9</td>
<td>2872</td>
</tr>
<tr>
<td>Unmarried</td>
<td>531,684</td>
<td>45.1</td>
<td>2266</td>
</tr>
<tr>
<td><strong>Maternal Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>6,469</td>
<td>.5</td>
<td>29</td>
</tr>
<tr>
<td>&lt;High School</td>
<td>232,957</td>
<td>19.8</td>
<td>999</td>
</tr>
<tr>
<td>HS or GED</td>
<td>369,431</td>
<td>31.4</td>
<td>1595</td>
</tr>
<tr>
<td>Some College</td>
<td>313,774</td>
<td>26.6</td>
<td>1335</td>
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<tr>
<td>Bachelor’s</td>
<td>180,936</td>
<td>15.4</td>
<td>828</td>
</tr>
<tr>
<td>Masters/Doctorate</td>
<td>74,807</td>
<td>6.3</td>
<td>352</td>
</tr>
<tr>
<td><strong>Pre-Pregnancy BMI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;18.0</td>
<td>36,661</td>
<td>3.1</td>
<td>161</td>
</tr>
<tr>
<td>18.0-24.9</td>
<td>577,159</td>
<td>49.0</td>
<td>2515</td>
</tr>
<tr>
<td>25.0-29.9</td>
<td>272,164</td>
<td>23.1</td>
<td>1205</td>
</tr>
<tr>
<td>30.0-39.9</td>
<td>184,227</td>
<td>15.6</td>
<td>781</td>
</tr>
<tr>
<td>&gt;40</td>
<td>35,104</td>
<td>3.0</td>
<td>139</td>
</tr>
<tr>
<td>Missing</td>
<td>73,059</td>
<td>6.2</td>
<td>337</td>
</tr>
<tr>
<td><strong>Previous Cesarean</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>151,654</td>
<td>12.9</td>
<td>716</td>
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<tr>
<td>No</td>
<td>1,025,294</td>
<td>87.0</td>
<td>4409</td>
</tr>
<tr>
<td>Missing</td>
<td>1,426</td>
<td>.1</td>
<td>13</td>
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<td><strong>WIC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>569,781</td>
<td>48.4</td>
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<tr>
<td>No</td>
<td>595,510</td>
<td>50.5</td>
<td>2609</td>
</tr>
<tr>
<td>Missing</td>
<td>13,083</td>
<td>1.1</td>
<td>49</td>
</tr>
</tbody>
</table>

24 Where missing is not reported, there were no missing values in the data set.
Table 4.5: Sample Characteristics after Exclusions (Continued)

<table>
<thead>
<tr>
<th></th>
<th>Hospital 1,178,374</th>
<th>Random Hospital 5,138</th>
<th>Planned Home Birth 5,138</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tobacco Use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>78,673</td>
<td>6.7%</td>
<td>338</td>
</tr>
<tr>
<td>No</td>
<td>1,082,445</td>
<td>91.9%</td>
<td>4720</td>
</tr>
<tr>
<td>Quit</td>
<td>16,098</td>
<td>1.4%</td>
<td>78</td>
</tr>
<tr>
<td>Missing</td>
<td>1,158</td>
<td>.1%</td>
<td>2</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>502,219</td>
<td>42.6%</td>
<td>2225</td>
</tr>
<tr>
<td>1-3</td>
<td>632,281</td>
<td>53.7%</td>
<td>2720</td>
</tr>
<tr>
<td>4+</td>
<td>40,135</td>
<td>3.4%</td>
<td>175</td>
</tr>
<tr>
<td>Missing</td>
<td>3,739</td>
<td>.3%</td>
<td>18</td>
</tr>
<tr>
<td><strong>Clinical Estimated Gestational Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37-41</td>
<td>1,174,661</td>
<td>99.7%</td>
<td>5123</td>
</tr>
<tr>
<td>42</td>
<td>3,381</td>
<td>.3%</td>
<td>14</td>
</tr>
<tr>
<td>&gt;42</td>
<td>332</td>
<td>.0%</td>
<td>1</td>
</tr>
<tr>
<td><strong>Birth weight</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;2500 grams</td>
<td>29,042</td>
<td>2.5%</td>
<td>118</td>
</tr>
<tr>
<td>2500-3999</td>
<td>1,063,113</td>
<td>90.2%</td>
<td>4628</td>
</tr>
<tr>
<td>4000-4499</td>
<td>752,273</td>
<td>6.4%</td>
<td>345</td>
</tr>
<tr>
<td>&gt;4500</td>
<td>10,910</td>
<td>.9%</td>
<td>47</td>
</tr>
<tr>
<td><strong>Breastfed</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>935,151</td>
<td>79.4%</td>
<td>4113</td>
</tr>
<tr>
<td>No</td>
<td>236,433</td>
<td>20.1%</td>
<td>995</td>
</tr>
<tr>
<td>Missing</td>
<td>6,790</td>
<td>.6%</td>
<td>30</td>
</tr>
<tr>
<td><strong>5-minute Apgar</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>&lt;7</td>
<td>9,520</td>
<td>0.8%</td>
<td>44</td>
</tr>
<tr>
<td>7-10</td>
<td>1,168,251</td>
<td>99.1%</td>
<td>5092</td>
</tr>
<tr>
<td>Missing</td>
<td>603</td>
<td>.1%</td>
<td>2</td>
</tr>
<tr>
<td><strong>Delivery Route</strong></td>
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<td></td>
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</tr>
<tr>
<td>Vaginal</td>
<td>765,445</td>
<td>64.9%</td>
<td>3128</td>
</tr>
<tr>
<td>C/S</td>
<td>412,152</td>
<td>35.0%</td>
<td>1858</td>
</tr>
<tr>
<td>Missing</td>
<td>777</td>
<td>.1%</td>
<td>152</td>
</tr>
<tr>
<td><strong>Birth Presentation</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cephalic</td>
<td>1,130,527</td>
<td>95.9%</td>
<td>4943</td>
</tr>
<tr>
<td>Breech</td>
<td>27,590</td>
<td>2.3%</td>
<td>112</td>
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<tr>
<td>Missing</td>
<td>20,257</td>
<td>1.8%</td>
<td>83</td>
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<tr>
<td><strong>Newborn Seizure</strong></td>
<td></td>
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</tr>
<tr>
<td>Yes</td>
<td>114</td>
<td>.0%</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>1,176,655</td>
<td>99.9%</td>
<td>5130</td>
</tr>
<tr>
<td>Missing</td>
<td>1,604</td>
<td>.1%</td>
<td>8</td>
</tr>
<tr>
<td><strong>Transfer Infant</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Yes</td>
<td>5,813</td>
<td>.5%</td>
<td>36</td>
</tr>
<tr>
<td>No</td>
<td>1,172,395</td>
<td>99.5%</td>
<td>5101</td>
</tr>
<tr>
<td>Missing</td>
<td>166</td>
<td>.0%</td>
<td>1</td>
</tr>
<tr>
<td><strong>Birth Year</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>193,827</td>
<td>16.4%</td>
<td>826</td>
</tr>
<tr>
<td>2006</td>
<td>203,565</td>
<td>17.3%</td>
<td>886</td>
</tr>
<tr>
<td>2007</td>
<td>205,866</td>
<td>17.5%</td>
<td>912</td>
</tr>
<tr>
<td>2008</td>
<td>198,478</td>
<td>16.8%</td>
<td>852</td>
</tr>
<tr>
<td>2009</td>
<td>191,105</td>
<td>16.2%</td>
<td>862</td>
</tr>
<tr>
<td>2010</td>
<td>185,532</td>
<td>15.7%</td>
<td>800</td>
</tr>
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</table>
Table 4.6: Characteristics of Planned Home Birth by Payer Status

<table>
<thead>
<tr>
<th></th>
<th>MEDICAID</th>
<th>PRIVATE</th>
<th>SELF-PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>30.9%</td>
<td>34.0%</td>
<td>31.9%</td>
</tr>
<tr>
<td><strong>Maternal Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WNH</td>
<td>69.6%</td>
<td>81.4%</td>
<td>81.4%</td>
</tr>
<tr>
<td>BNH</td>
<td>8.4%</td>
<td>4.2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>14.7%</td>
<td>11.5%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Haitian</td>
<td>2.5%</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>0.8%</td>
<td>0.5%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Other/Multi/Unknown</td>
<td>4.0%</td>
<td>1.9%</td>
<td>2.0%</td>
</tr>
<tr>
<td><strong>U.S. Born</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US Born</td>
<td>86.8%</td>
<td>85.5%</td>
<td>79.4%</td>
</tr>
<tr>
<td>Foreign-Born</td>
<td>13.2%</td>
<td>14.5%</td>
<td>20.6%</td>
</tr>
<tr>
<td><strong>Maternal Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-17</td>
<td>0.7%</td>
<td>0.2%</td>
<td>0.5%</td>
</tr>
<tr>
<td>18-24</td>
<td>26.0%</td>
<td>8.8%</td>
<td>13.8%</td>
</tr>
<tr>
<td>25-34</td>
<td>58.4%</td>
<td>64.7%</td>
<td>59.6%</td>
</tr>
<tr>
<td>35-50</td>
<td>14.9%</td>
<td>26.3%</td>
<td>26.1%</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>67.0%</td>
<td>93.9%</td>
<td>92.3%</td>
</tr>
<tr>
<td>Unmarried</td>
<td>33.0%</td>
<td>6.1%</td>
<td>7.7%</td>
</tr>
<tr>
<td><strong>Maternal Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than High School</td>
<td>6.7%</td>
<td>1.4%</td>
<td>4.6%</td>
</tr>
<tr>
<td>High School or GED</td>
<td>24.5%</td>
<td>10.5%</td>
<td>23.2%</td>
</tr>
<tr>
<td>Some College</td>
<td>43.4%</td>
<td>30.0%</td>
<td>31.4%</td>
</tr>
<tr>
<td>Bachelors</td>
<td>20.4%</td>
<td>39.6%</td>
<td>30.1%</td>
</tr>
<tr>
<td>Masters/Doctorate</td>
<td>4.9%</td>
<td>18.5%</td>
<td>10.5%</td>
</tr>
<tr>
<td><strong>Maternal Body Mass Index (BMI)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;18.0</td>
<td>5.1%</td>
<td>3.3%</td>
<td>5.2%</td>
</tr>
<tr>
<td>18.0-24.9</td>
<td>64.0%</td>
<td>67.6%</td>
<td>70.4%</td>
</tr>
<tr>
<td>25.0-29.9</td>
<td>20.7%</td>
<td>18.9%</td>
<td>17.2%</td>
</tr>
<tr>
<td>30.0-39.9</td>
<td>8.2%</td>
<td>9.0%</td>
<td>6.3%</td>
</tr>
<tr>
<td>40+</td>
<td>1.9%</td>
<td>0.8%</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Previous Cesarean</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous Cesarean</td>
<td>6.0%</td>
<td>5.2%</td>
<td>4.3%</td>
</tr>
<tr>
<td>No Previous C/S</td>
<td>94.0%</td>
<td>94.8%</td>
<td>95.7%</td>
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<tr>
<td><strong>WIC Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On WIC</td>
<td>48.0%</td>
<td>3.9%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Not on WIC</td>
<td>52.0%</td>
<td>96.1%</td>
<td>97.0%</td>
</tr>
<tr>
<td><strong>Tobacco Use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoker</td>
<td>3.3%</td>
<td>0.6%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Non-Smoker</td>
<td>95.1%</td>
<td>98.8%</td>
<td>98.4%</td>
</tr>
<tr>
<td>Quit Smoking</td>
<td>1.6%</td>
<td>0.6%</td>
<td>0.8%</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nulliparous</td>
<td>23.6%</td>
<td>22.8%</td>
<td>20.3%</td>
</tr>
<tr>
<td>1-3 Previous Births</td>
<td>63.6%</td>
<td>66.9%</td>
<td>66.9%</td>
</tr>
<tr>
<td>4+ Previous Births</td>
<td>12.5%</td>
<td>10.2%</td>
<td>12.8%</td>
</tr>
<tr>
<td><strong>Clinical Estimated Gestational Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EGA 37-39 weeks</td>
<td>98.0%</td>
<td>98.9%</td>
<td>96.7%</td>
</tr>
<tr>
<td>EGA 40 weeks</td>
<td>2.0%</td>
<td>1.0%</td>
<td>3.2%</td>
</tr>
<tr>
<td>EGA 41-42 weeks</td>
<td>0.0%</td>
<td>0.1%</td>
<td>0.1%</td>
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</table>
Table 4.6: Characteristics of Planned Home Birth by Payer Status (Continued)

<table>
<thead>
<tr>
<th>Birthweight</th>
<th>MEDICAID</th>
<th>PRIVATE</th>
<th>SELF-PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 2500 grams</td>
<td>0.6%</td>
<td>0.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>2500-3999 grams</td>
<td>80.9%</td>
<td>79.4%</td>
<td>78.5%</td>
</tr>
<tr>
<td>4000-4499 grams</td>
<td>14.9%</td>
<td>16.1%</td>
<td>17.1%</td>
</tr>
<tr>
<td>&gt;4500 grams</td>
<td>3.5%</td>
<td>3.6%</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

**Breastfed**

<table>
<thead>
<tr>
<th></th>
<th>MEDICAID</th>
<th>PRIVATE</th>
<th>SELF-PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfed</td>
<td>97.0%</td>
<td>98.9%</td>
<td>98.1%</td>
</tr>
<tr>
<td>Not Breastfed</td>
<td>3.0%</td>
<td>1.1%</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

**Delivery Presentation**

<table>
<thead>
<tr>
<th></th>
<th>MEDICAID</th>
<th>PRIVATE</th>
<th>SELF-PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cephalic</td>
<td>99.6%</td>
<td>99.8%</td>
<td>99.4%</td>
</tr>
<tr>
<td>Breech</td>
<td>0.4%</td>
<td>0.2%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

**Birth Year-By Payer Status**

<table>
<thead>
<tr>
<th>Year</th>
<th>MEDICAID</th>
<th>PRIVATE</th>
<th>SELF-PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>28.6%</td>
<td>36.3%</td>
<td>31.2%</td>
</tr>
<tr>
<td>2006</td>
<td>26.3%</td>
<td>35.8%</td>
<td>34.1%</td>
</tr>
<tr>
<td>2007</td>
<td>25.4%</td>
<td>35.0%</td>
<td>35.1%</td>
</tr>
<tr>
<td>2008</td>
<td>31.4%</td>
<td>35.8%</td>
<td>34.1%</td>
</tr>
<tr>
<td>2009</td>
<td>32.9%</td>
<td>33.8%</td>
<td>30.8%</td>
</tr>
<tr>
<td>2010</td>
<td>37.7%</td>
<td>32.0%</td>
<td>28.0%</td>
</tr>
<tr>
<td>Average 2005-2010</td>
<td>30.9%</td>
<td>34.0%</td>
<td>31.9%</td>
</tr>
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</table>
Table 4.7: Crude Odds Ratios for Planned Home Birth (Ref: Hospital) *

<table>
<thead>
<tr>
<th></th>
<th>Crude Odds</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payer Status (Ref: Private)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>0.88</td>
<td>0.80-0.96</td>
<td>0.00</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>4.12</td>
<td>3.66-4.64</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Other</td>
<td>1.48</td>
<td>1.17-1.87</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Maternal Race (Ref: BNH)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WNH</td>
<td>5.56</td>
<td>4.80-6.45</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1.30</td>
<td>1.10-1.54</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Haitian</td>
<td>0.98</td>
<td>0.70-1.35</td>
<td>0.00</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>1.09</td>
<td>0.77-1.54</td>
<td>0.88</td>
</tr>
<tr>
<td>Other/Multi/Unknown</td>
<td>2.90</td>
<td>2.22-3.79</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>U.S. Born (Ref: Foreign Born)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US Born</td>
<td>2.60</td>
<td>2.37-2.86</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Maternal Age (Ref: 13-17)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>3.22</td>
<td>2.08-4.99</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>25-34</td>
<td>8.13</td>
<td>5.28-12.53</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>35-50</td>
<td>9.92</td>
<td>6.40-15.38</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Marital Status (Ref: Unmarried)</strong></td>
<td></td>
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</tr>
<tr>
<td>Married</td>
<td>4.41</td>
<td>4.02-4.85</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Maternal Education (Ref: High School)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than High School</td>
<td>0.38</td>
<td>0.17-0.88</td>
<td>0.02</td>
</tr>
<tr>
<td>Some College</td>
<td>0.35</td>
<td>0.29-0.41</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Bachelors</td>
<td>2.14</td>
<td>1.92-2.38</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Masters/Doctorate</td>
<td>2.96</td>
<td>2.63-3.32</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Maternal BMI (Ref: 18-24.9)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;18.0</td>
<td>1.04</td>
<td>0.85-1.28</td>
<td>0.71</td>
</tr>
<tr>
<td>25.0-29.9</td>
<td>0.59</td>
<td>0.53-0.65</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>30.0-39.9</td>
<td>0.38</td>
<td>0.34-0.44</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>40+</td>
<td>0.29</td>
<td>0.21-0.40</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Previous Cesarean (Ref: Prior C/S)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Previous C/S</td>
<td>2.82</td>
<td>2.44-3.26</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>WIC Status (Ref: On WIC)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother not on WIC</td>
<td>4.40</td>
<td>4.02-4.82</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Alcohol Use (Ref: + Alcohol)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother no Alcohol</td>
<td>0.56</td>
<td>0.25-1.27</td>
<td>0.17</td>
</tr>
<tr>
<td><strong>Tobacco Use (Ref: Smoker)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Smoker</td>
<td>4.37</td>
<td>3.42-5.58</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Quit Smoking</td>
<td>2.64</td>
<td>1.72-4.06</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Parity (Ref: Nulliparous)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-3 Previous Births</td>
<td>2.41</td>
<td>2.21-2.64</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>4+ Previous Births</td>
<td>7.21</td>
<td>6.01-8.64</td>
<td>&lt;0.001</td>
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<td><strong>Clinical EGA (Ref: 37-39 weeks)</strong></td>
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<tr>
<td>EGA 40 weeks</td>
<td>3.21</td>
<td>2.94-3.51</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>EGA 41-42 weeks</td>
<td>5.79</td>
<td>5.02-6.67</td>
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<tr>
<td><strong>Birth weight (Ref: &lt;2500 grams)</strong></td>
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<tr>
<td>2500-3999 grams</td>
<td>2.82</td>
<td>1.94-4.08</td>
<td>&lt;0.001</td>
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<tr>
<td>4000-4499 grams</td>
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<td>5.13-11.18</td>
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<tr>
<td>&gt;4500 grams</td>
<td>12.89</td>
<td>7.91-21.01</td>
<td>&lt;0.001</td>
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<td><strong>Breastfed (Ref: Not Breastfed)</strong></td>
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<td>Breastfed</td>
<td>11.48</td>
<td>9.36-14.09</td>
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Table 4.7: Crude Odds Ratios for Planned Home Birth (Ref: Hospital)* (Continued)

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<th>Variable</th>
<th>Odds Ratio</th>
<th>95% CI</th>
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<tr>
<td><strong>Apgar (Ref: &lt;4)</strong></td>
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<tr>
<td>Apgar 4-6</td>
<td>1.01</td>
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<td>Apgar 7-10</td>
<td>156.36</td>
<td>36.57-688.5</td>
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<td><strong>Delivery Presentation (Ref: Cephalic)</strong></td>
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<tr>
<td>Breech</td>
<td>0.17</td>
<td>0.11-0.28</td>
<td>&lt;0.001</td>
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<td>Not Chronic HTN</td>
<td>9.89</td>
<td>3.94-24.83</td>
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<td>Maternal Pregnancy Hypertension (Ref: Yes)</td>
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<td>Not Pregnancy HTN</td>
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<td>8.20-24.35</td>
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<td><strong>Birth Year</strong></td>
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<td>2006</td>
<td>0.83</td>
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<td>2007</td>
<td>0.82</td>
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<td>2009</td>
<td>1.03</td>
<td>0.90-1.18</td>
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<td>2010</td>
<td>1.31</td>
<td>1.15-1.50</td>
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* Significant values are shown in **bold**
Table 4.8: Adjusted Odds Ratios for Planned Home Birth (Ref: Hospital)

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<tr>
<th>Category</th>
<th>AOR</th>
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<th>p value</th>
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<td><strong>Payer Status (Ref: Private)</strong></td>
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<td>Medicaid</td>
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<td>3.94-5.47</td>
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<td>Self-Pay</td>
<td>10.10</td>
<td>8.40-12.15</td>
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<td>Other</td>
<td>2.71</td>
<td>1.94-3.79</td>
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<td>WNH</td>
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<td>1.04-1.65</td>
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<td>Asian/PI</td>
<td>0.79</td>
<td>0.50-1.24</td>
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<td>Other/Multi/Unknown</td>
<td>2.33</td>
<td>1.64-3.31</td>
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<td><strong>U.S. Born (Ref: Foreign Born)</strong></td>
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<td>US Born</td>
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<td>18-24</td>
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<td>25-34</td>
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<td>&lt; High School</td>
<td>0.48</td>
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<td>Bachelors</td>
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<td>1.88-2.54</td>
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<td>Masters/Doctorate</td>
<td>2.67</td>
<td>2.25-3.18</td>
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<td><strong>Maternal BMI (Ref: 18-24.9)</strong></td>
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<tr>
<td>&lt; 18.0</td>
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<td>1.12-1.99</td>
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<td>25.0-29.9</td>
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<td>0.51-0.68</td>
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<td>30.0-39.9</td>
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<td>2.70-4.03</td>
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<td><strong>WIC Status (Ref: On WIC)</strong></td>
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<tr>
<td>Mother not on WIC</td>
<td>3.23</td>
<td>2.78-3.77</td>
<td>&lt;.0001</td>
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<td><strong>Tobacco Use (Ref: Smoker)</strong></td>
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<td>2.32-4.45</td>
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<td>Quit Smoking</td>
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<td><strong>Parity (Ref: Nulliparous)</strong></td>
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<td>1-3 Previous Births</td>
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<td>4+ Previous Births</td>
<td>10.73</td>
<td>8.19-14.07</td>
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<td><strong>Clinical Estimated Gestational Age (Ref: 37-39 weeks)</strong></td>
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<td>EGA 40 weeks</td>
<td>2.92</td>
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<td>EGA 41-42 weeks</td>
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<td>2500-3999 grams</td>
<td>1.07</td>
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<td>4000-4499 grams</td>
<td>1.55</td>
<td>0.90-2.66</td>
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<td>&gt;4500 grams</td>
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<td>Breastfed</td>
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<td><strong>Delivery Presentation (Ref: Cephalic)</strong></td>
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Table 4.9: Adjusted Odds Ratios after Modification Effect of Payer by Race (Ref: Private)

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<tr>
<td></td>
<td>AOR</td>
<td>CI</td>
<td>AOR</td>
<td>CI</td>
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<tr>
<td>WNH</td>
<td>4.213</td>
<td>3.40-5.22</td>
<td>14.921</td>
<td>11.46-19.43</td>
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<tr>
<td>BNH</td>
<td>2.399</td>
<td>1.42-4.06</td>
<td>4.622</td>
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<tr>
<td>Hispanic</td>
<td>5.142</td>
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<td>5.056</td>
<td>1.17-21.95</td>
<td>6.124</td>
<td>1.81-31.74</td>
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<tr>
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<td>42.595</td>
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<td>139.242</td>
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Table 4.10: Adjusted Odds Ratios after Modification Effect of Payer by Parity (Ref: Private)

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<td>AOR</td>
<td>CI</td>
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<tr>
<td>Nulliparous</td>
<td>6.361</td>
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<td>15.744</td>
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<td>Parity 1-3</td>
<td>4.156</td>
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<td>8.18</td>
<td>6.97-11.16</td>
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Table 4.11: Race/Ethnicity Rates - Hospital vs. PHB - Florida vs. 19 States

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<th>Total FL Hospital 2005-2010</th>
<th>Total FL PHB 2005-2010</th>
<th>% Change</th>
<th>19 states Hosp 2006</th>
<th>19 states PHB 2006</th>
<th>% Change</th>
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<td>WNH</td>
<td>44.2</td>
<td>77.6</td>
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<td>49.7</td>
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<td>5.1</td>
<td>.29</td>
<td>11.9</td>
<td>2.2</td>
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<td>32.3</td>
<td>5.6</td>
<td>.17</td>
</tr>
<tr>
<td>Asian (incl Haitian)</td>
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Figure 4.1: Sample Extraction
CHAPTER 5: PERCEPTIONS AND REALITIES

Semi-structured interviews were conducted with thirteen women who had given birth at home while receiving Medicaid insurance during the year prior to the initiation of the research project, as discussed in the Chapter Three. In addition, semi-structured interviews were conducted with thirteen midwives. To help protect the respondent’s anonymity and in an attempt to present results in a clear fashion, each has been assigned a pseudonym. In addition to a brief description provided as each participant is first introduced, Tables 3.1 and 3.2 present a list of the pseudonyms as well as basic demographics, previous birth experiences and other relevant data for each midwife and participant. The interviews with the thirteen women concluded with a brief demographic questionnaire (Appendix C) in order to contextualize the data based on a woman’s age, ethnic group, parity, insurance status, etc. Table 3.3 provides details regarding each participant’s insurance status, including when her pregnancy Medicaid became fully activate. The final interview questions prior to collection of demographic data related to participants’ perceptions of how society at large viewed midwives, home birth, and Medicaid, along with questions asking the women what their own beliefs about these concepts were. Specifically, the following sets of questions were asked:

“What do you think that most people imagine when they hear the word midwife?”
“What comes to mind for you when you hear the word midwife?”

“What do you think most people imagine when they hear the word home birth?”
“What comes to mind for you when you hear home birth?”

“What do you think most people imagine when they hear the word Medicaid?”
“What comes to mind for you when you hear Medicaid?”

This chapter presents the results of this portion of the interviews. While these questions were asked at the conclusion of the interviews, they are presented first in order to set a context.

25 Throughout this dissertation, the women interviewed will be referred to as “respondents” or “participants” while the midwives interviewed will either be referred to as “midwives” or “providers.”
for the upcoming chapters. However, the questions were purposely asked at the end of the interviews to avoid prompting or coaching answers to other questions throughout the interviews.

**Perceptions of Midwives and Midwifery**

While midwives as individual women and midwifery as a profession are not interchangeable terms, some respondents blurred the lines between these concepts. Seven of the thirteen respondents linked midwives with a bygone, remote era, though five mentioned a contemporary resurgence or new understanding of what midwifery is. Only Kate, a 28-year-old married mother of three, whose first baby was induced in a hospital, second was born at a birth center and seven-month-old was born at home, voiced that society’s perception, or at least the perception among her peers, was one that midwifery should be considered the “norm” and midwives, not obstetricians (OB), should be the primary pregnancy care providers. She stated:

> I mean, to me and my friends [a midwife is] just, that’s who you go to when you’re pregnant. I have a hard time even typing OB if I’m on Facebook or something, talking to somebody about their provider. Midwife just automatically comes out.

However, this contrasted with all the other respondents who invariably used terms like “hippy” “old” “something people used to do” and “archaic” when describing what most people imagine when they hear “midwife,” as if describing this as something that women used to do, but now defer all pregnancy care and talk to “OBs.”

An example of this came from Debbie, a married, White 28-year-old mother of four whose first two were born via cesarean and second two at home attended by the same Licensed Midwife. After commenting on how midwives were perceived as old, “witch doctors” she added:

> I think that’s slowly changing right now to us - a lot of my friends who have debated the option, they said, ‘No, I’ll go OB,’ and they went and then said, ‘You know what? No, I’m switching to a midwife.’ I have a couple of friends who are doing home births who I’d have never in a million years would think that they would do it.

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26 Where respondents gave short, mostly one-word responses, these are reported within the text with quotation marks.
Six respondents used the term “hippy” and/or added descriptions such as that of Chris, a married, White 31-year-old mother of two, whose first was born at a birth center in another state while her second was born at home in Florida. She described that most people hear midwife and think of:

A hippy, somebody with long hair, wearing Birkenstocks and long flowing skirts.

Jessica, a 24-year-old married, Black mother of two who worked as a paralegal, and whose first was a hospital birth followed by this home birth, stated:

Most people? Like a farm, hokey, granny, like this real retro, hippyish, and delivers babies with her bare hands, not clean.

Three respondents specifically described society’s view of midwives as “dirty”, which was often accompanied by the term “barefoot.” Two respondents used the term “witch doctor,” including Debbie who stated:

A lot of people think of it like a witch doctor [laughs] putting a knife under the bed to cut the baby out [laughs]. You know, kind of an old lady, like, ‘Ah, let me use my herbs and special concoctions to bring this baby out’ kind of thing.

It is likely true that home birth midwives do employ the use of herbs far more frequently than hospital-based midwives or obstetricians, but in this description, the use of herbs seemingly refers to an era of practitioners prior to the introduction of modern, pharmaceutical medicines.

Eight participants discussed that midwives were associated with the past, specifying that midwives were part of care before there were OBs. Three contrasted the modern use of midwives as a “last minute alternative to an OB,” thus describing that the cultural norm for American women is to see an obstetrician when they become pregnant, and only after they have perhaps had a bad experience with them or otherwise felt called to seek alternative care, did they happen to seek out midwifery care. Many responses were simply one or two words, and two respondents pointed to the perception that midwives are “unskilled” or “untrained.”
Four others referred to midwives as being “rural” or “country,” implying that women in cities with access to hospitals would not have to resort to this “archaic” practice.

Becky, a single, White 27-year-old who had been a public school teacher until she was laid off at the very beginning of her pregnancy (which was her first and for which she chose to deliver at home), shared an additional perception of midwives stating that besides the “hippy, barefoot” concept of midwives:

At the other extreme, it’s somebody who was one of those über religious people who live in their own communities, like they might be cults.

Four respondents, in the context of societal views of midwives and prior to being directly asked about their own understanding of midwife, discussed how their own opinions of midwives had changed, and mentioned that despite this historical perception of midwives, a contemporary movement is updating society’s views. Becky, the only single mother in the sample, stated:

I thought it was like an old - like things they used to have but don’t have anymore. So I was thinking like colonial times, what those people look like, I had an idea in my head of what a midwife would look like...That was my misperception before I met my midwife. Now, I know a lot of midwives, and now, when I think of midwives, I think of strong, knowledgeable women who have a lot of love in their hearts....So when I think of midwife now, what I think of is [name of her midwife]. My midwife, a strong, loving, trusting woman who believes in the power of birth and who believes that it’s important for mothers and babies to have that experience of a natural birth without interventions.

Others added comments that validated how these respondents shifted their views of midwives based on their own midwife, offering insights such as Jessica’s statement:

My midwife is like a young, gorgeous, healthy, you know, modern woman, and I don’t think people, it’s just with midwife, they think older.

Helen, a 27-year-old mother of two (one born in birth center, one at home), commented about the false perceptions society has about current midwives:

They don’t realize that they’re modern, they’re up-to-date, they’re well-trained, they know how to do CPR and provide Pitocin or oxygen. These people [i.e., society] don’t realize they [i.e., midwives] know a lot more than they actually do.

These comments also validate the fact that midwives struggle to prove that they are knowledgeable and competent, that despite holding national certification and state licensure
midwives still have to fight a societal perception that they are unskilled, untrained and dangerous. While the midwives in this sample did not specifically address this, there is certainly anecdotal evidence that they must defend their credentials.

Marie, a 26-year-old mother of two babies born at home, interpreted the question, “What do most people imagine when they hear the word midwife?” as a reference to out-of-hospital birth, thus linking midwife with birth setting. She stated that most people were of the mind that:

They think, no, I would rather have [the baby] in the hospital because they have all the machines there, they have everything at the hospital, it’s a vacation. That’s the word every time I talk to people, vacation, I’m like, in my head, what the hell does a vacation got to do with a midwife? [her emphasis]

Marie, who described herself as a Native American married to a Haitian, was notably the only respondent with Medicaid coverage prior to pregnancy (despite stating she worked and was married), and therefore perhaps hailed from a different socio-economic background than the other respondents. Her perception of women in her community was that childbirth in a hospital setting offered a rare opportunity to be taken care of, to receive respite from the stressors of daily life. To her, however, birth was an empowering way that she could express herself as a woman, in the way that God had made her. She described her births as:

An other-worldly experience, because I pushed out two kids, on my own, with my husband there… I would rather go through the pain and feel more empowered as a woman… I just let my body do what my body do. I felt power when I was pushing and afterwards because it’s tiring and it hurts, but at the end you feel real good, like, I actually did it without no meds, no nothing. It feels real good. That’s why God made us the way that we are, to give birth.

This certainly provides an example both of how women became empowered by their birth experiences but also of how women preferred the autonomy to follow their own body’s cues and proceed with a physiological birth, unaltered by technology or external interventions.

\[27\] Italics are used throughout this dissertation to delineate where inflection or emphasis occurred in the respondents’ voices.
Perceptions of Midwifery Types

Unanticipated responses came from what seemed to be a rather innocuous question asked of the mothers who had given birth at home. Early in the interviews, in order to get a sense of their recent home birth experience and to ensure that indeed the participants met the study eligibility criteria of having given birth at home, while on Medicaid and attended by a midwife licensed in the State of Florida, participants were asked, “What type of provider attended your recent home birth?” Care was taken to not initially inquire what type of midwife, but rather more generally what type of provider, in order to assess if perhaps it was truly an unattended birth or an accidental home birth attended by a physician. Inadvertently, this question was not asked of one participant. Among the twelve remaining participants, all stated that a “midwife” had attended their birth. However, only six could specifically state the type of midwife, and either specified a “certified nurse-midwife”, a “Licensed Midwife”, or one woman who said both, because in fact both types worked in the practice that had attended her birth. For all of these respondents who identified what type of midwife attended their home birth, responses were basically just a statement of the midwife type and did not involve any other description or lengthy discussion. Among the other six respondents who were not fully certain of the type of midwife that had attended their birth, much longer descriptions were given, mostly after prompting from the interviewer. Ann, who had two previous home births attended by different midwives and whose husband is an emergency responder, answered, “A midwife” that prompted the interviewer to clarify with: “A Licensed Midwife or a nurse-midwife?” to which Ann replied:

I think that they were both licensed, but I cannot say for sure. I mean, I hadn’t thought about that, if that’s different. [Name of midwife] was the second one, so I guess I’d have to look and see.

Becky answered with:

I had a home birth midwife in my, obviously in my home.
The interviewer then asked, “Do you know if she was a Licensed Midwife or a nurse-midwife?” and Becky responded:

Yes, she’s licensed, and I can give you her information and you can check with her too.

This statement leaves some amount of speculation regarding whether the midwife is simply licensed in Florida or if she belongs to the actual category of Licensed Midwives that by law require holding national status as a Certified Professional Midwife, as opposed to a Certified Nurse-Midwife who are licensed in Florida as Advanced Practice Registered Nurses.

Eve stated that “I had two student midwives and a home certified midwife” which the interviewer did not prompt for further clarification.

Jessica described that throughout her prenatal care and at birth she was uncertain of the type of midwife that was providing her care:

I’m not sure which type [of midwife]. I know she’s licensed. She had her own practice, too, but I’m not sure exactly what type she is.

Gloria, who received her care from a practice that had both a CNM and a LM, was not entirely sure which had been the one at her birth:

Well, I had a midwife. [Interviewer: Okay, do you know if she was a nurse-midwife or a professional midwife or ?] I think she was just a professional midwife but she’s in a practice, like, there were two midwives that I saw and one of them was also a nurse practitioner midwife. But the one at my home birth, I think, I think she was just like a Licensed Midwife.

Marie was the only respondent who equated Medicaid with “midwives” when asked what came to mind for her when she heard the word “Medicaid.” She had given birth to both of her children at home, and described the type of midwife that attended her home birth as:

She was a, um, like, a home-birth based, like she will do, like some of the midwives, she would, she’ll train, like other, ‘cuz you can go to school to be a midwife. I didn’t know that until she told me. And like, she’ll mentor, like others, other people to do it, and for like my first child, when I was going, she had like two girls there, and like they helped her with the birth and everything, and it was like pretty awesome.
Hence, while the majority of these respondents felt that societal perception of midwives was of archaic, non-modern women, half did not know the specifics of what types of credentials their own midwife possessed. According to the Florida birth certificates, among planned home births between 2005 and 2010, Licensed Midwives (CPMs) attended 86.9% of the births, Certified Nurse-Midwives attended 3.5% of the births, physicians attended 0.3% and “Other” attendants accounted for 9.3%.

Realities and Experiences of Midwifery

When respondents were asked what came to mind for them when they hear the word “midwife”, responses were invariably more personalized, with many participants referring to their own midwife, not just to midwives in general. For example, Lauren, a 20-year-old married mother of two whose first was born in a hospital after transferring from a birth center staffed by CNMs and whose second was born at home attended by a different CNM, stated:

I think of my midwife, she’s supportive, she’s empowering, she’s loving, caring, she’s strong, definitely.

The most common responses referred to “strong” “knowledgeable” and “supportive” women who help to “empower” the women they care for. Helen stated that when she hears midwife:

I think of a strong, well-informed woman who stands up for what she believes in and kind of goes against the grain of the norm…to give the pregnant woman the empowerment to do what they want to do…I think that a midwife gives them that extra push to say that you’re actually doing the right thing for your body and for your baby and it just kind of makes the whole experience that much better.

Towards this underlying theme that midwives help to empower other women, Gloria, a 25-year-old mother of two (one hospital, one home birth) stated that midwives, “will fight for and advocate for women and their babies.” Clearly, these responses are quite different from the way they believed society viewed midwives as archaic, dirty, unskilled and untrained; however, they do point to the acknowledgement given that midwives are engaged in a struggle against the societal norm.
A strong emphasis was placed on the “personalized” care that midwives provide as well as the “holistic approach” they take. Ann, a 34-year-old mother of three who had a home birth after cesarean, acknowledged that she thought of midwives as women who helped other women birth before there were OBs, but now thinks of midwives as:

Someone who’s in touch with women having babies and who’s more personalized, not just pushing women through an office, but actually building a relationship with them.

These relationships formed over months in the midwives’ care and several women acknowledged in the course of the interview that a key reason they sought home birth was so that they would not only know the person who would be attending their birth, but also to have a chance to bond with them prior to the birth. Throughout the interviews, several respondents stated that the relationship they developed with their midwife made it feel as though they were friends, something they never felt possible with an OB.

Two respondents acknowledged the “responsibility” that a midwife assumes, with Chris describing midwives as being:

Very knowledgeable and supportive and [having] a lot on her shoulders because she has two lives in her hands the whole time and is making sure that everybody’s healthy.

Gloria described the responsibility as being towards the mother-infant dyad, and stated:

[The midwife] is someone that supports the mother and the baby. They’re for the mother and the baby, rather than being for the schedule or the paycheck or convenience. Someone that will fight for and advocate for women and their babies, that they want the best for you and they’ll go to great lengths to make sure that you have the best. To make sure that you feel confident, supported, and that you can trust yourself, and that you could trust them as well.

This sentiment was repeated by other respondents who described that midwives “truly want to help people” or that “midwives help other women.” Kate expanded on these concepts of support and trust, and said that when she hears the word “midwife” she thinks of:

A little bit of relief, honestly. Because I know that as long as you’re definitely with a midwife and not a medwife that whoever is pregnant is in pretty good hands.
For the most part, when the term “medwife” is used, both by these respondents as well as in general either on blogs or in casual conversations, this refers to certified nurse-midwives that some women view as having become too medicalized and practicing more like physicians than midwives. This could in part come from the fact that nurse-midwives generally worked as labor and delivery nurses in hospitals prior to obtaining their advanced training and certification as nurse-midwives, and in that way, perhaps become more ‘indoctrinated’ within the medical model. Becky also acknowledged this concept of ‘medical-midwives’ versus ‘midwife-midwives’ when she stated:

Midwives who work in the hospital who are a lot more like doctors than like midwives, they have the title of midwife but they act like OB-GYNs.

Thus, these two respondents shared a perception that some midwives have been co-opted by the dominant medical model of birth and do not demonstrate the more holistic and caring qualities that they associate with ‘true’ (usually home birth) midwives. This is one way that some respondents expanded from thinking of an individual midwife to more of the type of care they provide, which for it to be “midwifery” was viewed by Eve, a 28-year old mother of three who had given birth in a hospital, a birth center and then at home, as:

A very holistic approach to the pregnancy and birth, and the normal approach that it isn’t a sickness or anything that is likely to be complicated.

Marie further blurred the lines between a woman’s experience with birth, her choice of birth site and her overall view of midwifery by stating that when she hears midwife:

In my mind, it’s like a perfect opportunity to be a woman, to be strong, and you have to take control of your body and let your body do what your body do [sic].

Similar to her earlier quote, in her mind midwives allow her to become empowered through fulfilling the natural function that her body was designed for, but that our current medical practices perhaps render us incapable of actually doing. She talked about how her home birth had changed her through empowering her to make decisions and take control of who would be
with her at birth, which she viewed as allowing her to set the course for the health trajectory of her children’s lives:

You can invite however many people you want to [your home birth], but when you get a lot of negativity, that ain’t what you need, and [others] are like, ‘Oh, I’d never do that’ [have a home birth], but, you’ve got to realize, it’s not what they want, it’s what you and your husband want for that kid. Do you want your kid to live a healthy and better life, or do you want your kid to have a lot of complications later down the road or get cut, because a lot of my friends and my family members who had kids went to the doctor and when they were giving birth I told them, ‘Heck, they’re going to give you a C-section’ and they told me, ‘Oh, no, no, no, no I’m not’ but push come to shove, they did have a C-section, they did get the Pitocin, they can’t hardly make it stop, and they’ll say that there’s something wrong with the kid and they need to hurry up and get him out.

In this statement, Marie provides an example of the iatrogenic complications associated with birth in hospitals.

Debbie, who believed that societal perceptions of midwives were as “witch doctors” was the only respondent who made direct reference to the “hippy Farm midwives” when she discussed how she (as opposed to society) viewed midwives:

I tend to think of this very calming presence. It’s more like just kind of relaxed, like the old famous midwife Ina May28.

Thus, by and large, these respondents’ own views of midwives contrasted to their views that society at large sees midwives as archaic, dirty, hippies, while they themselves see midwives as modern, strong, informed women that help to empower others. Particularly for the two women interviewed who had given birth at home with their first pregnancy, but to an extent for all of the women interviewed, they made a choice to stand up to a societal perception of midwives as archaic, dirty, and uneducated and still pursue a home birth that for most would be considered unsafe and dangerous.

In a separate part of the interviews, but reported here, the participants were asked what were the most important characteristics of their own midwife, and if there were any ways that their midwives could have been better. Two of the participants were inadvertently not asked

28 Ina May Gaskin contributed significantly to the natural birth and midwifery movements with her work on The Farm, a commune in Summertown, Tennessee, and through her book *Spiritual Midwifery.*
these questions. Among the remaining eleven respondents, six felt that there wasn’t anything that could have been better about their midwife. Among the others, areas for improvement primarily related to care provision and reflected less about the midwives themselves. Three of the respondents wished that their midwives could have been geographically closer to them. This was more of an issue in relation to prenatal appointments rather than the birth itself, which occurred at home, although this could have theoretically related to the distance the midwife would have to travel to the women’s homes and whether this would impact her arrival time when the woman was in labor, although none of the respondents specifically discussed this in regards to how their midwife could have been better. However, for Lauren, one of the best parts of her midwife was that:

I really liked that she came to us for all of our visits, since she doesn't have her own home office, she came to our house so I didn't have to, you know, pack up my daughter, and I think that she is just really convenient.

Perhaps the fact that her midwife came to her home contributed to Lauren’s other comment about the most important characteristics of her midwife:

I liked that she was supportive of everything that we wanted, she included my daughter a lot, and she was friendly.

Two of the respondents discussed how there had been issues with the care they received because they did not have a midwife that worked independently but rather with at least one other midwife as well as students. This contributed to a sense that they might not be getting the personalized care they so valued. As Faye said, the midwife could have been better in that:

I think she also works with student midwives and so there were a lot of different people that were coming in, and so I saw a lot of different [people], because sometimes I would go there and I wouldn't see [midwife's name] at all, I would see one of the students. So sometimes that, you know, bothered me a little bit but I still saw [midwife’s name] enough, I think.

Jessica also discussed that the presence of two midwives in the practice could be considered a drawback, in that she seemed to feel more comfortable with one of the two midwives. However,
she also had stated that she did not transfer her care to the home birth midwives until later on in the pregnancy after being seen by the “Medicaid-appointed health department staff.” She stated:

There were two midwives that work together, maybe, just [getting care from the one] being the one that’s at the birth? I don’t know, I really enjoyed my experience with her.

Gloria had received care from a practice that was staffed by both a CNM and a LM, and she discussed that the difference in the professionalism between the two could have been a drawback. She and her husband seemed to prefer not only this higher level of professionalism of the CNM but also her more medicalized training. Ultimately Gloria felt the care she received was fine, but that she perhaps had more respect for the degree of attention paid to her care by the CNM was more professional and less “laid back” than the care provided by the LM:

My husband wished that, well, there were two different midwives that we saw, and that one that is a nurse practitioner, my husband really liked. I guess she kind of had that medical background, so she came off overall as like more professional, just in her appearance and just the way she carried herself and the way she talked to us and stuff. So, it gave us a little more confidence. Our other midwife was not so much, she’s just more like laid back… and just didn’t have that professionalism about her…I think it was more of a personality thing more than anything, but I mean that’s with any doctor or with any person in general, you’re going to people that you click with or you know, personalities that rub you the right way or rub you the wrong way. So, as far as the care that was given, I wouldn’t have anything to say about that [that needed improvement].

Ultimately, however, she felt she received quality care, and was the only respondent who discussed this contrast between the styles of a CNM versus a LM. A few respondents did, however, discuss a sense of relief in knowing that a CNM could continue to provide care if a hospital transfer was needed.

Contrasting this “laid back” personality as a possible area for improvement, Helen actually found that the best characteristic of her midwife was that she was laid back, and also related this to how personalities must click in the type of relationship that one develops with their home birth midwife. She said the best part of her midwife was:
She was just a very laid back person. I think that really, for every person to have a midwife, you have to kind of like tell how their personalities work together, like there are people who work better [together] than other people.

The concept of caring as being an important characteristic the participants found in their midwives was described in several ways. For some, it was an outgrowth of the amount of time that the midwife spent with them. As Becky put it:

The best characteristics of her as a midwife? First off, is the level of respect that she gave to each and every person that she saw. Every time I saw, even her working with the people in her office, there’s always warmth and respect. She treated everybody with love like a mother, like an aunt, like a grandmother. That’s by far the most important thing right there. There’s also the amount of time that she spent. I mean, our meeting wasn’t over until I was done asking questions.

Faye, who was having her first baby, echoed this by saying:

She definitely listened to everything that we wanted to do at the birth. She spends a lot of time with the patients, with us, she spent a lot of time with us, I’m not sure that would happen in a different setting.

She also discussed the importance of the holistic approach that her midwife took to providing care, which was not merely about the clinical aspects of prenatal care:

She would give me advice about my diet, exercise, different things like herbal teas, just listening to all of our concerns.

Chris, who had previously given birth in a birth center and for this birth planned a home birth with a CNM, also appreciated this holistic approach, and found that the most important characteristic of her provider was her ability to continue providing care in case she needed to transfer to the hospital:

I did want somebody to have the ability to go in a hospital if needed. I thought that was really important because if I did choose her, if there were problems, I would want her to be the person with me because that was the person that I’ve been with for nine months and that’s the person I trusted and that’s the person that I knew I wanted. And along those lines, as far as being the person you trust, the prenatal care is fantastic when it comes to actually talking to the whole person. You know, it’s not like when you go to the OB doctor and they listen to the baby and work down the checklist and then, ‘Okay, you’re done, get your weight, whatever.’ [Midwives] take a lot of time with you, the midwife sits with you, each appointment, at least half an hour, you’re talking about everything from what you’re eating to how you’re feeling emotionally, physically, you know…really knowing the whole person and getting to know everything that’s going on and
taking care, not just of what’s going on in your uterus, but taking care of all of you.

The personalized care that looks beyond simply “checking off a list” and looking at each patient individually was also important to Debbie, who had two previous cesareans and then two home births with the same midwife. She found the most important characteristics of her midwife to be:

She took her time with us, and any questions I had, she answered them and she genuinely cared, I think, because I’ve gone to quite a few different OB/GYNs and it’s kind of you’re a number, they don’t, you have to do what they tell you to do, wherein she was, ‘Here are your different options, here’s the pros and cons’ and she was just totally supportive of everything and so it was just a different type of care that I had gotten before. I had always had low iron, with all my pregnancies, and she kind of worked with me and found out, well, I just don’t seem to absorb the iron pills themselves, so I needed like the chlorophyll or like more plant based things, more fruit based things to get my iron [up], and my iron was like the best it had ever been. There’s just a lot of things that she took you as a person, not just a patient, or ‘this is what our policy is’.

Thus, the characteristics that were important to these respondents contrasted significantly to the ways that they felt that society views midwives, primarily as outdated, dirty, archaic. Perhaps the starkest contrast between these impressions and the actual experience these respondents had with their own midwives was best stated by Helen, who described her midwife as:

I would call her the ‘modern mom’ kind of like that. She wasn’t the [person] some people are scared of, like of the midwife being like a hippie, ’70s, groovy-type people. She was just more of the modern mom, like a soccer mom... She was just like a very laid back, modern person, and just was also well-informed and was just a great person and it ended that she felt like family with both boys. It was like you didn’t want to leave her because she really was, we became so close with her.

**Perceptions of Home Birth**

Similarly to the way that respondents felt that the societal view of midwives was that of something that “used to happen a long time ago”, they expressed that the societal view of home birth is that of something that happened in another era, “in the 1700s” and “a long time ago” but that now “we’ve evolved.” In addition, the perception was that home birth is something society views as “crazy” “scary” and “dangerous.” Irene, who had developed a pregnancy complication,
pre-eclampsia, during her first birth that had occurred in a hospital in another state, simply stated that in relation to society’s view of home birth, “I think that the number one word that comes to my mind would be fear.” Jessica echoed this and stated, “Backwards, dangerous, not safe for either you or your baby.” Respondents were often met with amazement when they told their own friends or families of their plans for or of their successful home birth. Lauren, a 20-year-old married woman stated after her second birth:

Crazy [laughs]. My neighbor, most of our neighbors knew that we were planning a home birth, and, you know, we talked to them, and our one neighbor, she had just moved in and she thinks we were just absolutely crazy. [Laughter] She’s like, ‘I can’t believe you did it at home, and you didn’t have an epidural, and how did you do that?’ and just was blown away. Even the people from Medicaid whenever they called after to ask questions about the delivery, they’re like, ‘In which hospital did you have the baby?’ And I was like, ‘Oh, we had the baby at home.’ And they were like, ‘Okay, was it vaginal, was it C-Section?’ [laughs] I was like, ‘Well, it was a vaginal birth, we didn’t do the C-section on my coffee table’ [laughs]. They couldn’t even, I mean, they don’t wrap their head around because it’s normal.

Helen shared similar views in describing people’s reactions to the practice of home birth:

I think the majority of people think that you’re crazy or that you don’t really know what you’re doing or that it’s an out of the box thing to do because it really is. It is like under 1% of all births in America are home births. So, home birth is very weird to most people but yes, I guess that people’s reactions to me is the way it was because they’re like, ‘Oh, you’re so brave, I don’t think I could have done that.’

Becky, one of the two primparous women (who had her baby at home), admitted that earlier in her life when she had heard a story of a woman having a home birth, she thought:

Home births and people that have births at home are crazy [laughs] until I met my midwife and now I actually think...you don’t have to do the things that [our] culture teaches us that we need to do in order to have a good childbirth.

All of these responses speak to the overwhelming societal acceptance of the hospital as the place to give birth. Furthermore they suggest that it takes either a leap of faith or a very strong will to go against the grain and have a home birth.

Gloria pointed to the “stigma” that home birth carries, and compared it to the stigma associated with home schooling, stating that most people think of home birthers as those
“people that just want to rebel from society.” Faye, the other primiparous respondent, who had previously commented on the religious contexts of midwives, stated that most people that hear “home birth” think:

It’s something that very few people do, maybe like people that are really religious or like Christian Scientist or something, you know, people that don’t go to doctors for any reason.

Perhaps in this way these respondents are demonstrating how people can only accept such a strong deviation from a societal norm by referring to the people they associate with the behavior as extreme or deviant.

If the societal view of home birth is one of fear and danger, it is only more so when a woman has had a previous cesarean section. Two respondents gave specific details about comments they had received from acquaintances that knew they were planning a home birth after a prior cesarean. Debbie, who had two previous cesareans followed by two home births, spoke of a health care provider that she knew through her older son’s soccer team, who was very unsupportive of her decision to have a home birth and would share comments like:

‘You’re harming your baby. It’s crazy. I was talking with this world-renowned OB-GYN and he said that you’re harming your baby.’ [Debbie continued]: You know, when you get things like that, it’s really frustrating because you’re trying to tell them, ‘Look, I know. This is what my gut is telling me to do, I’ve done my own research and you think you’re using facts, but where are they really from?’ They’re kind of biased.

Ann, a 34-year-old mother of three whose first baby was delivered by cesarean due to a placenta previa (one of the true indications for a cesarean) described the treatment her husband, an emergency responder, received from an obstetrician when he was at work:

My husband was dropping someone off at a hospital once, and he was talking to an OB there and she went off on him for having a home birth, especially a VBAC, and I mean she was very strongly opinionated that that was not where you do a VBAC, at home, and how dangerous it was, and I think home birth in general she felt was dangerous and she was not afraid to express her opinion to anyone.

Clearly, these women believe that society views home birth as “dangerous” and many experienced friends or neighbors calling them “crazy” to even contemplate a home birth,
although some were hailed as “brave” by those who found them foolish to have had a home birth. As Helen stated, although the majority of people thought she was “crazy” for having a home birth, there was also a perception of bravery:

I guess that people’s reactions to me is that way it was because they’re like, ‘You’re so brave’ or ‘Good for you. I don’t think I could have done that.’

Again, there is a stark contrast between what the respondents viewed as society’s perceptions of home birth and their own realities of it as actually being the “safe” place to give birth.

Realities of Home Birth

Similarly to the shift that many respondents felt was occurring in society regarding the perception of midwives, a shift in home birth is beginning to occur, but mostly among those who have experienced a medicalized birth and are looking for an alternative. Eve, a 28-year-old married mother of three who had given birth, in order, at a hospital, at a birth center, and at home, stated:

When I heard home birth, I thought ‘very hippie’ [laughs]. I can’t say that when we got married or anything that it was something I would’ve ever wanted to do. It was really more kind of something we looked into as we began to learn more about what the current medical culture is, and then after that, what our options were here in [name of town] where we live.

As she reported, after her home birth, what comes to mind for her regarding home birth is:

A very relaxed environment. A very peaceful environment to give birth and really low stress because you don’t have to go anywhere, everybody comes to you.

Similarly, Becky stated:

Now when I hear home birth I think of a peaceful, loving awesome environment that I’d like to be part of. I’m seriously considering being a doula just so I can be a part of the birthing community and be present when other women have the experience I had or even better.

These descriptions are certainly in contrast to the standard societal perception of birth as painful, loud, intense and anxious. Gloria turned the fear concept upside down, stating that to her home birth meant:
Love, peace, comfort, security, safety. I can’t stress enough that it felt, like, I felt *fear* about going to the hospital, and I felt *safe* and comfortable and secure in my home.

Similarly, Faye summed her view of home birth in contrast to that in the hospital:

A natural experience that’s free of all the nonsense that can happen when you’re involved with hospitals, paperwork, um, all that sort of thing. A natural event.

Thus, many respondents contrasted their feelings of safety and security in their own homes to the societal view of hospitals as being the “safest” place to give birth, and viewed home birth as an extension of their natural, every-day lives, whereas, as Faye stated, hospitals brought stress especially from paper-work.

Three respondents, two of whom had previous cesareans, contrasted the sterility and sanitation at home versus the hospital. Ann stated:

If I hear somebody that’s going to have a home birth I’m happy for that because I know it’s a good thing, and I think that probably, in general, babies are safer, because hospitals are full of germs.

Debbie, who experienced the ultra-sterility of the operating room during her two cesareans, viewed the advantages of a home birth environment as being the opposite of her view of hospitals not as “full of germs” but rather too sterile:

Able to move around, and kind of relaxing, it’s kind of peaceful. Not that starched white, ultra-sanitary hospital kind of a thing.

Chris, who had only given birth at a birth center and at home, echoed this sentiment that hospitals were sterile, though perhaps this sterility was more in contrast to the comforts of home rather than the lack of germs:

Being in a really supportive, comfortable environment, and safe. Safe, it doesn’t feel sterile and scary.

Among the women who had previously agreed with the larger societal perceptions of home birth as something “crazy” or “dangerous”, Jessica, a 24-year-old respondent who had one hospital birth (induced) and one home birth stated:

I know what I thought when I first thought of home birth, I thought it was so old school, and definitely not the way to go. Not safe for either you or your baby,
that’s probably what I would originally think of home birth. Now, I just think of like power when I think of home birth, I think of like comfort, comfortableness, and easy, trance, like not a difficult transition, and I think, like, way to go! Whenever I hear about a home birth I think of like, that turns into strong, like in control. Empowerment.

These perceptions of home birth, both those that respondents felt were held by society as well as those they hold themselves, demonstrate that their decision to have a home birth with their last pregnancy was in contrast to what they believed society felt was the normal thing to do, in fact, at times it was in the context of what society viewed as dangerous. Several of the respondents stated that they “never thought [they’d] have a home birth” until they experienced first-hand the medicalized, de-personalized and disempowering environment of the typical hospital birth. Finding it incongruent with their beliefs of what was in the best interest of their family, they sought alternatives and found home birth and home birth midwives to better fit with their goals, and in so doing, became empowered. These concepts are addressed more directly in Chapter Seven, which describes respondent’s motivations for home birth, as well as their perceptions regarding the advantages and disadvantages of both home and hospital birth.

**Home Birth Satisfaction: The Birth Satisfaction Scale-Revised**

The Birth Satisfaction Scale-Revised (BSS-R) (Hollins-Martin and Martin 2014) was used in this study to objectively detail the extent to which respondents were satisfied with their home births. Full results are presented in Appendix Q. The BSS-R is not site-specific and has not been specifically validated for use in the home setting. However, the ten items can be collapsed into a composite score to elicit an overall sense of satisfaction. Composite scores can range from 10 (least satisfied) to 50 (completely satisfied). During BSS-R validation testing, the mean score among women who experienced “normal childbirth” was 29.19 (SD 5.86) and “non-normal childbirth” 26.51 (SD 5.13) (Hollins-Martin and Martin 2014). The range of scores among this study’s sample was 39-50 (mean: 44.44). Three standard deviations from the mean of the validation “normal childbirth” sample is 46.77; thus, while the numbers are somewhat
crude and the sample size of this study is small, it is quite clear that these women who experienced home birth expressed a very high degree of satisfaction with their births.

The key components of the Birth Satisfaction Scale relate to the perceived quality of care provided, women’s personal attributes and stress experienced during labor. It seems reasonable to conclude that the participants must have perceived their care quality to be superb, their own sense of control to be high, and their stress to be relatively low. It will be important to compare scores from this scale between women in Florida who had a home birth while on Medicaid with those who had a hospital birth while on Medicaid in order to gain more context for these high scores. Additionally, women who complete home births but received either private insurance or were self-pay could be used to compare to this sample of women who completed Medicaid-funded home births. For now, there seems to be no doubt that women are highly satisfied with their care, not only as evidenced by the score on this scale, but also by the report of all but one of the women interviewed who stated that she would only have a home birth again, unless there were extenuating medical circumstances.

**Perceptions of Medicaid**

When asked what most people imagine when they hear the word Medicaid, respondents unanimously used derogatory terms. “Poor” was the most frequently used term, and many associated Medicaid with poverty. Stigma was highly referenced and several respondents used the terms “welfare queen” “lazy” “ignorant” and “fat.” Becky described how she had probably lived up to what she felt was the societal perception of an average Medicaid recipient, but then dispelled the assumptions behind it:

> People think of Medicaid the same way they think of food stamps. They think of poor, fat, lazy people. It’s such a stigma. It’s so ridiculous. Even though for some of us it’s true - I was a poor, fat woman [laughs]. But you know what? I wasn’t uneducated. I have an MFA. And I wasn’t lazy. I was working my butt off, but I couldn’t find work.

Lauren stated simply that:
I think they think of lower income, needy families, poor, that type of thing. There’s a lot of judgment passed on it, I believe.

In Kate’s simple description, she perhaps unwittingly agreed with the “judgment” that is placed by simply adding the word “unfortunately”. In her words, when people hear the word “Medicaid” they think:

Uneducated, low income, poverty-stricken, unfortunately.

Only Faye, who was pregnant with her first baby when on Medicaid, and had a masters degree but worked only in the third trimester at a summer camp, suggested that the societal view of Medicaid might be split down political party lines, suggesting that:

Well, I guess that depends on your political leanings or something. I mean, some people would think that I mean, you know, that if you’re on Medicaid you’re not working, maybe you’re lazy or something.

Chris spoke to a common confusion in society about the difference between Medicare, which is for the elderly and disabled, and Medicaid, which is generally for low-income people that also fall into one of the eligibility categories discussed in Chapter One:

My husband always gets Medicaid confused with Medicare, and then he thinks they’re old people [laughs]. But, if you’re not getting the two confused, then I think that there’s definitely some stigma as far as being poor, being raggedy or dirty, or you know, missing teeth, or you know, being a welfare queen, that weird idea that doesn’t really make sense. So, I think a lot of people think ignorant and poor.

Several women mentioned a sense that people on Medicaid are “using the system” or “mooching” instead of working. Eve, a stay-at-home mom described how her family had to overcome the stigma associated with being on Medicaid:

There’s a lot of stigma with being with, using Medicaid, that we don’t have a job at all, versus, in our case choosing to have a job that, working for a company that just isn’t working for a Fortune 500, it’s a health mission, so we get a salary but we’re not financially rich [laughs]. Yeah, in fact our families are not happy that we’re on Medicaid because we’re taking the government hand out, but it works for us right now. I wanted to have that, to be able to stretch our finances further and as a result to take care of our family.
During her interview, midwife Tammy echoed that particularly among her “religious” clientele, taking a ‘government hand out’ was not in line with their lifestyle but they did accept Medicaid for pregnancy out of economic necessity:

We had a lot of Evangelical Christians who were married, and had lots and lots of kids, and probably would not have wanted to rely on government to pay for their health care, in general that wasn’t sort of their philosophy, but if they couldn’t afford the out-of-pocket costs, then they would go on Medicaid specifically to have the birth paid for, and then kind of be done with [Medicaid after that].

Similarly to how respondents turned the question of societal perceptions into their own experiences, Helen, a married 27-year-old who was self-employed as an interpreter for the deaf during the pregnancy, echoed this sentiment that making ends meet in today’s world does not always bring health coverage with it:

[People think of Medicaid and] probably think you’re poor, I would say [laughs]. It’s kind of like that terminology that people that don’t have a lot of money and stuff but I think in the economy that we have, most people kind of have to have it otherwise you wouldn’t have any kind of medical care.

Irene, a 21-year-old stay at home mom who was raising her first child while pregnant with her second which she had at home, addressed it in this way:

Most people would probably think, ‘Oh, well that’s for poor people.’ That is okay. It is true to an extent, but it’s only an extent [laughs].

Debbie suggested that perhaps the perceptions are out there because Medicaid recipients are not exactly advertising to their social networks that they are accessing this government assistance program, which could therefore put more of a known face to those who are operating under an assumption of who is on Medicaid. She said:

I’ve gotten into many, many debates with people that honestly think of somebody who is ignorant or using the system or just poor, I think, is what they think of when they hear Medicaid. Well, actually, a lot of people, like especially, you know, on Facebook, that there’s a lot of things that people think, ‘Oh, well. It’s the poor people and they’re pregnant and they’re trying to use the system.’ They don’t realize that there are a lot of people out there who aren’t saying, ‘Hey, I’m on Medicaid’ or ‘I’m on welfare’ or whatnot, because of their situation. They don’t know [that I’m on Medicaid] and they think that, ‘Oh, well, you’re going to agree with me’ [laughs].
This echoes a sense of entitlement that is commonly ascribed to Medicaid recipients, and demonstrated by Gloria, a 25-year-old mother of two who had attended one year of college and worked as a nanny while pregnant, who stated:

They think that they’re people who think they’re entitled, that they don’t have to work for whatever. I think like all the others think, like, ‘Oh, you can afford an iPhone but you still have to be on food stamps.’ It’s all the stuff where they think people are lazy, which is definitely not the case for me. I mean, I don’t have an iPhone, never have. We don’t pay for cable or anything. Yes, like, I mean people think that those who are on Medicaid are just lazy and taking advantage of the system or something. I just felt blessed that my husband works very, very hard and I work very hard at home with our kids too. I mean, I can’t think of anything that we are really lavish about or whatever. We’ve never been on vacation [laughs]. Literally, never taken a family vacation, we can’t afford to, so, just, yes, [these perceptions] are not true.

Jessica, a 24-year-old mother of two who worked part-time as a paralegal during her pregnancy, also echoed this sense that society views Medicaid recipients as “moochers” but she was the only respondent to differentiate between the various types of Medicaid, stating:

People think of poverty, government poverty, and moochers, hand-out programs. But there’s many facets to Medicaid, you know? Like there’s the pregnancy Medicaid which I think is a beautiful thing, it doesn’t last forever, it’s not permanent insurance, but it’s a coverage that I think is really good.

Interestingly, none of the respondents discussed Medicaid as a system of care until they discussed their own experiences as a Medicaid recipient. Instead, when asked how society views Medicaid, the responses revolved around how society views Medicaid recipients. In regards to the question of how society views Medicaid, none of the respondents discussed how difficult getting on Medicaid can be or how very few providers will accept it. Only Becky contrasted Medicaid to other forms of insurance by stating, “Medicaid only goes to people who make too little money to be able to afford real insurance.” None of the respondents contrasted how Medicare, also a ‘government hand out’ is provided to elderly and disabled Americans while Medicaid is a safety net system designed to support low-income families. Furthermore, none of the respondents discussed knowing that Medicaid provides insurance coverage for nearly 50% of births in the United States. Similar to how these women could not separate
midwifery from their own midwife, they internalized the question of how society views Medicaid based on their experience of what society views as a typical Medicaid recipient.

Realities of Medicaid

As noted above, many of the respondents felt they had to overcome the stigma of accepting a government hand out in order to enroll in pregnancy Medicaid, but did so because they felt it was a necessary strategy to get health coverage during pregnancy. Only one of the thirteen women interviewed, Marie, was already enrolled in Medicaid when she became pregnant, and in fact she was the only respondent who remained on Medicaid after the six weeks of post-partum coverage expired. While Chapter Eight will describe in detail the difficulties women faced with the Medicaid enrollment process, the following section discusses the way in which the participants experienced being on Medicaid from the perspective of this societal stigma, as well as how they compared Medicaid to other experiences with health insurance coverage.

The majority of respondents felt that having Medicaid coverage in pregnancy was a “blessing” or a “relief” and it provided “help when it’s needed.” As Irene put it:

For me, it’s just a great program that helps people to be healthier when they’re on hard times.

Kate, who had worked in her County’s Health Department as a peer breastfeeding educator and still faced challenges in getting enrolled in Medicaid, expressed that despite the hassles, she was relieved once she finally got coverage:

[Medicaid] is a blessing, as difficult as it is to deal with. Relief, once you can finally get it, you know that you’re taken care of.

This gratitude for coverage in a time of need was also expressed by Lauren, a 20-year-old mother of two who had transitioned off her parents insurance but was unable to get coverage on her husband’s policy because they had missed the open enrollment period. As she explained:

[Medicaid] was helpful when we needed it. It’s not something we need all of the time, just, you know, for our lack of insurance, and we couldn’t get covered and we needed it then.
Gloria, a 25-year-old mother of two who worked as a nanny during her pregnancy, referred to Medicaid as:

"A blessing, it’s almost like a lifeline. Really, what comes to mind when I think of Medicaid is ‘Thank God.’"

Jessica acknowledged that being on Medicaid can come with hassles, but that it also provided protection. Although Medicaid is a state-administered program and therefore when one makes contact with a Medicaid office one is actually dealing with a State agency, she referred to the challenges of dealing with the federal government in her description of Medicaid as:

"I think of Medicaid like an umbrella, protection. I still think of it like as a big hassle sometimes when you have to deal with them, calling the federal government and dealing with them, but most of all I think of Medicaid as you know, a blessing for someone in my situation.

Several respondents spoke beyond what Medicaid meant to them personally and discussed the larger implications of Medicaid as a health insurer, particularly in pregnancy. Chris, a 31-year-old mother of two whose first birth had been covered by the private insurance she had while working during her first pregnancy, responded to what comes to mind when she hears the word Medicaid by saying:

"Well, I don’t know. I think that we need a universal healthcare system. I’m like, ‘Wow, this actually works pretty well’ and maybe everybody should have something that works well.

This sentiment was also expressed by Eve, a 28-year-old mother of four, who had two home births after two cesareans, the second of which she had to pay the hospital up front to provide care:

"It’s definitely something that we had to swallow our pride to get into, but I do think of it more of as a help, I mean, there’s some things of course I would change on it, but it’s been very, very helpful. I don’t think that a lot of people realize that there are a lot of people - they only see the ones who are using the system and what they don’t see is that there are a lot of people who just kind of need that hand out during hard times. Right, and then it’s really pathetic that how, even if you have insurance, how it could, how insurance is just so, I think that we’re so backwards with our maternity care that it’s like Medicaid really does, I mean it covers so much, that a lot of regular insurance companies just won’t even cover"
and, I mean, people are paying out-of-pocket huge amounts for maternity. It’s like, this is where life starts, do we want to start it out wrong?

Finally, Becky, a single mom who had her first baby at home, expressed a keen understanding of how the Medicaid system works with her astute observation that:

What comes to my mind when I hear the word Medicaid is people who are working their butts off trying to make it. Getting it - well, and not even people, mothers, because you can’t get Medicaid pretty much unless you’re a mother. So these are mothers who are working their butts off, living paycheck to paycheck and trying to do the best they can for themselves and their babies. They need help. That’s what it is.

Thus, these women, many of whom were stay-at-home moms, but some of whom worked during this pregnancy, were grateful for pregnancy Medicaid coverage, often stating that Medicaid allowed them to focus on their pregnancies, not their finances, and helped to ensure a healthy pregnancy, as evidenced by their successful, low-risk, home births.

**Midwives’ Perceptions of Medicaid Clients**

Midwives were asked to describe both the demographics of their Medicaid clients, as well as to discuss ways in which their Medicaid clients differed from their non-Medicaid clients. Additionally, midwives were asked if they had any ideas about how their Medicaid clients might be different from Medicaid-funded women that pursue hospital birth. Those responses are included in Chapter Seven, which also reports the responses of the moms interviewed as to why they pursued home instead of hospital birth.

The majority (n=8) of the midwives described a “range” or a “wide variation” of demographic characteristics among their Medicaid clients, and even the remaining midwives who might not have used a descriptive term such as “spectrum” they described their Medicaid clients as being socio-demographically diverse. Vera discussed that this variation “differs county to county.” Two midwives specifically stated that the “overriding” characteristic of their Medicaid clients was that they were “low-income.” Some of this low-income status was attributed to their being unemployed. However, some midwives suggested that this status might have been a somewhat recent sign of the times, in that some of the Medicaid families might
have experienced a change in their normal economic status due to the economic downturn.

This resonates with how the women themselves responded that Medicaid was “there in a time of need”. Penny, one of the longest-practicing midwives interviewed and whose current practice is nearly 70% Medicaid, referred to this as:

> Typically, [my Medicaid clients] were women that had means [but had] fallen on harder times or [had] some family crisis that led them down that road.

Olga, a newer midwife with around 50% Medicaid clients, described this as:

> More and more people are qualifying for Medicaid, you know, just because of losing jobs and you know, the economic times.

She also described that among those that were working, they either ran their own small businesses or:

> If they do work, they have jobs like some type of retail or in the food industry, something like that, they’re typically in very low-paying jobs that don’t provide health care.

Tammy, who had experience practicing both in and out of Florida, echoed this by stating:

> I’d say, probably most of them were not employed, and those who were employed were not necessarily employed in full-time positions, they may have worked part-time here or there. I would kind of group them into two groups, the women who were from religious backgrounds, often their husband was the bread-winner, either employed full-time or running his own small business, for example, which is why they might not have had traditional health insurance. And the women that were not from these religious communities, I would say, most of them were not married, they were with a boyfriend, and the boyfriend kind of had the, you know, he might have worked at Walmart for a few months, and then might have worked at Pizza Hut for a while after that, so nothing steady or professional.

Five midwives specifically referred to the fact that “at least half” or “most” of their Medicaid clients were “stay-at-home moms.” Rose, who referred to herself as the “VBAC queen” and had about one-third of her clients on Medicaid, stated:

> Most of my moms are stay-at-home moms. Medicaid moms, all of them are unemployed. All of them are stay-at-home moms, which is probably how they get Medicaid. And their partners are employed.
Xenia, one of the newest midwives interviewed and whose clients were nearly 75% on Medicaid, was the only midwife who felt that instead most of her Medicaid moms were employed, but described the types of jobs they held as:

Waitresses, massage therapists, service industry type things.

Yvette, who also had experience working in a hospital, instead described mostly working, middle-class families:

A lot of them, especially with the husband’s companies, I mean, I did have some that were unmarried and lower socioeconomics, but not a lot. It was primarily middle class, self-employed or without insurance, and qualified for Medicaid because they did not have maternity coverage in any way. What sticks out with my clients is that they tend to be self-employed, and could not, um, they had medical insurance but wouldn’t have maternity benefits because it was just too expensive to have maternity benefits.

Additionally, the midwives’ perceptions of their clients’ marital/relationship status played into how they felt these women were able to qualify for Medicaid. Responses to their Medicaid clients’ marital status ranged from two midwives who said “primarily married,” to one who said, “married, definitely married,” to “just about everyone is married,” and on the other extreme to one who said “90% not married.”

Data from the Florida birth certificates suggests that the majority of women who had planned home birth while on Medicaid were married (67%), but these rates were lower than among women on private insurance (94%) and self-pay status (92%).

Four midwives described their Medicaid clients as “partnered, but not necessarily married.” Rose seemed hesitant to discuss this topic openly, but described that this “partnered” status is one way that perhaps Medicaid clients take advantage of the system:

I have some that you know, I don’t know how they do it, I don’t know how they get approved [for Medicaid], I don’t know. I shouldn’t say this. Are you going to tell anybody this story? Just simply because they are not married to their partner, and they ‘just don’t know where he is’, I guess. But, they do. It’s aggravating to me, though.

Ursula, who attends births in both a birth center and at home, described another way that she sometimes saw Medicaid clients perhaps taking advantage of the system:
The demographic obviously it goes without saying that the income is low. All of that isn’t always the case and we all hear horror stories within our community of, you know, Medicaid client Mrs. Jones, turning up for appointments in a Porsche. If fact, we recently learned that one of the birth centers in Orlando turns people in if they suspect that they’re claiming Medicaid falsely.

One midwife discussed a client whose male partner is a player in the NFL but who still applied for and got approved by Medicaid because she is not married. She discussed how she felt this was unfair, particularly because of the low Medicaid reimbursement rates. Specific quotes are withheld as they might inadvertently disclose either the midwife’s or the client’s identity.

Several midwives discussed how it upset them that they themselves were financially struggling, and yet their Medicaid clients could afford luxuries, like vacations, and described how this did not seem to make sense with their “low-income” Medicaid status. For instance, Xenia, who stated that she herself had been on Medicaid when she gave birth, admitted:

I kind of even get a little resentful of what’s happening there when I see they have like these elaborate homes and better cars and TV and cable and blah-blah-blah. I’m like, I’m feeling a little bit uncertain about that situation, and it didn’t affect me so much when I was a student, since it wasn’t a part of my income but I still - I felt I could see what it was like, the burden it was on the midwife because she was taking on so many clients to try to make ends meet. But in general, I would say [the Medicaid moms live in] average homes, average to me, I mean I live in a teeny tiny little - my children share a room and we have one bathroom.

Susan, one of the most experienced midwives and who had also practiced outside of Florida in the past, described her Medicaid clients as “a lot of them are partnered, not necessarily married but partnered in some shape or form,” and admitted she was not sure what factored into the Medicaid approval process when she described what types of residential structures Medicaid clients maintained:

Their housing would be, some of them would own homes, and I don’t know if that’s like, in violation of anything [laughs], and some of them would be renting.

Quincy, another relatively new midwife who said about 70% of her clients were on Medicaid, questioned how some Medicaid clients were able to qualify:
I get [Medicaid clients] all the way from poverty level to high-end level, which that’s what I’m trying to figure out, how do the high-end women get Medicaid? And they just say, ‘I don’t have insurance. I just need it to cover pregnancy and that’s it.’ And that’s all they get. And they get approved. They can make a bunch of money and they still get approved. So, that’s what I don’t understand how some people don’t get approved and they’re at the poverty level, and then these women that have jobs and like make $100,000 a year and it’s reported on the W2 and they still get Medicaid.

Penny seemed to think these women qualified based on their family size, as eligibility does depend on household size. She began to describe the parity status of her clients, and went on to share that her Medicaid clients:

They would also tend to have several children, I should have put that in there, I mean, they weren’t very often first time mothers, but they were also highly likely to have had more than you know, a few, like two to, four, let’s say three to six [children]. I mean, that’s not what you’re asking me now, but I’ll just throw it in there, that really increases your likelihood of the eligibility, too, because of the numbers of family members, so that would be why some of the women that would receive the Medicaid. You would look at them and wonder, ‘How did you get Medicaid?’ And it was because of the family number more so than income issues, because there’s some women that you would, you know, think, and they also in turn would say, ‘I don’t think I’m going to get it, I don’t think I’m eligible’, and then they’d come back, ‘I got it!’ You know, so it was interesting that that was the dynamic for the women, for the home birth Medicaid population. That sometimes they were borderline or didn’t think they’d get it, but the number of kids would make it more likely that they would get through.

Data from Florida birth certificates, however, did not indicate any major difference in parity among women who had planned home birth when comparing their payment status. Twenty-two percent of all planned home birth was to nulliparous women, with 24% of Medicaid women, 23% private and 21% self-pay. The vast majority (65%) of women having home births had 1-3 prior births, and again, little difference was found by payment status (Medicaid 64%, private 67%, self-pay 67%). Those of higher parity (>3 previous births) represented 12.5% of planned home births, and again, little difference was found by payment status (Medicaid 12%, private 10%, self-pay 13%).

When it came to describing the race and/or ethnicity of their clients, again midwives reported a range that likely varied based on their location within Florida. Tammy, in South Florida, described her mix as: “maybe 60 to 70% were White, non-Hispanic White, and I would
say the remaining were African-Americans or Haitians.” The other midwife practicing in South Florida reported:

My population is Hispanic, and also African-American, and Caribbean, and also Haitian, so I’ve got a nice little mix there, it’s pretty spread out.

Ursula and Vera, who both practice in greater Tampa Bay, noted that one of their only clients who was African-American wanted a birth center birth but had a home birth because she had a previous cesarean, referring to the Florida statute that allows vaginal births after cesarean (VBAC) at home, but not in birth centers, as will be discussed in a later chapter. Otherwise, their clients were nearly all White. Among all planned home births in Florida, 77% were to White, non-Hispanic women, 5% to Black, non-Hispanic, 13% to Hispanic or Haitian, and 4% Other. These rates were similar for private and self-pay women (with slightly higher rates of WNH), but among Medicaid recipients, only 70% were WNH, 8% were BNH, 17% were Hispanic or Haitian and 5% other. Chapter Four presents more stratified analyses of the effect of race and payer source on planned home birth rates, as well as age and educational status.

Rose, also in greater Tampa Bay, described how African-American clients were more likely to take advantage of her providing prenatal care to them at home, but then not actually having a home birth:

The majority of my clients and, I don’t know why, always are, um, Caucasian. I could, I mean, that is a good point that I could talk to you about, if you want me to talk to you about it. I find that young, African-American women, they call me, and they love the fact that I’m coming into their home to take care of them, and then when it’s time for their births, they head to the emergency room when they go into labor and the only way that I know that it’s happened is the hospital calls me for the records. So, here’s this woman that I’ve taken care of and made a pittance, because you know the only money that you make is for the birth, and I don’t even, you know, and they never call me [for the birth], I’ve had about 5 of those.

Rose was the only midwife who seemed to describe clients that “took advantage” of her providing home visits but then would go to the hospital to give birth, although Quincy also described how some clients had sought her care because she would make home prenatal visits, and while these clients were up front with her about ultimately wanting a hospital birth, some of
them decided to have a home birth with her anyway, because, in her opinion, these women learned that home birth would be much easier and less stressful.

As far as the ages of their Medicaid clients, while there was again a range, most of the midwives described that the women were either older, by nature of the fact that they had already had several children, or that they were younger, and “un-established” in life. Five made a statement such as, ‘I’ve had everything from 15-year-olds to 45-year-olds.” Three stated that the median age was ‘20s to 30s.’ Rose described that her moms tended to be “younger” and that this was related to the fact that her Medicaid clients did not seem to have “established themselves” as adults, which she seems to primarily relate to whether they have standard insurance, as opposed to relying on Medicaid:

I’d say most of them are younger, I’d say 25 and younger, ‘cuz people that are over 25, most of them have established life, not really 25, maybe 30, established life and have, you know, insurance.

Beyond describing their perceptions of their Medicaid’s clients’ demographics, eleven of the midwives were also asked how their Medicaid home birth clients differed from their non-Medicaid clients. Yvette denied that there were any differences, and she stated:

I would have to say no. I always had really, really great people that I worked with and I still keep in touch with a good portion of them. It just didn’t matter to me what their payment source was.

Penny similarly found that there were few differences, other than that Medicaid clients tended to have larger family sizes, which in fact is what she attributed to them qualifying for Medicaid to begin with.

Among the other nine midwives interviewed, the most common response to how their Medicaid clients differed from non-Medicaid clients was that their Medicaid clients had a lower nutritional status, stated by six of the midwives. Olga, who was relatively new to midwifery in Florida but had worked in the capacity of another type of health care provider in the past, described it as:
Poor nutrition, definitely, living on bologna sandwiches and Kool-Aid, so, you know, you see dental problems.

Nancy, in practice for over ten years, described client's decreased nutritional status as being directly related to the Medicaid client’s lower financial means, and, similar to the comment of Olga, also tied this into an overall lack of preventive care:

[The Medicaid clients] tend to overall have less, or more limited, financial resources for things like nutrition, supplementation, you know, transportation, um, alternative care... For all pregnant women, but particularly for Medicaid women, they don’t have preventative care in place. Their care with us is the only primary care that they are getting. So as midwives, we make sure we are doing a really thorough head to tail [sic] exam, even if we find an issue [that] we cannot diagnose or treat. Just the routine, eye exams and dental care, and all of the preventative health cares are significantly lacking.

Rose linked her Medicaid clients’ decreased nutritional status to other government assistance programs, notably food stamps and WIC. Whereas some of the women interviewed discussed how these programs allowed them to stretch their food dollars further and therefore buy better quality foods, Rose felt WIC in particular encouraged women to eat poorly:

Most of them, if they’re on Medicaid, most of the time, they’re getting food stamps as well, and WIC. WIC is like so horrible, to me. Here, eat a pound of cheese, and drink some sugary apple juice, yeah. Milk. And that, you know, milk. We should not drink milk. Cows don’t drink our milk.

One of the Medicaid moms interviewed, however, did note that she did not use her WIC vouchers because they did not allow her to buy the organic milk and eggs she would normally feed her family.

Tammy also suggested that the Medicaid clients had lowered nutritional status, but attributed it to their lower income status:

Diet was sort of different, because a lot of these women who were lower income didn’t have the income to buy the sorts of foods that I associated with more of a traditional midwifery clients who might have been buying food at the organic food co-op, and, you know, make their own yogurt and that kind of stuff.

Pointing also to how the “traditional midwifery client” makes lifestyle choices that would support better nutrition, Xenia stated that the nutritional status was the same among all of her home birth clients:
Interestingly enough, in general I find that people choosing a home birth often have very well thought out and intentional nutritional goals and ideas, as well as they’re usually self-educators and self-thinkers. I think that seems to be common among all the families at my practice, they all have one diet, one way or the other. They’ll either be a vegan or paleo, but they’re really thoughtful about it and very well planned.

The difference that Xenia found between her Medicaid and non-Medicaid clients (who were all self-pay because she had not established any contracts with commercial insurers) related to the types of stressors that the Medicaid clients faced:

In general, my Medicaid clients are struggling financially, so then they’re higher stress. They have more things to sort of balance and figure out. Whereas my self-pay clients think they have a lot to balance and figure out, but when I’m looking at the lives of them, they’re well supported. The things that they have to figure out, are like, they’re so worried about their baby showers and their invitations that match and things. Whereas my Medicaid clients will be like - not all, but I have, I’m thinking of one in particular, they don’t have a car so they have to figure out how to get both of them to work when she’s still going to work until this time. Her boss is putting a pressure on them for this reason, and they moved down here from out-of-state so they’re not connected to their normal family support system and they just – they’ve got hard things to figure out. They wanted to move because they felt that this house was good for them…but I have these other [self-pay] families over here that are like – they’re usually very well-supported by their partners. It’s almost like they just have more time to think about these things, they have more time to think about less consequential things and then so they do think about these things more. The self-pay clients that I have more time with their lives to think about things like their baby shower.

Both Olga and Quincy stated that their Medicaid clients were more likely to be anemic, with Olga stating: “in some cases even requiring blood transfusions.” Olga also stated that all of the clients she had ever had that developed pre-eclampsia were Medicaid clients, which she tied back to their nutritional status, “it’s considered to be nutritionally caused, I mean, I don’t know exactly why, but it definitely seems to be a link between poor nutrition causing pre-eclampsia.”

Only Susan discussed that although most of home birth clients breastfed, her Medicaid clients were less likely to maintain breastfeeding over time:

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29 In reality, there is no known direct cause for pre-eclampsia, although several risk factors, such as poor nutrition, have been suggested. Increasing evidence points to a link between the father of the baby and pre-eclampsia, possibly related to the paternal genetic contribution to the trophoblast (and ultimately placental) development.
If you were gonna look at home birth clients that were not Medicaid and those with Medicaid, I think there might not be the same consciousness in terms of nourishment, how they are eating and stuff like that. And, less breastfeeding, less amount of time, of breastfeeding. I think that’s one of the biggest things I’ve probably seen and I’m not sure why. But they tend to not, not breastfeed maybe longer than two or three months, and then they start, you know, introducing the bottle sooner, and then eventually you know that they’re finished, it’s mostly the bottle.

Similar to how Rose described that her Medicaid clients just “didn’t have life established,” Quincy described how her Medicaid clients required more attention from her especially in linking them with additional services:

Their life’s not together, they’re, I have seen homeless people that are pregnant, battered women in their women’s shelters because of, men who have abused them, so, I have to do a lot of work with them, and of course, I think I do more work with the Medicaid clients than I do with the private pay. Because the private pays come in, they’re educated, they know what they’re doing, they want it so badly, they know exactly what they need to do to get themselves the way they need to do it, but the ones on Medicaid they don’t even know that I do home births, they don’t even know that I can do nutritional counseling, they don’t even know I can do general counseling, and I have to work with them, I’ve got abused women, sexually abused women, drug abuse women, it’s like I have to really work with these moms and send them to clinics, send them to perinatologists, things like that, I have to do extra stuff for them.

Two midwives stated that the only home birth clients that they’d ever had that smoked cigarettes were Medicaid clients, although Xenia stated that the only smoker she’d ever had was “an extraordinarily affluent couple, but they are self-pay clients.”

Two midwives described how their Medicaid clients differed from others in their “sense of entitlement.” Rose prefaced her response with: “It’s not a good thing” and then described what this entitlement was like:

Most of them have a sense of entitlement. You know what I’m saying. A lot of my Medicaid, not all of them, I’d say about half of them, are more demanding of me, and my time, and my answering the phone at 8 o’clock [to ask], ‘What should I do for a headache?’ you know, than my moms that are paying me $4,000 in cash [don’t do that], it’s a sense of entitlement.

Ursula echoed this by saying:

They don’t appreciate what is, sometimes, the care that is given to them. Sometimes they [do]. There’s a lot of times [they do], but there are some that do not appreciate, it’s just expected. ‘I’m on Medicaid’, that I’m expected…
there’s not appreciation. There’s not respect. They’re not paying for anything, so they don’t value it as much as someone who’s actually paying out or pocket or paying insurance premiums because they’re getting what they’re entitled to.

However, Vera, who works in conjunction with Ursula, found that Medicaid clients had overall lower expectations related to their care:

I would say that the education level, really, I didn’t – I would say that they’re not quite so inhibited. Not as well educated, people who kind of...so low educated that they just take, they just like breeze along, and it seems like nothing’s a problem and they have an easy pregnancy because they’re not expecting A, B, C, D, and E to go wrong with them, you know, whereas some people who know too much, who are highly intelligent, highly educated, read everything to Kingdom come and then think, ‘Ooh, I’ve got this, I’ve got that, I’ve got the other’ and they don’t have such a cool pregnancy.

Olga echoed this sense that Medicaid clients came into care with lower expectations, but not because of their not being as actively involved, but rather based on their prior experiences as Medicaid recipients:

I would say that I don’t think their expectations are quite as high, you know...I think if they’ve been in other health care facilities as a Medicaid patient they probably haven’t been treated very well, so, I don’t think their expectations are quite as high, although we treat everybody the same.

She continued, by describing how lower educational attainment might also contribute to both the Medicaid client’s lower expectations as well as to simple misinformation regarding health issues, which in turn, similar to how Quincy stated, require more effort and time on her part. Olga stated:

[Medicaid clients] probably [have] less education, I would say, [they’re] usually on the younger end, you know they’re starting a family a little earlier than the two professionals who are in their mid-30s, who you know, planned their pregnancy out very carefully...Also, [Medicaid clients have] more sexually transmitted infections and a lot of miseducation on what that is, like I might call up a mom and tell her that she has Chlamydia and she’ll say, ‘Oh no ma’am that’s a false positive, I had that in my last pregnancy too’, so you know she just doesn’t really understand what it is and so I have to give a lot more education.

Clearly, an entire dissertation could be devoted to the perceived and actual characteristics of pregnant Medicaid clients, regardless of their chosen birth setting, and these comments represent just a small sample of these midwives’ experiences.
Discussion

The perception among the Medicaid women interviewed is that society views midwifery as not only archaic, but also as a type of care that is relegated to people who live on the margins of society. This is interesting given midwifery's history, particularly in the U.S. South, including Florida, where midwives were traditionally maintained within the health care “system” but only for poor, primarily Black and rural, women. These midwives were phased out once payment mechanisms (primarily through Medicaid after 1965) were secured that ensured OBs would receive reimbursement when caring for these low-income women. It is clear from these interviews that the current perception of midwives is that of women who are not modern and provide somewhat backwards care, and that an extension of this perception is a persistent societal assumption regarding who “should” receive midwifery care, notably those women who live on the margins, are impoverished, or otherwise cast away from mainstream, modern medicine.

Among these “fringe” groups are religious communities who are viewed as rejecting mainstream society, including two west central Florida communities. One religious community in Sarasota has experienced several untoward birth outcomes and has been involved in legal and criminal proceedings against community members who attended births for each other but who were not licensed to practice midwifery in Florida (Cormier 2008). The second is the large community of Scientologists, mostly in Clearwater and its surrounding communities, which is very distrustful of medical providers and has been known to utilize home birth midwives, including one who participated in this dissertation research. Perhaps the notoriety of legal proceedings within these communities contributes to this perception of midwifery, or perhaps the larger, more national, religious communities of Amish, Plain, or other traditional groups have led to this perception.

On the other end of the perception are the “hippy midwives.” Indeed, it was “hippy midwives” such as Ina May Gaskin of The Farm that gave birth to the resurgence of natural birth
and midwifery in the 1970s. But no new cultural model of midwifery had truly emerged in the U.S. until the 2008 documentary *The Business of Being Born* (Epstein 2008), which seems to have sparked a midwifery and natural birth resurgence. Nearly forty years of “modern” midwifery in the U.S. appear to have been invisible until a “contemporary” documentary reached the masses. Perhaps this allowed the cultural image of the midwife to persist as an herb-using, hippy woman with long hair and flowing skirts who was separated from mainstream society.

Another interesting finding to emerge from these interviews is the link that was associated between “midwife” and “home birth” despite the fact that there are several types of midwives in the U.S., as discussed in Chapter One. The largest group, Certified Nurse-Midwives, primarily (up to 99%) attend births in hospitals (see also Table 1.1, Maternity Provider Types). Furthermore, it is interesting to note that in this portion of the interviews, when asking about societal views of midwives, no respondents mentioned the different types of midwives. This is particularly interesting considering that half of the respondents were not able to identify which type of midwife had attended their home birth. Also, no respondents discussed that perhaps there were different perceptions of the different types of midwives. However, the idea that “not all midwives are really midwives” came up several times in regards to those participants who described some hospital CNMs as “medwives” more than “midwives.” Both of these concepts perhaps represent an opportunity for midwives to promote a more accurate branding of midwifery not only to potential clients, but, as some of the midwives will discuss later in relation to issues they had in dealing with state agencies such as Medicaid, to legislators, regulators, and even insurance companies. If obstetricians are eager to maintain dominance over maternity care in the U.S., they will have to address the fact that while it might be easy to ‘divide and conquer’ midwives by type in order to ensure that none gains too much strength, many consumers are not able to accurately delineate between midwifery types anyway. Therefore, while obstetricians have at times acknowledged the expertise of CNMs, their
attempts to alienate non-CNMs may in turn backfire if women see obstetricians as attacking midwives in general.

Clearly, according to these respondent mothers, “midwives” and “home birth” are concepts that are outside of the typical American childbirth narrative. However, for the various reasons that will be described throughout the remainder of this dissertation, these women chose to go against the societal norm and entrust their pregnancies, labors, and births to home birth midwives. Many of the respondents themselves had harbored views of home birth as “crazy” or “unsafe” and of midwives as “archaic” and “outdated” prior to their awareness of the current, modern practice of midwives. Furthermore, for various reasons, primarily financial and a lack of other health insurance coverage during pregnancy, these women chose to stand up against societal views of Medicaid recipients as “moochers” and “welfare queens” and enroll in Medicaid. It would be interesting to assess among the general population the knowledge of the hassles of enrolling in and maintaining Medicaid coverage as well as the usual hassles of locating providers willing to accept Medicaid, particularly in contrast to the views that Medicaid recipients are “lazy.” Despite these factors, most of these respondents found that Medicaid offered a more comprehensive coverage than traditional, commercial insurance, and several wished that “all women had access to coverage this good.”

At times the midwives caring for these Medicaid recipients could not help but harbor some of the perceived societal attitudes towards these women as “moochers.” Several discussed viewing them as demonstrating a “sense of entitlement” that they did not find among their self-pay or commercially insured clients. The following chapters will detail more closely the experiences of interacting with the Medicaid system by both the Medicaid recipients and the midwives. They will also describe these mother’s decisions to choose home birth and the ways in which their home birth experiences empowered them.
CHAPTER 6: THE MEDICAID EXPERIENCE

For the women participating in this study, one of the most challenging parts of being a Medicaid recipient was the application process. This is discussed in detail in Chapter Eight, along with other aspects related to access to Medicaid and to care. Chapter Eight also addresses participants’ and midwives’ perceptions about the services to which Medicaid either increased or decreased access during the pregnancy. This chapter, therefore, will present results related to women’s overall experiences with Medicaid, including both the best and worst parts and how having Medicaid impacted having a home birth. Perceptions and realities of the stigma associated with being on Medicaid were addressed in the previous chapter. This chapter will more fully address the midwives’ experiences of being a Medicaid provider, including their own challenges with applying. It also addresses both the advantages and challenges of being a Medicaid provider and reasons why some midwives may choose not to be providers or to limit the number of Medicaid clients they will accept into their practices.

The Medicaid Experience: Pregnant Recipients

By far, as expressed by eleven of the thirteen respondents who had received Medicaid coverage during their recent pregnancies and home birth, the best part of having Medicaid was that there were “no co-pays” and that “everything was covered.” To many, this contributed to “not having to worry” during the pregnancy and a sense of the “ease of it all.” Many of the participants’ responses were quite similar, but are presented here in order to give the full range of their descriptions. Gloria stated that best part of Medicaid was simply, “Free. The word ‘free.’ That pretty much covers it, like, it was free.”

Faye also expressed how the lack of out-of-pocket expenses eased her worries:

Well, it was a load off my mind, to know that I was going to have some help in paying for everything. Yeah, I mean it was very - it was great that I was able to get some help to pay for it. I don't know what else to say about it.
Similarly, Irene described how knowing that the expenses were covered eased her worries:

> The fact that we didn’t have to worry about how we were going to pay for the birth and seeing that everything was going to be taken care of [was the best part of being on Medicaid].

Eve also appreciated that everything was covered, but furthermore enjoyed the simplicity of the plan:

> To know that everything – whatever needed to be done – was covered. And, that it was a pretty simple plan – insurance plan to have – to not have to worry about the finances and who pays for this and who pays for that, whereas, it definitely helped us.

Chris also enjoyed not having to worry about the expenses of a pregnancy, and was also relieved that having Medicaid didn’t preclude her from having a choice in her care provider:

> I think [the best part of having Medicaid] was not having to worry, knowing that we could get covered, that we could go and have prenatal care and childbirth. And knowing that I could do it the way I wanted to do it was actually really amazing because I was afraid, ‘Oh, you’re on Medicaid’, I’m going to be required only to see their in-network, crappy Medicaid doctors and have to go to the hospital. So I had a lot of trepidation going into it, but being able to choose who I wanted to see and choose the way I wanted to birth, and knowing that it was covered was actually quite refreshing.

For Debbie, particularly in the case of home birth, she also felt relief in knowing that if she had to transfer to a hospital that that expense would be covered as well. Given that she was still paying off the debt to the hospital she and her husband had incurred during their second pregnancy, delivered via a repeat cesarean section, the fact that Medicaid would cover hospital expenses, if needed, were an additional source of relief:

> The best part about having Medicaid was that we didn’t have to worry about like the expenses, like the one thing that I did love about home birth is that it is so much cheaper to do everything. I didn’t want to be like, ‘Oh, well, you know, Medicaid’s paying for everything, they will take care of everything,’ but it was in case of any situation of an emergency or transferring care, or if we – the ultrasounds, or any lab work, or anything that had to do, it was kind of like peace of mind, we didn’t have to worry about like what we did with baby number two, well, can we afford it? You know type of thing, we’re kind of still struggling after my husband had lost his job and we’re still in recovery from that. So it was that peace of mind, I guess, of knowing, ‘Hey, it’s going to be covered.’
This coverage no doubt brought significant relief with both her third and fourth pregnancies, which were both home births attended by a Licensed Midwife. Debbie described in detail the process she had gone through to pay for her second birth, a repeat cesarean, including how she had to decide what prenatal tests to have done based on their costs more than their true clinical indications. She had already stated that she did not know that home birth was an option for a vaginal birth after cesarean (VBAC) so she was not pursuing that. She had applied for Medicaid but the family’s income was too high to qualify. She described how they paid for the second birth:

We actually had a really good OB and he was more than willing to do the VBAC, but the hospital wouldn’t cover – wouldn’t allow it. He worked with us; we had to do like a little bit of a monthly plan and then there was like five months, four, something like that, we had to have like the full amount turned in [to him for his services], which we did with our income tax return, and then we had - the hospital basically said, ‘Okay, you can either pay $30,000.00 for your C-section afterwards, or you can pay…’ I think it was something like $7,000.00 or $8,000.00 upfront. So we basically had to take out a loan, which I totally regret doing that. We had to take out a loan and are still paying for it like five years later [laughs] for the birth, so we didn’t have to pay $30,000.00. They were not willing to – they would be willing to work with us, but it would be based on we owe them $30,000.00, not $8,000.00, and that was really frustrating. You’re kind of stuck in-between. We weren’t like, ‘Oh, we have lots of money.’ No insurances were going to cover us, because of the preexisting condition [the cesarean section], and then Medicaid, we made too much for it. So it was just kind of very, very frustrating on that, and we had to pay the anesthesiologist upfront and I mean everything, we had to pay cash, but we really were ‘what’s necessary and what’s not’, and our OB had a word with us and said like, ‘You don’t have to have this test, but you could,’ however we feel about it and he wasn’t very pushy like, ‘Well, our center requires you do this or that’ kind of thing. So he was very good on that.

This example poignantly describes the stressors associated with financing prenatal and birth care, particularly when a family has “fallen on harder times” and in fact speaks to the need for universal coverage for all pregnant women.

Only Helen acknowledged that while it was a relief to know that she would not be responsible for any out-of-pocket expenses, her midwife might actually be at a disadvantage by accepting Medicaid patients:
I would say [the best part of Medicaid was] not having to pay anything out of pocket, like having that means of knowing they were going to cover it, you know, I just wish that...I know of course, for the midwife it doesn’t cover her full fee, which I felt bad for her, but we loved our midwife and we felt like they deserve every penny that they earn, and so it was a downfall for her, that she didn’t get the whole fee. For us it was good because I didn’t have to pay any money. I didn’t have to – nothing out-of-pocket for any lab tests or anything like that. That was so nice.

Particularly among the respondents who had experience with commercial insurance, either in this pregnancy as a secondary insurance or from previous coverage, the sense that there were no out-of-pocket expenses particularly contributed to their sense of not having to worry. Lauren, who had not experienced any problems with the Medicaid enrollment process, and whose first pregnancy was covered under her mother’s commercial insurance, stated:

Not being stressed about the financial aspect of it, and not having to worry about the co-pays, the deductibles. It definitely helped a lot because, if not, you know, we were planning to pay out of our pocket, which would have been stressful.

Jessica also discussed the ease of Medicaid, particularly in comparison to previous experience with a commercial insurance plan:

It’s the ease of it, I guess, you know, the fact that it covers everything. I didn’t have to deal with a co-pay. I did not have to deal with calling the insurance company, which I had to do with my first, delivery of my son. It was just so much easier, you present the [Medicaid] gold card and the office just takes care of it so, I just like the ease of it.

Ann, whose primary insurance coverage during this pregnancy was her husband’s commercial insurance plan through his job, while Medicaid acted as a secondary coverage that therefore ‘picked up’ any co-pays or deductibles, also stated that the best part of Medicaid was:

Not having any co-pays. Everything being covered. Like I said, with our insurance, the deductibles and the co-pays were, I mean, thousands of dollars, which you know we’re very blessed, my husband is [an emergency responder], so, you know, we are very blessed that he has that job, and we are on a budget but we make it work, but to come up with thousands of dollars isn’t, not that it’s impossible, but it’s not the easiest thing to do.

Similarly, Kate, who had been covered on share-of-cost Medicaid (which requires enrollees to meet a high monthly deductible, up to thousands of dollars, before Medicaid will “kick in”; see also Table 1.5 detailing the types of Medicaid in Florida) prior to pregnancy and
had previously had a pregnancy covered by commercial insurance, described how this lack of worry for the out-of-pocket expenses contributed to her actually going to the doctor to address health concerns. For her, this was particularly important because she experienced such severe nausea and vomiting in two of her pregnancies that she had to present to the emergency room. However, at least in her most recent pregnancy, because her Medicaid was not fully activated until she was fourteen weeks pregnant, i.e., out of the first trimester when nausea and vomiting is generally the most worrisome, she did not truly benefit from coverage when she needed it most, though did feel reassured that once Medicaid was fully activated, the coverage would retroactively pay for expenses incurred. She described the best part of Medicaid as:

There’s no copays or anything like that. So it was, ‘Okay, well I’m really sick. Okay. We need to go to the emergency room,’ which knowing that I’m covered 100%, it’s nice, because $30.00 copays here and there add up, too. So you’ve met your deductible and when you are spending twice the deductible in copays, so – and generally [Medicaid is] good insurance, and some of the better insurance that you can get. You know, it’s a blessing to have, especially when there’s nothing else there and there is a true emergency…So, knowing that it’s full coverage and that you’re okay, not holding off going to the doctor because you can’t afford a $30.00 deductible is nice to know that you have that benefit.

In addition, two of the respondents felt that the best part of Medicaid was the fact that it covered their midwife. As Becky said:

The best part of having Medicaid for my prenatal care and birth was that [name of her midwife] accepted Medicaid [laughs].

She elaborated on why this was the case, as it related to her ability to access care at all. Considering that she self-described as an obese woman who would have likely had a cesarean delivery without the prenatal care she received from her midwife, the access to midwifery care under Medicaid was key to her having a successful healthy pregnancy and delivery:

I mean if I didn’t have [midwife’s name], I wouldn’t have any prenatal care until December, until two months before I had my baby, and that would have been, the birth would have been an emergency. Because, at that point, you’re already in your third trimester and you start your relation with the doctor at that point and if you’re obese that would be terrible. That would have been horrific [Laughs].
Marie also referred to the best part of Medicaid as allowing her to receive care from a midwife, which granted her additional benefits that she did not feel she would have received from a traditional obstetrical practice:

[The best part about Medicaid was] I could go to a midwife. And by going to a midwife, she gives you, you know, everything. She’ll give you the prenatal pills and iron pills and stuff like that, you don’t have to pay for it. But if you go to like the doctor in a hospital or something, if you have Medicaid, you have to take it to the pharmacy and wait for it. But, if you go to the midwife, she’ll give them to you there.

However, as noted by midwives Ursula and Vera, one of the disadvantages to their practice as Licensed Midwives in Florida is their inability to write prescriptions for things such as prenatal vitamins, and therefore, they keep a supply that they can either sell or if patients have no resources, give away, particularly to Medicaid clients, though this is at a loss. This is described in more detail in Chapter Eight.

After respondents were asked to describe the best and worst parts of having Medicaid, as well as the ways that Medicaid increased or decreased their access to other services, they were asked specifically if there was anything related to Medicaid that made their home births difficult or that had made them great. Similar to the participants’ beliefs about the best part of Medicaid, eight of the ten participants specifically asked this question stated that the way that Medicaid had made their home birth great was simply “not having to worry about the finances.” Among the other two respondents, Faye simply stated, “No, I don’t think I can [think about anything that was specific to having Medicaid that made this home birth great], sorry.” Ann, who had previously said that the lack of co-pays was the best part of Medicaid, said that in addition having Medicaid made this home birth great because it ultimately reduced the need for her to stay on top of the paperwork:

We didn’t have to deal with any of the insurance, it was just all taken care of by the midwife.

Women were asked about the worst parts of being on Medicaid. While the previous chapter described the experience these women had with being stigmatized, which participants
discussed when asked about how they felt society perceived Medicaid recipients, only one respondent, Chris, discussed stigma when describing the “worst” parts of being on Medicaid:

The stigma, the stigma that goes with it. And even though the birth center and the office that I went to for my prenatal care, they’re great, you know, they never treated me any differently, I still felt like, you know, maybe like I’m some kind of moocher or, you know, that maybe – I don’t know. And again, with being talked down to in the pamphlets and the literature [provided by MomCare and the Medicaid office] kind of stuff, it made me feel like, you know, ‘here you are, just some poor white trash’ [laughs] I guess. And you know, I have my Master’s degree and my husband and I are both very well-educated and we just ended up – we had no insurance, it was bad timing.

Only two respondents primarily stated that there was not a “worst” part of being on Medicaid, though both couched that within a “but” type statement. For Lauren, this lack of “worst” on Medicaid derived because she was able to see her midwife, perhaps if she had not had that access she would have felt that the worst part of Medicaid was not being able to see her midwife:

For me, personally, I don’t think there was [a worst part of being on Medicaid] because my provider took it, I think maybe without that I would have it stressed about finding a provider that took it but since mine did, it didn’t really have an effect on me.

Eve was also glad that she had the access to, and the choice of, her midwife, which she contrasted to her lack of choice in picking her child’s pediatrician:

Not so much that – I mean for my kids being on Medicaid, we can’t choose the pediatrician that we prefer to use – but as far as being pregnant on Medicaid, it wasn’t an issue at all.

Helen admitted that the worst part of Medicaid was the fact that her midwives did not receive the full fee she would have from other payer sources.

Marie discussed a similar problem, though it related more to the fact that she was inadvertently switched to a Medicaid HMO that resulted in difficulties for her midwife getting reimbursed (as is also described in more detail in Chapter Eight). This is interesting because Marie was the one respondent who had been on “straight” or “full” Medicaid prior to getting pregnant, and without her knowledge was switched to a Medicaid HMO in pregnancy:
The worst part of it is, ‘cuz like when I had my son [the recent home birth], it’s like, I had went onto an HMO, instead of having straight [pregnancy] Medicaid. [Medicaid] was telling [the midwife] like, she had a problem. Like she had this before, like with the HMOs, like she don’t accept Medicaid [HMOs] and we was having a problem with that, like she wasn’t going to get paid for having my son, and, I think that wasn’t right, because it’s not a lot of midwives out here, so I, you know, so we had to fight, I had to um, call my Medicaid and tell them to send the paper that she didn’t get paid from um, Medicaid, so, and then she had to send it off and she finally got her money, but that’s the worst thing about Medicaid and Medicare, if you have an HMO with Medicaid, that they’re not going to pay because she doesn’t take [the HMOs], but she takes straight Medicaid.

Three participants described the length of time that it took for the Medicaid application process to be completed as the worst part of being on Medicaid, which is also discussed in Chapter Eight regarding access. However, the way that Irene described it, the fact that the waiting time was so long actually contributed to her even having a home birth, as by the time her Medicaid was active, no other providers would enroll her in care:

[The worst part was] the fact that it took so long to be approved. But at the same time, it was kind of a blessing because we might not have been in that same position to actually have the midwife.

For Becky, who discussed above how she did not get enrolled in Medicaid until she was seven months pregnant, the time was a factor, but Medicaid only covering one ultrasound also affected her:

The worst part was – first off was how long it took to get it. Then after that, what they wouldn’t cover. Like they only covered one sonogram. The reason that I was on Medicaid was I couldn’t find work, [laughs] if you needed an extra sonogram, then you need an extra sonogram. That should be covered.

Debbie echoed the sentiment that it was difficult to determine what was and was not covered on Medicaid. Both of these sentiments are interesting considering that most of the respondents described the “best” part of Medicaid as being that they would “cover everything,” although this perhaps was more related to Medicaid not having “co-pays” or that the moms themselves didn’t have to “cover” any of the expenses related to standard care. However, finding out what Medicaid “covered” proved challenging, as there is not a list of services covered available to the pregnant women themselves, although a fee schedule for Licensed Midwives is
available so that the midwives know what services they are allowed to bill for. However, this still does not fully address whether a service is covered for the enrollee, only what services the LMs are able to bill for. Debbie also described the challenges of finding providers that accept Medicaid:

The worst parts were, like I said, trying to go a hold on what is covered [and] what isn’t. I didn’t have, ‘Here’s some options, here’s what’s covered by MomCare’, or ‘Here are some providers that are local or that will – that take it’. And it was very hard for us trying to find like for chiropractic care, especially. It was really hard to try and find anybody else [that will] take Medicaid, and I think for baby number three, too, it was hard trying to find a local midwife that would take Medicaid as well.

Only Jessica discussed that what took so long was not getting on Medicaid but getting in to see a provider. She lived in one of the counties where women with Medicaid were basically instructed to receive care at the Health Department. In contrast to other respondents who were glad that they did not have to go to the “crappy Medicaid doctor”, Jessica felt that she was relegated to substandard care by having Medicaid:

I didn’t care for the federal government, because they tell you exactly where to go. You know, sometimes you don’t get the best quality care. You have to go to like the lower income places and you have to, and sometimes you have to wait weeks to be seen…Medicaid didn’t send me a list of near possible midwives that accept their insurance. They didn’t give out that option, I had talked to a friend who let me know that this particular midwife and her facility accepts pregnancy Medicaid and that’s how I was able to choose her. The Medicaid plan was pretty much XYZ, black/white, you go to the Health Department and you stay there until 32 weeks, and then you go to A or B OB-GYN to deliver at A or B hospital, and that’s what would happen. So I don't think Medicaid helped me at all in trying to choose a home birth or finding my midwife.

Unlike Jessica who had stated that ‘pregnancy Medicaid is good for when you need it’, Gloria discussed that the worst part of having Medicaid was that it was only available during pregnancy, and that the coverage ends at six weeks post-partum. Before the pregnancy, she and her husband had a high-deductible plan, and after the pregnancy they were both uninsured:

For me, the worst part is like my baby, she’ll be on Medicaid for the next year but mine ran out six weeks after I had her. So to me the worst part would be that like my kids can be on it but I can’t because it just, I feel like, I’m the one that has to take care of the kids. So if something happens to me and I can’t get medical care then that’s not any good for them either. Because we definitely, [my husband] just, the insurance that we were on was, I think we were paying like $500.00 a
month or I think it was almost $1,000.00 a month actually, and then our deductible was like $5,000.00. So we’re paying like all of this money every month, like so much money that is not going into savings. It’s not going anywhere. Just giving it to the insurance company and then if anything does happen, we have to pay $5,000.00 on top of that and there’s just no way. I’d rather be putting that money in savings every week, every month, and then if something happens we’ll have like a cash cushion where, you know, with the health insurance we were just barely able to cover our bills and barely able to buy food. So it was just, it sucks because like right now none of us – well, only the kids have insurance [Medicaid], like my husband and I don’t have insurance, so if something [happens] to us either we’d have to pay out-of-pocket or it’s going to be purchase-your-own. I mean, I wish all the time that everyone in this country would have health insurance, but it’s not that’s simple.

Two respondents described the worst part of Medicaid as being able to actually contact someone from the Medicaid office, and their lack of customer service skills. Ann stated: “the customer service line, that, I think, that’s it.” Later in the interview, when asked about her experience of applying for Medicaid she similarly stated:

The one really horrible thing about Medicaid in Florida is their customer service line is horrible. If you call and they have too many people on hold, they won’t even let you go on hold. They just say call back later and they hang up on you.

Kate, who had worked at the beginning of the pregnancy within her county’s Health Department, which is a state-funded agency where the MomCare staff themselves are located, described how getting in contact with the Medicaid staff was the worst part, which is particularly ironic since she theoretically was in ‘insider’. She described the worst part as:

Physically just getting a hold of them, to ask them a question, to find out approval, to any of that stuff. Their communication is bad unfortunately. I mean I worked for the State, but people that they hired, there was very minimal education on the end of the people that were hired. They’re just getting through calls as quick as they possibly can and there’s no specialized individual care. [The worst part is] just on the customer service side.

Among the nine mothers that were asked, “Was there anything specific about having Medicaid that made this home birth difficult?” only Eve said yes. She stated that she would have had more difficulty during the prenatal care with Medicaid related to getting in contact with staff, but that her midwife was able to answer most of her questions so she was able to
circumvent talking to the actual Medicaid office. For her, though, having a home birth on Medicaid made it more difficult to get her baby enrolled in Medicaid. She described it this way:

Actually, that was one thing, it was difficult to deal with Medicaid for the newborn, with the home birth, because we had to do all of it ourselves. It wasn’t something that the hospital staff or anybody did for us. So that was definitely something that was more complicated because it was very unclear what, which phone number we had to call, and then the line’s busy and such to actually get that all paperwork. It literally was all on us. They sort of, I mean, we had our initial card, ‘baby of mom Gold Card’ and we used that but they also told us that we needed to make sure that we called right away or say, ‘The baby is here and here’s the name and the information.’ And that was just – you know, within those days after birth, that we really could have gotten more of a help. I had been the one dealing with all the insurance coverage, and so it wasn’t something that I could really hand off to my husband who wasn’t familiar with their phone system choices, what information was needed since I had set it all up to begin with and I stay home with our children.

Debbie elaborated on how there really was not anything particular to being on Medicaid that made her home birth difficult. In fact, she was pleasantly surprised that the Medicaid staff were relatively supportive or her choice to have a home birth:

No, I mean really, they were – it wasn’t, ‘Oh, well you can’t have a home birth.’ There’s nothing that made my home birth difficult in that sense, because it was, I also think, having a midwife who kind of knew how to work with Medicaid made a difference as well, because she wasn’t like, ‘Well, I don’t know if Medicaid will cover that or not,’ or she knew like, okay, Medicaid will cover this, or not. So, I can’t remember anything, really. I was actually kind of pleasantly surprised when I found out that Medicaid did cover home birth and they, and when I talked to them on the phone, they weren’t like, ‘Oh, you’re crazy for having a home birth,’ or [laughs] anything.

In sum, then, women felt that Medicaid was a blessing that allowed them to have insurance coverage without the stressors of co-pays and deductibles, but they did experience stressors in their interactions with Medicaid staff, particularly getting through.

**The Medicaid Experience: Midwives**

In addition to the one midwife who had stopped taking Medicaid, ten of the midwives were specifically asked about the rewards and advantages to working with Medicaid. The vast majority (7/10) described something to the effect of ‘even though Medicaid doesn’t pay well,
they pay *regularly* which contributed to them having a reliable source of steady income. Yvette described this as:

> It’s just consistent. I think, Medicaid doesn’t pay that great but they’re consistent.

Quincy further described this consistency as:

> I love Medicaid in the sense that I get paid every Wednesday. There’s no flaw in that!

She also stated that Medicaid offers a form of advertising through the MomCare program that gives pregnant women a list of maternity care providers in their area. Because Quincy is in a county with relatively few providers, this probably helps to increase the chance that she will receive a call from the women who receive this list. Quincy also enjoys Medicaid’s web portal where she can check in real-time any patient’s Medicaid eligibility status as well as check on the status of any claims:

> I have an access to [the client’s] eligibility. And, if you go to the web portal it tells you right there if [a claim is] approved, denied, paid or not paid, you know it’s like, it’s so easy, and then it’s downloadable for your practice management [software], you don’t have to enter anything in like before, or to copy and put it in the patient’s chart, you know, everything’s there, electronically.

Rose also felt this ability to check eligibility on the web portal was an advantage, and in fact it saved her from having to pay someone else to complete an eligibility check. In addition, she also liked the weekly payments:

> A week after you bill it, you get money in your account. I can depend on it. The other benefit is that I don’t have to pay an insurance company to do the verification and all that. I have to pay my insurance verifiers, you know, my insurance billers to verify, I’ve got to pay them so much, you know, with Medicaid I can check it myself very easily through the web portal.

Ursula described the reimbursement system favorably as well, and offered her hope that other insurers would make their systems so easy as well:

> Actually, the reimbursement is painless. I bill on a Wednesday and the money direct pays into my bank the following Thursday. I wait eight days. The actual reimbursement from the state [Medicaid] is quite painless and quick and it’s a fairly good system. I wish the insurance companies had a system where when you realize you made a mistake on a claim, you can go in and null and void the claim. The state [Medicaid] has that. It’s a fairly decent, robust system.
Olga also compared the ease of reimbursement through Medicaid to other insurance companies, and discussed how Medicaid helped her to increase her business:

It obviously increases your business because if its 50-70% of my business obviously that’s a large amount. It does pay like one-third, you know, of the cost, of what we charge, and typically what insurance pays, between one-third and one-half, but you can bill very, very easily online through their web portal and seven to ten business days [later] the money is deposited right into your account, so it doesn’t take weeks and months like insurance does. Also, we don’t have to haggle with them, you know, like we do with insurance.

This refers to the fact that there is a fee schedule provided to Licensed Midwives by Medicaid that clearly delineates what services are covered and at what rate. With commercial insurers, particularly when the midwife is “out-of-network” the reimbursements are negotiated and the process is lengthy.

Two midwives discussed both the timeliness of payments as well as how Medicaid increases access to a type of care that is often not available to low-income women. Susan described this relatively selfless advantage as:

Other than being paid timely (laughs), I don’t know that there’s any other rewards [to accepting Medicaid]. You know, it’s just that, you know there are more and more women who are, you know, needing to, you know, access and use Medicaid, so that just, you know, I think one of the rewards is that many more women have access to home birth and midwifery care.

Tammy almost echoed this sentiment, discussing in more detail how these weekly payments can help midwives ‘get by’, and also the impacts of this type of care on the client’s lives:

Definitely [the rewards are] financial, like I said, they didn’t pay a lot, but they did pay promptly, so if you were a practicing midwife and you needed a certain small amount of income each month, just to get by, Medicaid could certainly provide that. But, I guess for me, it was just helping these women who had a really fierce determination to have the kind of birth they wanted and would not have had that in a traditional setting, and I guess to see that they had that self-determination and to see that I guess to hope that they would begin to apply that to areas outside of birth, and hopefully use that birth as a catalyst to transform their lives.

Vera described how this ability to provide women with a choice of how and where they gave birth was more important than the actual reimbursement she would receive:
Women should all have a choice and if this is what they want, they should be entitled to it. It wasn't even a – we know we're not going to get paid as much as we would for a self-pay. But it’s not about money. For us, it's about taking care of them. So that’s why it wasn’t even a question.

Xenia also found that the reward to working with Medicaid was to be able to provide this type of care to people she viewed as deserving:

Well, basically being able to provide care for those women that I really enjoy, being a part of their lives and who deserve their home births and they deserve to be able to pick the midwife they want. Yes, they could go down and get another midwife that is just as competent, that would provide them wonderful great care, but it’s definitely nice to be able to choose the person that you actually want at your birth. I mean it’s the birth of your baby. You want someone who is sort of in alignment with who you are.

The only CNM interviewed offered a bit of a different perspective. While she stated that she could not think of any advantages to working with Medicaid, she did note that for Medicaid clients, it was more advantageous for her if the client delivered at home, because in that situation she would also be able to get reimbursed for providing the initial newborn care, whereas in the hospital, that fee would likely go to a pediatrician.

Despite these rewards, midwives described a number of difficulties that they encountered with Medicaid. These varied from the very personal level to the system level. For instance, for Xenia, her biggest problem with Medicaid revolved around what several other midwives also referred to, the issue that some pregnancy Medicaid recipients seemed to be abusing the system. Xenia, who was relatively new to midwifery practice after three years of midwifery school, harbored some resentment that while she was struggling, and while she and her children did not have health insurance, she saw her Medicaid clients living somewhat extravagantly. She said:

I guess the worst part – the only part that I don’t like about [Medicaid] - is when I come to see families that have so much more than I have, and I don’t have Medicaid anymore. I’m not eligible for it. My kids don’t have it but I barely make ends meet. I don’t have cable. I don’t have health insurance. I don’t have any of that. And when I go to their house and I see how much more they have than I have, and I see how much more they’re able to give their kids – and they’re going to Disney World, ‘Oh, I have to cancel my appointment because I’m going to
Disney World this week.' That *bothers* me because I feel like, I don’t necessarily, I feel like *I’m personally* being taken advantage of.

Ursula also spoke about some of the characteristics of Medicaid clients that made working with Medicaid challenging, and described that compared to non-Medicaid clients these women had less investment in their care:

I think maybe their dedication to their care, they seem to be very hit and miss, you know. If they decide they’re not going to turn up one day, they just don’t turn up, rather than others who will phone in and apologize and reschedule, they’ll be like, they don’t turn up, so we phone them up, ‘Where are you?’ ‘Oh, I can’t get a ride, or I couldn’t get this. I can come tomorrow.’ ‘Well, no, there’s no space for you tomorrow. We don’t have an appointment.’ A little blasé in terms of their care.

Vera also spoke about how beyond these challenges of working with the Medicaid clients themselves, there are challenges of working with the Medicaid system, in this case, particularly when clients transfer in to their care from another provider:

Of course, a lot of visits go unpaid anyway because Medicaid will only reimburse ten [prenatal visits]. And we see them fourteen, sometimes sixteen times, if they come in real early on in the pregnancy.

She added:

The other thing, not to cast dispersions, but if they transfer in from an OB’s office and they’ve had them in three times a week for the last three weeks, so *they* [the OB office] get the 10 visits, they come in to us, and I'll bill one, two visits and then [the claim will be] denied [for] over 10 [visits], I’m like, ‘What the hell, she's 30 weeks. I’m going to give another six, seven visits for free.’ And the overuse of the ultrasounds in the OB’s offices, means invariably [that the ultrasound we do won’t be covered], and I *can* charge them for an ultrasound if it’s not covered by Medicaid, but hey, if they’re not able to pay $12.00 for prenatal vitamins, they’re not going to have the money for an ultrasound. So invariably we eat that cost [of the ultrasound].

Yvette stated that her only real difficulty in working with Medicaid was related to their low reimbursements:

The only *problem*, which you can’t really do anything about, is just that it doesn’t, the pay is not quite the same as insurances or doesn’t reimburse at the same rate as the physicians are. That’s really the only problem.

Nancy discussed how Licensed Midwives do not have the sheer numbers to be a priority to Medicaid. She spoke of how:
Every so often the state will change fiscal agents, who actually processes the claims on [Medicaid’s] behalf, so sometimes there’s a lag in technology. Like, randomly a year and a half ago, our [billing] code for midwives, just for midwives, not for OBs, changed, [so all of a sudden, none of us were getting reimbursed for the delivery], for about a third of the pregnancy care we provide, $440, so the way that Medicaid actually fixes problems seems to be based on volume]. So, relatively speaking, we are a small number of claims that they get.

Quincy described a similar situation:

The only thing that I can say and complain about Medicaid, is that the fee schedules that we have that they say they pay, when you go enter it in sometimes it says, I’m sorry, it’s denied. Because of the type of provider that you are. And I have to call my local Medicaid rep, and tell them that that happened. They have to look into it, then they tell me I have to resubmit the claim by itself.

Quincy was one of three midwives who discussed how challenging the web portal would become when the third party vendor was contracted to fix bugs in the system. Although she described how she normally puts her claims into Medicaid every Monday, she would hold off when she would see that the system was being updated:

When like things are updated there is a lot of glitches in their system. So, when they say update, I’m like, ok. I’m not submitting any claims until you fix it.

If the Licensed Midwives found their reimbursement rates low, the one CNM that was interviewed discussed how her rates are even lower. While she did state that she supports her LM colleagues, she does think that based on her higher level of education, she should not be getting reimbursed less than the LMs:

Do you know what’s crazy? Do you know that Medicaid pays Licensed Midwives more than nurse-midwives? So for a prenatal appointment, LMs get $50.00 and I get $41.60 - my staff is telling me. So for some reason, they’re getting $54.00 and I’m only getting $41.00. So I’m getting like $25.00 less on this antepartum visit that includes a Healthy Start Prenatal Screen, they’re getting, yeah, for an initial [visit], they’re getting $150.00 and I’m getting $125.00. I mean, why is that? That makes me angry [laughs] ‘cuz, I don’t like to play the trump card, either, but my midwife was a Licensed Midwife, I support Licensed Midwives in the community [but] I’ve got a higher education, I should be making more.

Vera additionally discussed that one of the financial challenges of providing care to Medicaid recipients is that the reimbursement rates have not increased in some twenty years. Zoe also recommended this be addressed and asked whether other professions would tolerate
stagnant pay over twenty years. She also pointed out that if women were encouraged to pursue home birth, the cost savings to the State would be immense:

So how does the state, I mean, you ask the Governor’s office if he’s getting paid the same amount as the Governor twenty years ago and I bet you the answer is no. So, it’s just a fair reimbursement, and don’t get me wrong, my understanding is the reimbursement rates, like an obstetrician will not get much more for an uncomplicated vaginal delivery. So, I don’t think it’s kind of cherry-picked, only pay midwives this and we are going to pay obstetricians that. I just think the whole reimbursement amount is a joke.

Two of the midwives described that they had no real difficulties in dealing with Medicaid, with Penny [who now primarily provides birth center births] stating, “With home births, I had no difficulties” and Yvette, who said, “No, I wouldn’t say I’ve had difficulties with the system” but then went on to describe that the challenge of taking Medicaid is the low reimbursements, as discussed above.

Despite these difficulties, the vast majority of midwives (9 of the 10 asked) described how they had never considered not taking Medicaid. However, some of these views had changed over time, including for the one midwife who initially thought she would not take Medicaid. Xenia, who was relatively new to midwifery practice when interviewed and stated that 70% of her practice is Medicaid, discussed how when she was a student precepting with a midwife in her community she did not think she would be able to afford to see Medicaid clients given the low reimbursements rates. However, she decided to become a Medicaid provider both when one of her own friends on Medicaid needed her as a midwife, and when she realized that her connections with her clients were in ways that other midwives might not be able to provide:

The whole time I was in school, a single mom, trying to raise two kids, I was saying ‘Oh I just can’t afford that. I’m not going to do that [accept Medicaid].’ But the second I got out of the school, one of my favorite people in the world needed me to apply for Medicaid [to be her provider]. So of course I’m going to do that. It’s the same with all my other clients. And I’m just thinking, what would they do if I didn’t have Medicaid? I mean, there’s other perfectly competent, great midwives, but they’re not going to – it’s a different connection that we have which is why I’m their midwife. So yes. I like being able to be there for those women that need it. Right, no way I could afford to do this, yes. But then what happened
was I realized, as a student I’d been doing all these prenatais and births for free for the last three and a half to four years. So if I get $5.00 for going, it’s more than I’ve ever gotten [laughs]. So I was like, ‘Wow. I am getting something from my time.’

The only other midwife who questioned whether it was feasible to continue taking Medicaid was also relatively new to her practice. As discussed by Wanda who does not take Medicaid, there was a sense among the midwives that Medicaid does bring in business and allow a new practice to get established and built up with clients. Zoe has thought about at least capping the percent of patients that she will accept that have Medicaid, but as of yet has not done so:

I mean there’s a thought at times where I go, ‘Oh, my gosh. How can we take Medicaid?’ But again, some money is better than no money, so until we get to a point where we’re turning people away, [Medicaid is] something. So I’m not in a position to say at this point that I can’t accept Medicaid. Now, we’ve definitely have in our mindset, ‘Okay, three a month’ but it’s never been that we’ve had to say - maybe once or twice, we’ve said to a Medicaid patient [that] we’re not taking any more patients for that month, whereas if a self-pay client would have come in, I would have maybe gone one number up over that [the number of patients that I normally book] to make $4,600.00.

Rose also described how Medicaid helped her to get her practice established, and also that in fact she likes working with Medicaid, as was described earlier in this chapter because they pay promptly:

No, not for a second [did I think I wouldn’t take Medicaid]. ‘Cuz when you’re just getting going, you’ll take what you get. And it was necessary. I like Medicaid clients, because I know that I can, if they’re straight pregnancy Medicaid [as opposed to Medicaid HMOs], I can bill for it and the next business day I’m going to have it, I’m not going to have to wait 60 days like I do for the insurance companies to pay. You know, everything’s all set up. And then they send you the print out of what they paid you that week. The system, the system does have some good things, you know.

Nancy also described that she accepted Medicaid from when she first started her practice, but that to this day she accepts it because it is rather easy to deal with:

Going into it originally, there are women that have need [and are on Medicaid], and I’m going to get paid, and even now after 10 years [I still accept it]. If you know how the system works, and you follow the way, it’s really one of the easier entities to deal with. It’s electronic, it’s online and straightforward.
Among the nine midwives who said they had never thought of not accepting Medicaid, Yvette added:

"Actually, no I never did [think that I would not take Medicaid] because I knew they were consistent in what they do."

Susan was one of two LMs interviewed who had moved to Florida from another state in order to practice in a more autonomous way. She had worked for a significant amount of time in two different states where the practice of non-nurse-midwifery was illegal, and she stated:

"One of my reasons for moving to Florida, to become licensed and legal, was because I wanted to be able to, you know, to be able to accept insurance, and Medicaid, so I haven’t thought about not getting [Medicaid]."

However, she did acknowledge that some midwives in her community do not accept Medicaid, and described some of the challenges that accepting Medicaid brings (which were echoed by other participants as well):

"There never has been [any thought I would not take Medicaid], um, there are a couple of midwives now who do not take Medicaid, and you know, part of it is they pay so poorly. I mean, you have to fight for every little $5 that you get from them. [Like] if a woman comes into care kind of early, you only have 10 prenatal visits that Medicaid is going to pay for, so do you think like, if she’s 34 weeks and we’re up to 10 visits that we’re going to say, well, sorry, no [more visits]? Often, we’re doing care and not being compensated for it, ‘cuz we’ve reached the magic number of 10 prenatal visits. Or, the most challenging one is you know we can have a woman that we labor with for 24 hours, and we don’t birth at home, and wind up going to the hospital and we get paid a full $200 for that. That’s like, you know, highway robbery. So, you know, this one midwife [name], she is like ‘I’m not taking Medicaid anymore.’ You know, it’s nice that when you bill Medicaid you get paid the following week, but there’s often some reason they’ll, you know, ‘This code wasn’t correct’ or that code, and you actually don’t get paid, or, if you don’t go back and check, you might not realize that, ‘Oh my gosh, they didn’t pay for that date of service.’ You know, it’s a bit of work, you’ve got to file it and then you’ve got to double-check it to make sure that you did in fact get paid for the services that you filed for."

Susan also described the challenges that the women applying for Medicaid faced, and the implications of this to her practice, particularly to when their Medicaid is not fully active until the pregnant women are well into their second trimester:

"So, I think one of the challenges is women dealing with Medicaid….for some women, the process of getting Medicaid can be just a big challenge and a nightmare. And so, if she comes to care somewhat early and we’re providing"
care for her and her Medicaid is denied, you know, then we’re kind of, we’re up shit’s creek for lack of a better word, or if it’s delayed, if she comes into care at, you know, ten weeks or twelve weeks, but they don’t approve her Medicaid until she’s 20 weeks, you know, I don’t know how far back we can go in terms of getting that paid for, I’m not sure how far back we can go.\(^{30}\)

Tammy echoed that there was a problem of needing to “back-bill” for care provided prior to the when the client’s Medicaid was active:

Probably the only difficulty we encountered was just, you know, the wait, just to get reimbursed, or to get the woman enrolled in the system. You know, once she decided she wanted to apply and then having to wait and then back-bill for that 90 days previous, or whatever the case may be. So, just the enrollment issue is probably the largest issue, you know.

Wanda eventually experienced so many frustrations with Medicaid that she stopped accepting it because:

I just frankly became really discouraged with all of the bureaucratic BS because it wasn’t worth my time, and like I said, I was getting paid less than minimum wage.

She discussed that her two biggest concerns with Medicaid were that they repeatedly changed their third-party technical contractor leading to major computer glitches, and that their reimbursements were so low and had not increased in many years. She felt that as with other types of providers, when midwives start to see that Medicaid is more of a liability to the way they want to run their practices, they will stop accepting Medicaid clients, and thus reduce or block access to home birth within this population. Furthermore, according to Wanda, because the reimbursements were so low, the volume of patients that a midwife would have to see in order to make ends meet would ultimately change the very nature of the type of care that she was aiming to provide. In this instance she was talking about commercial insurers offering to list her in a network of preferred providers so that she could ultimately have a larger volume of business, but she did not want to increase her volume, and thus trade her ability to provide quality care:

\(^{30}\) Technically, with “presumptive eligibility” care can be provided to women before their Medicaid is activated, and can be billed for 90 days prior to the activation date, even if the woman does not ultimately qualify for Medicaid.
[Insurers] call me all the time and say, ‘We will pay you blank for prenatal care, birth and postpartum and newborn services, and you can’t charge the client anything above that, and in return, we’ll put you in our panel of “preferred providers” and we can throw lots of business your way’. And I’m like, you know what? I don’t want lots of business. I prefer to do quality midwifery vs. quantity midwifery, and I don’t need your business, I never spent a single penny in advertising. I don’t need any more people coming, I turn down probably a client for every client that I spoke with this morning, I just don’t need it. And so, why would I agree then to accept $200 over what the accepted Medicaid allowance is in return for doing thirty births a month? I don’t want to do thirty births [laughs]. I’d be perfectly happy doing four.

Along those lines, she also stated:

My philosophy has always been, if you pay peanuts, you get monkeys. If you pay a reasonable amount to somebody, you’re paying for the experience, you’re paying for the background and training that they have, and I think that’s a fair thing. People will respect you if you let them know where you’re coming from, what your background and training has been, certainly encourage them to talk to your previous clients, let them know what they’re getting and what they’re not getting, and that’s it. If you want to pay this kind of money, then pay this kind of money. If you want to pay half that, then you need to go to somebody else, because I’m not going to accept that, it’s not appropriate remuneration for what my level of skill is at this point.

Some of the most candid and insightful responses about their experiences with Medicaid and their desires for reforms for Medicaid coverage of home birth in Florida came at the conclusion of the midwives interviews when they were asked simply, “Do you have any other observations or comments about Medicaid-funded home birth in Florida?” Two midwife respondents offered that the option of home birth and midwifery care could be used as a cost-effective solution, and that support by government programs such as Medicaid could help to promote this option and help it to become more normalized. Zoe said:

I think [Medicaid] needs to look at the amount of money that they’re saving when women stay home, and increase, if not drastically increase, the amount that they’re paying for home birth deliveries. To actually motivate people, to motivate practitioners to take on home birth, and to also educate the clients that that is an option, and it is a safe option, and it’s actually a much more affordable option for the entire state, for the nation.

The promotion of what is termed “physiologic” birth has been increasing on both a national and international level. When asked what general comments she had on Medicaid and home birth,
Yvette described how the U.S. needs to shift to a focus on normal, physiological birth and away from our interventionist model:

Honestly I kind of think it needs to go back to - oh gosh, I don’t really know how to explain this. We need to stop thinking of pregnancy as a disease, as an illness, for most women. It’s a normal life event. We need to stop encouraging mothers or whoever they are, to treat it with the fear and that, I believe we should start with the lowest intervention provider, whether that be a Licensed Midwife or a nurse-midwife, either one – or even a physician could do a home birth, whoever, they should be able to do it. And it should be offered to anybody who qualifies in the risk category, and we need to start it at that level and a lot is needed. Does that make sense? Again, it doesn’t have to be a Licensed Midwife, but let’s start out with the lowest denominator with regards to who provides what care, the lowest interventionist, that’s going to be your Licensed Midwife, because they’re going to give the least interference, if you will, of anybody. So, it needs to be promoted from, personally, I think from Obama down. You know, we’re too, we need to look at other countries to their model of care, because we are too into everything and everybody has to be fixed, and that’s not always the case.

If this were to be the case, a top-down approach, then state laws would have to be updated as there is wide variance between states on their approaches to non-nurse-midwives and out-of-hospital birth. Two midwives summarized their final thoughts on Medicaid-funded home birth in Florida by acknowledging its legality. Wanda discussed how this variance is not fair, particularly to Medicaid recipients:

Well, just that I feel that every state everywhere should be able to – I think it’s silly that one state can do it and one state can’t. I mean everyone needs access to the birth that they want and if they’re using Medicaid then they need to have access to the same thing everyone else has. It’s not fair that some women have access to certain things and some women wouldn’t.

Despite the Florida state laws that do mandate all types of insurance to cover midwives in all birth settings, Rose spoke to how it was refreshing that Medicaid does cover home birth, and that it is good that Medicaid is theoretically accessible to the women who need it:

I’m really happy that [Medicaid] even recognize[s] home birth. I mean, so many insurance companies won’t. So, I think that’s very good, that they recognize home birth and they pay for home birth. You know they don’t pay what they should, but they don’t pay what they should for anything. And women can get [Medicaid] if they put forth the effort. You know, I think it’s a good thing.
However, despite Rose’s belief that Medicaid is accessible, two midwives discussed ways that Medicaid could help to improve the experience of recipients, particularly their application process. Susan said:

The [application] process just needs to be made easier for women to be able to get in and access.

Quincy suggested that the actual, physical, staffed offices re-open:

I wish the offices would open again (laughs), for more face-to-face contact instead of the phone. ‘Cuz a lot of clients complain about that. And then a lot of them say, I don’t know how to, I don’t have access online, so like for instance the Lutheran Church [located the next driveway up from her office] is an ACCESS site so they can go and there’s three, four, five computers where they can apply for benefits.

As has been documented elsewhere (Hebert 2013), the closure of the Medicaid and Florida State benefit offices has shifted responsibility primarily to community based organizations, such as the Lutheran Church mentioned by Quincy, that assist low-income residents to complete online benefits applications. The new online process is called ACCESS Florida, standing for: Automated Community Connection to Economic Self Sufficiency. This automated, self-service process began in 2003 with the Florida Legislature mandating budget cuts within the Florida Department of Children and Families (DCF). These resulted in a 43% workforce reduction, and as DCF officials started to shift responsibilities from the state to the local level, local staff looked for ways to improve efficiency. These included the elimination of the in-person application process for benefits and the shift to self-service applications completed online. The process was furthered in 2004 when four hurricanes inundated the DCF system with hard-copy benefits applications, to which DCF responded by creating an online portal that DCF staff entered paper copy application information into in order to more efficiently and effectively address this sudden spike in applications. This electronic system formed the basis for the ACCESS Florida, which now accounts for over 90% of benefits applications. Applicants can still obtain the paper application copies and fax them in to DCF, but this is not widely advertised (Hebert 2012; Lange 2009). Certainly, this entire process can be critiqued from a
Critical Medical Anthropology lens by acknowledging that access barriers are being erected to further disadvantage an already underserved population. Low-income Florida residents who already suffer from the “digital divide” (Sipior, et al. 2011; Wilson 2014) are now essentially required to obtain benefits through an online system, and rather than paid, state employees to assist, task-shifting to voluntary or non-profit organizations has occurred.

Penny used this opportunity to describe work force issues related to increasing home birth access. In addition, she cited a particular challenge for Medicaid home birth would be the different demographics of the Medicaid providers and the Medicaid recipients:

I think you know that, to turn it around again, that, you know, the midwives that would serve more Medicaid clients don’t look like the Medicaid clients, and that the access, training and education for midwives is so desperate that we have a very small work force, so it’s almost like if we are having Medicaid for home births as an option, that we want also to know that we also have supply, we can supply down the pipeline, practitioners who are able and willing to accept Medicaid for those same home births, and, um, I think that’s a losing proposition only because you know, the CNMs typically aren’t doing home births and the Licensed Midwives are struggling trying to be entrepreneurs and Medicaid is helping from the angle of the reimbursement that they get for doing that, that service. Right. So, you know if we can find more practitioners who can afford or be supported in providing care to indigent, or low-income women, that would be a great step as well in the right direction. So, yeah, I mean, in so many different convolutions, versions, and circles that this issue raises that um, you know, yeah, to me, home birth is the crème de la crème and I wish every single woman in this country had access to it.

Nancy used this question to provide a summary that poignantly summarized what many of the midwives had said:

I guess just as sort of a summary, is that there are positives to [Medicaid], you know, cash flow and things like that, but there are, you know, certainly drawbacks with not, you know, having a limited amount of coverage, not coverage, but reimbursement for the care that you are providing. And, as midwives, you’re usually, you know, it’s time-intensive, time intense, and you’re spending an hour with someone not 10 minutes, and then you’re getting a third of what you would get from someone else. So, you know, there’s certainly that impact to your overhead and your bottom line, from a financial perspective. But from the global view, you know, I think most midwives are not in it, you know, for the reimbursement, it’s to provide the care that’s needed, so. You know, overall, it’s not, it’s not a horrible [thing]. From an administrative standpoint [Medicaid’s] probably one of the easier payers to be reimbursed from.
This last portion of this chapter regarding the Medicaid experience for providers will focus on the opinions of Wanda, who no longer accepts Medicaid. Wanda became a Florida Medicaid provider when she moved to Florida after the Licensed Midwifery statutes were adopted, and attended births both at home and at a birth center. She blames Medicaid for putting the birth center out of business, and now only attends home births and only accepts self-pay clients, i.e., she does not accept either Medicaid or commercially insured clients. To Wanda, the key reasons she stopped accepting Medicaid were financial, not just because of the low reimbursement rates but also because of the challenges of working with their electronic systems and the system administrators who were contracted by Medicaid:

The number one [challenge of working with Medicaid is that] the Medicaid system is actually administered by somebody else. So, every time they changed who administers the plan, there’s a switch over, the computer program has to change, you have to go train on the new computer program, install it in your computers, they used to be OK if you file paper claims, but they now strongly encourage everybody to file electronically, but in order to do so, you have to jump through all these hoops with the electronic provider representative, whoever that happens to be. And that contract apparently gets re-bid like every four years, so it’s kind of constantly in flux. You just get one system under your belt, one system works fairly easy, you get it, and when it’s running smoothly they’ll automatically deposit your checks into your account, and you’ve got the money within 10 days of the time the claim is filed, assuming it’s a clean claim, works like a charm. But then four years later you start all over again.

She described the ‘final straw’ that made her stop taking Medicaid as when one of those computer glitches significantly delayed her reimbursements. In the end, it was a business decision that drove her away from accepting Medicaid, and as she said, that ultimately made her close the birth center:

I didn’t make a distinction between who got what kind of care [based on their payment source] and what time was involved, [but] it didn’t make any sense for me but to be paid 2/3 less by Medicaid or maybe an insurance company, it’s just, it’s a racket. And my way of thinking was just that it wasn’t a good business decision for me if…there’s just only so many hours in the day, and so many days in a week, and if you’re trying to provide quality care, like I said, it’s time consuming. And, it just became, ok, here’s my resources, here’s what I need to get remunerated for my time and effort to keep the business afloat. And during the time unfortunately Medicaid changed their electronic providers again, and it took me another 18 months to get paid for about $25,000 worth of claims that I had against Medicaid, because the electronic provider frankly sucked, and they
[said], ‘Oh, midwives aren’t approved to do prenatal visits’ and ‘Midwives aren’t approved to do post-partum visits’ and ‘Oh, yeah, you know, maybe we should change that code.’ They had one IT problem after another IT problem after another IT problem and it became incredibly time-consuming, and from my way of thinking, they literally sat on $25,000 worth of valid claims because they couldn’t straighten out the thing, not remunerating me for a valid claim that was nine months ago. ‘Oh, well, I’m sorry, we’ll get to it when we can.’ Uh-huh. Should I tell my landlord that? [laughs]. And I was just between a rock and a hard place, and when we came out of that experience I went back to doing home births, I started phasing out of Medicaid and then I stopped completely.

Notably, the problems encountered related to Medicaid’s sub-contracting of its information technology services were only mentioned by Wanda and Nancy, perhaps because they were among the most experienced midwives interviewed. It is possible that some of the newer midwives had not yet encountered these issues because Medicaid was still on the original contract and system from when they had started being Medicaid providers.

Discussion

Clearly, the biggest advantage to having Medicaid for the moms was the fact that it “covered everything”. Particularly for women who had the experience of paying significant copays or deductibles with previous pregnancies, the fact that there were no hidden expenses while on Medicaid contributed to a decreased sense of worry and reassurance. A few of the respondents did make the link between this lack of out-of-pocket expense and the decreased revenues of their midwives, and these women expressed concern that this was not necessarily fair to their midwives. Furthermore, respondents demonstrated the sense that even though this was essentially free coverage, they found that it actually provided better coverage than they had experienced when insured through a commercial insurer. At various points in the interviews, several participants described their belief that ‘maybe everybody should have access to care that is this easy and good.’ Descriptions of the Medicaid enrollment process for both the Medicaid recipients and the Medicaid provider midwives are presented in Chapter Eight.

Midwives primarily enjoyed the ease of the Medicaid web portal for checking patient eligibility and claim status, as well as the steady income flow that the weekly Medicaid payments
provided. However, midwives expressed concerns that their patients were experiencing a lot of difficulty in getting enrolled in Medicaid. Midwives also had significant concerns with the actual amount they received for providing this care. Particularly when it came to Medicaid HMOs, midwives were reluctant to provide “pro bono” care when it was not intended to be “pro bono”.

Finally, although midwife Yvette felt that ‘there’s really nothing you can do about the low reimbursement rates,’ it is important to mention that a federal class-action lawsuit has been filed in Florida\textsuperscript{31} challenging Florida Medicaid to not only guarantee Medicaid recipients’ access to care but also to guarantee equitable reimbursements to providers, allowing them to at least cover their own costs of providing care. While this particular lawsuit was brought by a large provider group that included pediatricians, the benefits would be felt across all types of Medicaid providers. It would be important and interesting to compare Florida Medicaid reimbursement rates, particularly for home birth, with other states’ Medicaid reimbursement rates to better understand if this disparity in payments occurs nationwide or if this is a Florida-specific problem. Anecdotally, Medicaid is generally considered the lowest paying insurer. It could also be interesting to conduct a comparative study among midwives practicing in the other states where Medicaid reimburses for home birth to better understand if the challenges and rewards Florida midwives have are similar in other states.

\textsuperscript{31} In 2005, a class-action lawsuit was filed by pediatricians, pediatric dentists and three families alleging that Florida Medicaid did not meet the legal requirements established by the federal Medicaid Early Periodic Screening, Diagnostic, and Treatment (EPSDT) program when they failed to provide 1.6 million children who were Florida Medicaid recipients with appropriate access to care. They also alleged that Medicaid failed to adequately reimburse providers. In 2007, the suit was allowed to proceed to the U.S. District Court, in the Southern District of Florida. The case heard its final arguments in 2012 but the federal judge overseeing the case has yet to issue a final ruling.
CHAPTER 7: HOME BIRTH

This dissertation reports on the home birth experiences of women on Medicaid as well as the midwives that cared for them. This chapter in particular reports on the reasons both the midwives perceived and the Medicaid recipients stated for choosing home birth. It details the experiences of the women in receiving prenatal care from midwives who would ultimately attend their birth at home, as well as the women’s views on the advantages and disadvantages of both home and hospital birth. The chapter also presents the participants’ concerns regarding each birth site, and whether or not they would ultimately choose to birth at home versus in a hospital again. The concept of risk as it relates to birth setting is also presented in this chapter.

Motivations for Home Birth: Midwives’ Perceptions

Essentially all of the midwives highlighted their belief that women sought home birth first and foremost as an expression of their autonomy. They believed that women wanted to be able to make decisions and have these supported by their providers. Nancy described it as:

Being able to make the decisions for themselves and being supported in those decisions….certainly it goes into that whole idea of having their wishes respected, not having to fight for what it is they believe is right or the way they want things done, you know, if they say they don’t want Vitamin K injections for their child they don’t have to wage a battle about it, they just say it and have it be the way it’s going to be.

These midwives all spoke to their model of care that promotes true informed decision-making and respect for patient’s choices. Although several mentioned clients whose desire for autonomy arose during their initial pregnancy, Xenia specifically linked this desire for autonomy to women’s previous experiences with birth in hospitals:

They’ve had experiences where they felt their decision-making was maybe taken away from them in the hospital or this happened and they’ll name like six things that happened in a row that led to something else that they didn’t like, or, that they just wanted to be able to control that themselves, that this was a special event for their family rather than a factory and paper work and a number. They want it to be that special event.
Yvette echoed this by saying:

About 30 to 40% [of the women] would say that they had a bad experience with their first birth in the hospital so they were trying to look for other ways to have a positive birth experience.

Five of the midwives tied the reasons their Medicaid clients sought home birth to a reaction to the previous care the women had received because they were on Medicaid. Quincy stated that she has had women come to her looking for more “personalized” care, that:

They’ve had the experience before with Medicaid where they go to a doctor’s office that that’s all they do, is take Medicaid clients, there’s like a two to three hour wait, their records have medical errors, they don’t know who the doctor’s going to be at the time of birth….so I’ve had moms that just come here for prenatal care [intending a hospital birth], that are like, ‘I really don’t trust the home birth process.’ So I try to educate them, so by the time they’re like 34 weeks they’re like, we can try home birth and if it doesn’t work we can go to the hospital, and they end up just doing the home birth because they’re like, ‘Oh, this is so easy, there’s nothing wrong with me, I’m not tied up to a bed, I can walk, I can eat, I can do this, I’m never going to the hospital again!’

Midwives further described how this “assignment” of care providers that Medicaid clients endure results in them seeking out alternatives, which then leads to the clients having a home birth.

Zoe stated:

What happens in our community is that [Medicaid recipients] go to the Health Department for care, but then they’re divvied up in the communities to providers, like after twenty-eight weeks. So, at that point, if they are looking for a midwife, a lot of times they’re not coming to me because they’re looking for a birth center or out-of-hospital birth, they’re looking for a midwife and then when they find out they can do a home birth, they’re like great.

Irene, one of the moms interviewed, concurred with this:

The reason why we didn’t decide to stay with the Health Department was because we would have seen a different doctor every single time we would have gone and I wanted to have a personal relationship with the person that was going to be assisting with my pregnancy and the delivery of our child.

Vera, a midwife who had previously worked for Healthy Start’s MomCare that links pregnancy Medicaid recipients with prenatal care providers, further pointed to how Medicaid recipients often fail to realize they even have a choice of what provider they can see during pregnancy:
A lot of it is just realizing that they even have a choice because I think when they get Medicaid, a lot of them don’t even know they have a choice. A lot of them don’t even know that they can go to private physicians. They think they have to be put through the Health Department, that they don't have a choice. So a lot of them, once they find out they have choices, then they actually do some research and they learn what their options are [including home birth].

Penny described these Medicaid recipients who sought out their options as “resourceful.” She described how, despite these women’s primary reasons for seeking home birth being “autonomy, independence” and the desire for a “natural experience”, that even among those who simply “hated needles” or would say, “I’m so scared of the hospital that I’d rather stay home” that these women still were able to figure out how to avoid these and get the births they wanted. Penny stated that she would:

Still count those as women who had resources, because, you know, they still would figure out on their own how to get their home birth.

This comment made reference to her earlier statement regarding the demographics of her Medicaid clients as those who were:

Typically, these were women who had means, and would have, you know, had fallen on harder times, or some kind of family crisis led them down that road, but they would be the kind of women that are resourceful, who have support, you know, so that they would have somebody who would be in their corner and would understand and recognize that they were choosing this birth consciously.

Essentially all of the midwives also described another key motivation for these women seeking home birth as their desire for a “natural” “unmedicated” or “less intervention” birth.

Tammy linked this care choice to their Medicaid status by stating:

[The birth choice] was philosophical and the Medicaid was sort of the financial vehicle to get the home birth that they wanted.

Olga echoed this comment, that home birth Medicaid recipients were likely to have home births regardless:

If they’ve got full pregnancy Medicaid, it’s really not because of the money, it’s because they want this kind of care.

All but two of the moms I interviewed stated that they would have chosen home birth regardless of whether or not they had received Medicaid, that they would have “found a way to pay for it”
but that, as Tammy stated, Medicaid allayed any financial stressors regarding their birth site choice.

Susan did not find that finances played a role in Medicaid clients’ desire for home birth, since, “Medicaid pays for everything.” However, she did feel that it was important to have her Medicaid clients make an investment in their birth choice:

I have my women actually purchase a birth kit, just so that they have the opportunity to, somehow or other, participate in their care in some way, shape or form, it’s important for them to, you know, get their birth supplies, all those things together, and the towels, and the [rubbing] alcohol and the cotton balls, all those things that you can make them an active participant, because, you know, especially with the Medicaid women, everything’s paid for, they don’t have a deductible, so does that make sense?

Olga was one of two midwives who did feel, however, that some women sought home birth because of financial constraints and realities, but these were women that had not qualified for “full pregnancy Medicaid” but rather “share of cost” Medicaid which is similar to a “catastrophic coverage” plan and requires a large out-of-pocket maximum per month. Olga stated:

I had one Medicaid patient who only had a home birth because of financial reasons. She would have loved to have an epidural, but she was, she didn’t get full pregnancy Medicaid, she got share of cost, medically needy Medicaid, and so, you know, she had a certain amount that she had to pay out of pocket each month, and so to have a baby at home [was much cheaper], but obviously women who have full Medicaid, their services are going to be covered wherever they go, completely.

Quincy echoed Olga’s statement that the only home birth clients she felt pursued home birth for financial reasons were those who were uninsured or who had share of cost Medicaid:

Yeah, I’ve had moms that don’t qualify for Medicaid at all, or they get share of cost Medicaid, like one mom that her share of cost kept going up and up and up. It was like $1,500 [per month] when she started pregnancy, but by the middle of the pregnancy it was up to $3,000. I had a girl that came here, she was like, ‘I have share of cost Medicaid, they are going to pay you.’ I’m like, ok, well, let me look it up, and her share of cost was like $10,000, and I said, no, you have to pay me $10,000 a month in order for them to pick up anything, and I don’t charge more than like $3,000 for the whole pregnancy, it’s like the whole entire pregnancy, so, you’re just going to have to pay out of pocket, and they’re like, ‘Oh my God!’
However, Olga and Quincy did state that because these clients qualified for share of cost Medicaid that they were then obligated to charge the Medicaid reimbursement rate, so this did ultimately save these women significant money. For example, rather than a $3,000 or $4,000 fee the midwife would normally charge for the prenatal and delivery care, they could only charge the mom the $1,800 they would normally get reimbursed through Medicaid.

Interestingly, Penny stated she felt that women did not pursue home birth due to financial reasons, but did state this was increasingly common among her birth center clients:

I would say [financial reasons] is now a very common issue with the birth center, ‘Well, we’re here because it’s cheaper.’ But home birth is a little different, it’s a bit more of a reach to be ‘I’m home because it’s cheaper’ but then I’m sure that might be a factor, too, because, it is cheaper, but I see that more frequently, much more frequently, with the birth center clientele.

Additional reasons that at least one midwife mentioned as motivations for their Medicaid clients to pursue home birth included: “not having to go anywhere for the birth or afterwards” “child care” “transportation” “religious reasons” including among those who want to “avoid blood transfusions” who want “water birth” and who do “not want to be prodded or probed.” “Personalized care” also included being treated respectfully as an individual rather than as a stereotype, as Tammy described:

We had one client who was a Haitian immigrant, she was also very religious, and with her previous births, being in Miami and being black and being Haitian and not having a lot of money and going to the public hospital, she felt like she was treated like a second-class citizen. She felt that people assumed that she had HIV, which she did not, because she was monogamous and a very Christian lady and so she was very offended that everyone assumed she had HIV and she was treated badly because of her race and her ethnicity. So, she thought that midwifery care would give her that respect that she wanted to have.

Zoe echoed this by describing how the philosophy of “universal precautions” in the hospital setting is ultimately distrustful towards laboring women and creates an environment where birth is viewed as dangerous:

When you look at what paramedics do, and they have like a one-year education, and when you look at how independent, you know, look at the autonomy that they have [you realize that birth] is not an emergency….Definitely, after being in the hospital, I had to step back and say, this is not an emergency, people walking
in 8cm is not an emergency....Everybody would always say, you know, if we walk into the hospital, everyone’s got HIV, everyone’s been cheating on each other, you know, it’s every baby’s going to die, and that’s just the way they approach it.

This approach is what some of these midwives, and moms, described as wanting to avoid in pursuing home birth.

Although many of the midwives discussed that women seeking home birth did so in order to have a “natural birth” and to “avoid interventions” common in the hospital setting, only one specifically discussed that women who have not had a previous cesarean were seeking home birth to avoid a cesarean. Rose spoke specifically about obese women who were looking to avoid what they viewed were inevitable cesareans if they chose hospital birth:

I get some obese moms that know they’re going to have a C-section if they go to an obstetrician because they just plain old give them a C-section because they’re fat. And I give them a chance. And most of them are successful.

This echoed the voice of one of the participants, Becky, a nulliparous woman who was successful in having a home birth under the care of a Licensed Midwife. In her words:

I didn’t want to give birth at the hospital because I was obese and I was afraid that if I had to have a cesarean section, which is very likely when you’re obese, that I would take forever to heal because I had friends, well, I knew people, who had cesarean births that were obese that were still packing their wounds a year or two later [laughs]. Because it just takes so long to heal because when you have a cut in that area – it’s just infected, or whatever.

Three other midwives specifically mentioned women seeking vaginal births after cesareans (VBAC) as a motivation for their home birth choice. Susan found this particularly among her “educated” clients:

I think the other reason may be, for some of the educated women, is if they’ve had C-sections before, they may be looking to avoid a [repeat] C-section.

Tammy described one mom who felt she would be better respected by receiving care from midwives, but also chose midwives because:

The birth prior to coming to us was a C-section, and she wanted to have a VBAC and felt like a home birth was the only way she was going to be able to achieve that.
Xenia voiced concern that women seeking vaginal birth after cesarean (VBAC) were not seeking home birth for the “right” reasons:

Some women, like the VBACs in particular, I worry about them because they just want a home birth because they don’t want another cesarean and they feel like maybe I’m the only option for that. So, I worry about that because they don’t want the cesarean but they don’t necessarily really want a home birth. So I’ve seen transfers [in labor to the hospital] just because of that reason.

Two midwives expressed a view that some of their Medicaid clients seemed to specifically be seeking home birth in order to avoid routine drug screening conducted in most hospital labor and delivery units. Quincy stated:

I do get a lot of, um, the ones that may feel that if they go to the hospital, it’s because they don’t want to be drug screened. Because they have Medicaid [the hospital staff] automatically assume that they’re drug addicts, but I tell them, it’s the same here, I drug test you if I feel that something’s wrong, and then they’re like, oh, and then I never see them again.

In fact, most hospitals perform routine drug screens on all women who present for care in labor.

Olga expressed it this way:

Sometimes I wonder if I might occasionally get a patient who is really trying to avoid the system, you know, like, who knows what, drugs or illegal things, you know, and I kind of get some red flags you know, it’s very rare, but I think that’s just part of the [Medicaid] demographic.

Thus, among midwives, while they saw the primary reasons women sought home birth related to the women’s desire for autonomy and respect, they also acknowledged that some women did so because of previous poor hospital experiences, and others who might be ‘trying to avoid the system.’

Motivations for Home Birth: Medicaid Recipients

Various themes emerged among the women interviewed regarding their reasons for choosing home birth, some of which were in agreement with what their midwives perceived, but others were not. For some, the desire for safety was paramount to their decision to birth at home. Particularly if they were low-risk, some respondents felt safer in their homes than in the hospital. Becky, a nulliparous respondent, stated:
If I had known [that a home birth with a midwife was an option on Medicaid] I would have been planning since the very first because I know that natural birth is safer for mother and child and healthier and more pleasant all around. I knew that home birth was safer and better than a hospital birth, for most women I should say. For 99% of women maybe.

Kate, who had her third baby at home, stated:

For a low-risk pregnancy, birth at home is safer than a hospital birth.

Eve spoke less about risk but more about health. She stated:

You’re not exactly sick when you are pregnant, and we knew we were low risk so it seemed like [home birth] was a good choice.

Her reasons for choosing home birth, particularly after having a hospital and then a birth center birth, focused more on the lack of stress, and the comfort of not having to leave home:

The personal care. The less – the low stress of – well, I guess, the low key of having it. When we called the midwives, for both my last two pregnancies – I was seven to eight centimeters dilated when they arrived. For my second one, she was actually born two hours after we got to the birth center. And we feel like to go in to triage in that same situation, it would’ve been a state of emergency and people rushing around and, ‘Oh no, what are we going to do?’ And instead we were able to go into the birth room, and just relax, everything’s fine, and let’s get in the birth tub, and it was just very chill and relaxed, which also helps with the birth process before it’s actually progressed. Because there weren’t any distractions and they were able to just come alongside of us and support us and just let my body do what it needed to do instead of trying to make it work to their schedule like it would be in a hospital. And the home birth was just different than at the birth center, in that they were just able – yeah, we never left our home and it was low key, and it just sort of happened and the kids came home – the big kids came home and their little brother was here. And that was important to us to have that kind of thing. We never really – my husband and I have never spent any time in a hospital besides when our first was born, and so it just worked out that we were really comfortable being at our home.

Four of the participants cited the desire for a “natural” birth, with Faye specifically stating:

I didn’t want to take any medication, or epidural, I just wanted it to be as natural as possible.

Irene expanded on this concept and linked standard medical interventions to this lack of a natural environment for birth:

I liked the idea of not having a whole bunch of interferences. Doctors like to hook you up to IVs and diagnose you with problems before they’re really actually problems. We just wanted a more natural way of giving birth.
Among the six respondents who had a previous vaginal birth in the hospital (in other words, not including the additional two who had previous cesareans), four specifically mentioned their previous unsatisfactory experience with hospital birth as a reason for having a home birth. Gloria stated:

The number one reason I chose the home birth was the way my hospital experience went, which was… once they induced me with Cervidil\(^\text{32}\), I had contractions on top of each other, like every minute of so.

Lauren, whose first birth was planned at a birth center but transferred to a hospital in labor, stated:

We didn’t want to have the pressures of the hospital. We didn’t want interventions, we just wanted to do it as much just us as possible.

This points to another common reason for home birth: to allow birth to happen naturally, and not to be put on a schedule. Lauren went on to echo what Eve stated above:

I mean I’m pretty confident with birth, and that it’s natural, it’s what you’re meant to do.

The women also pointed to the personalized care they would receive, as well as ‘being in the comfort of their own home.’

Ann and Debbie, who both had previously given birth by cesarean section, expressed that a home birth was the only environment that would support their choice (and chance) for a vaginal birth. Debbie specifically mentioned that the obstetrician in her community was supportive of her desire for a vaginal birth after cesarean, but that the policies at the hospital where he delivered precluded this option. Among the respondents that had not had a previous cesarean, only Kate specifically mentioned the desire to avoid a cesarean delivery:

Knowing that if I walk into a hospital, I’m increasing my chance for major abdominal surgery by at least 33%. No, thank you.

\(^{32}\)Cervidil is a cervical ripening agent inserted into the vaginal canal and generally used in an induction when the cervix has not begun to soften or thin prior to then continuing the induction with an agent such as Pitocin which promotes uterine contractions.
Several also mentioned not wanting to be away from their other children. Lauren described this as:

My daughter was there for the birth, she didn’t have to be away from us, she got to see the baby as soon as he was born. We didn’t really prep her because she was still pretty young, we weren’t really sure that she was going to get it. But, as soon as he was born, she ran over to her toy box and brought him a toy over and so definitely, it was better bonding for her I think than having us be gone for a period of time and, surprise, there’s the baby.

Advantages of Home vs. Hospital Birth

Going beyond the exact reasons for choosing home birth, moms described the ways in which there were advantages and disadvantages to birth depending on the location, with a great number of advantages for home birth being the avoidance of the disadvantages of the hospital. Helen summed up the key reasons that respondents wanted to avoid hospital birth, and in particular described the “horror stories” she had heard from her friends:

I knew I didn’t want the doctor, the medical stuff. I really wanted to just do it as naturally as possible, the way our bodies are meant to work. I didn’t want to have any unnecessary interventions. We had a lot of friends that had done the hospital birth and stuff and you know the horror stories that come out of it, that kind of thing. I didn’t want that stuff. I didn’t want that for our child or for me. We’re very natural people to begin with so it was just kind of, it fit to be where - a natural birth [could occur].

Lauren highlighted the other key reasons respondents wanted to avoid the hospital: that they perceived they would be separated from their babies and be subjected to routine interventions that would depersonalize the experience:

I just wanted a more personal experience. I didn’t want to have to go away from home, be away from my daughter [her first born], I didn’t want to have to, you know, have the pressures of what if this happened, I don’t want my baby away from me, out of the room, that type of thing.

While only one of the moms specifically mentioned avoidance of cesarean section as a reason for seeking home birth, six moms did mention the risk for cesarean when asked what concerns they had about hospital birth. Chris, who had previously given birth at a birth center in another state, described how she had experienced the hospital first-hand during an early pregnancy complication, and how that experience helped her to seek an alternative birth option:
Well, [my concerns about hospital birth] started with my first pregnancy I guess. I started my first pregnancy with an Ob-Gyn that was through a hospital. But I saw a lot of the people that I knew getting C-sections, um, you know, very quickly. And I knew I didn’t want that. I had to go in for dehydration, I ended up in the hospital early on in my pregnancy and I really didn’t like the care. I didn’t like how the nurses treated me. Um, and I had “good” insurance at the time. But it just wasn’t, I don’t know, it wasn’t for me. And then I started reading some books and reading different things about natural childbirth and I saw the Ricki Lake documentary \textit{The Business of Being Born}. So, I saw that and my husband watched that with me, and then he was definitely on board with exploring other options. Then we went and we toured the birth center and it was so much more fitting for us and so that’s how we decided to go with the birth center the first time and then that experience worked out. So we knew we definitely didn’t want to do a hospital this time. I didn’t want the IVs and the catheters and the pressure to get the epidural or the Pitocin or the inevitable C-section.

Others voiced concerns about the high rates of interventions in the hospital setting.

Becky, a nulliparous woman who gave birth at home, voiced several concerns about hospital birth, and raised the possibility of iatrogenic complications:

I had a lot of concerns about hospital birth because primarily what I understand about hospitals from every experience I’ve had with them is that they look for problems. And if you look for problems, you’re going to find one. A lot of times, if you have no problem, they create one…My number one concern with hospital birth was the cesarean section rate, especially in a Florida hospital, like the one in my area that has a 33% cesarean rate. And cesareans are dangerous, they’re surgery. I’ve never had surgery. I had gallstones. I did not get my gallbladder removed because I think that’s ridiculous. [Laughter] ‘Oh you have gallstones, let’s just cut it out.’ That’s ridiculous. ‘You’re having a baby? Oh let’s just cut it out.’ I think that’s also ridiculous unless there’s a real reason like the placenta is over the cervix. That’s a good reason. [Laughter] That’s the reason that’s necessary, but because the doctors induce you too early, that’s not a good reason to have a cesarean. I’m not judging the mother on that, but I think that’s irresponsible of doctors.

In addition to the fear of interventions, others described the lack of autonomy in the hospital setting. Kate simply stated that her concerns with hospital birth were, “Just the lack of informed consent, and the risk for C-section.” Irene further voiced this while also echoing Becky’s concerns that interfering with a natural process would lead to problems:

My friend’s experience with the hospital here was that they would not let her raise her arms above her head and they would not let her get up and walk around and they would not let her lay on her side, and they would not let her do a \textit{whole} bunch of stuff. That is just really uncomfortable and unnerving, and I did not want the doctors to try interfering with something that really did not need to be interfered with.
Indeed, fears that hospital birth would increase their chances for interventions appear to be justified by rates of interventions noted among hospital births in the Florida birth certificates analyzed in this dissertation. From 2005 to 2010, the rate of epidural use among hospital births was 71%, although among women that gave birth vaginally, the epidural rate was 64%. Among hospital births, 23.1% were induced, and 18.0% had augmentation of labor. While rates of these interventions among planned home birth might expected to be zero, 0.3% were in fact induced and 0.7% were augmented, nearly all of which were attended by LMs. However, these were likely done with “non-pharmaceutical” methods such as the suggestion of coitus to induce labor or the use of nipple stimulation in labor to augment.

Eve discussed that an advantage of hospital birth lies inside of that ‘unknown’ factor, that there are many ‘what-ifs’ that particularly first-time moms who have not birthed before are concerned about. She described her first birthing experience, in a hospital, and summed up the common contemporary narrative of the ‘what if’ factor that contributes to so much fear of childbirth in our culture:

I think when you’re really high risk or you don’t know, you have a lot of that ‘what if’ situation. We did the hospital for our first birth and really, as I looked back on that, for me, I probably wouldn’t have done it differently because you don’t know what you don’t know and we weren’t, we took the hospital birth class during the pregnancy. So, we had that security, that if something happened, you know, we would be [in the hospital].

Kate also described some of the advantages to hospital birth, but then offered a keen analysis of the cost savings that Medicaid in particular could realize if they promoted out-of-hospital birth:

*Is there a place for hospital birth? Sure, absolutely. Is it *overused*? Yes. Do I think Medicaid should push towards a home birth and a birth center experience for a low-risk, healthy mom? *Absolutely*. And you know they’re not going to do advocate for that. It would cost them less money, when you have 60% of*

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33 Actually, in the Florida birth certificates from 2005 to 2010, among women who gave birth in the hospital, those with Medicaid funding were less likely than privately insured women to have a cesarean birth. Among women with Medicaid, 35% had a cesarean while among private pay women 41% had cesareans. Self-pay had the lowest rate at 33%.
Medicaid patients ending up with a C-section? Why? ‘Oh, they’re on Medicaid, we know we can cut. We know their insurance will cover it.’ And they just get all cut-happy and fear mongering and scare the mom out of her wits and obviously what mom doesn’t want a healthy baby? ‘I don’t care what you do to me, just make sure the baby’s ok.’

Helen, who had two out-of-hospital births, described from the mother’s perspective, as opposed to Medicaid or an insurance company, many women simply do not have time to explore their options related to out-of-hospital birth:

There are some people that need [hospital birth], like they might need it for one or another complications or they’re hypochondriacs or something, that kind of thing. Some people are just better with hospital births, but I think for the majority of people, I think a home birth or a birthing center birth really could fit for a majority of people but they just don’t take the time to look into it and found out what really goes into it.

Thus, a dissonance emerges, in that some respondents feel that for their first birth, they would prefer to be in the hospital for the “what ifs” but that future births out-of-hospital birth is more acceptable. However, this therefore exposes first-time mothers to the stressors and iatrogenic complications of the hospital, which several respondents discussed ultimately drove them to seek out-of-hospital births in subsequent pregnancies.

Gloria was disappointed with her previous experience with hospital birth and felt as though she had not been listened to. She worried that the one intervention (an epidural) that would have helped her choose a hospital birth again would not be appropriately used:

One of the main selling points for me to be in a hospital was the epidural. And so, they like, they actually like redid my epidural, and took it out, and like redid it when it wasn’t working and it still didn’t work. They had like the head of the Anesthesiology Department come in and be like, ‘Oh, don’t worry. I’m going to take care of you. I’m like the best,’ or whatever. It still didn’t work. So for me like if the epidural is not going to work for me and obviously – because they were telling me, ‘We can give you a C-section with the amount of epidural you have, and we can roll you in for a C-section right now.’ I was like, ‘Like hell you would [laughs] because I feel everything right now. There’s no way you would give me a C-section.’ It’s like, ‘Well I can’t put it up any higher.’ So, anyway. Well, let’s see. There was that – like the hospital held no appeal to me after that.

Gloria went on to describe her views about doctors and hospitals in general:

I mean, there are just so many different things about paying an OB and being in a doctor’s office, and being in the hospital that’s automatically - you walk into a
hospital, that’s where people go when they’re dying. That’s where people go when they’re sick and something’s wrong. So, even if you’re not like thinking in your head, it’s kind of like this subconscious thought, ‘Oh, I’m at a hospital, something’s wrong’ and like something bad must be happening.

Lauren discussed that hospitals can be important, but that among those who choose to birth at home, they must feel safe in the home setting:

I think in complicated pregnancies there can be, you know, you can need intervention. But otherwise, I think as long as you’re comfortable doing it at home, as long as you feel safe, as long as you have a good provider, then you’re okay [at home].

Eve revealed a common concern that in a first pregnancy a hospital birth helps allay fears of expectant parents due to the “unknown” but that once a mom has successfully birthed once, the hospital loses some appeal:

[Home birth] is definitely what we would do again. I think it can be scary. It’s not a choice we would have probably made for our first child, but it’s something we will never go back to doing anything but if we do have more children.

Midwives were asked how their Medicaid-funded clients who chose home birth might be different from Medicaid-funded moms who chose hospital birth. Only five midwives were able to offer any insights, which is not unexpected since all of these midwives (except for the CNM who also had experience with hospital birth) only attend out-of-hospital births. Of these five, only Tammy spoke more generally about women who seek home birth as opposed to specifically about Medicaid-funded home birthers. She related the motivation for home birth more towards a sense of desire to have more self-determination about the birth experience:

I guess it’s sort of an education or information literacy, you know, going out on the internet and researching options, or maybe I guess even the, I don’t know what quality or personality characteristic that you would call it, but they, I guess, had a sense of more self-determination, they really wanted to have some say in what happened to them. They weren’t just willing to go along and go to the hospital like everybody else. They really wanted some control, I guess, over their own body and their own birth.

Nancy echoed this sense of self-determination, but did not think this was unique to the Medicaid population:
I don’t think that it’s necessarily that it’s because they’re on Medicaid that they chose to have an out-of-hospital birth, I think they have that increased sense of personal responsibility that they’ve taken on themselves.

Penny also felt these moms had made this extra effort to educate themselves on their options, and while she did feel that Medicaid-funded moms were more likely to just go along with whatever they were presented with as the care they would receive, she also felt that the Medicaid-funded home birthers had made special efforts to seek out their options:

I think they are way different in [that] they have made an effort to find out more information, empowering themselves, have created a support team and a system, get their family members on board, um, husbands on board, um, you know, doing that extra work to um, support their, their wishes. Um, I’m seeing much more of a laisser faire angle with Medicaid women going to the hospital, you know, ‘I’m pregnant, I’m having a baby at the hospital because it’s what I’m supposed to do, I happen to have the Medicaid, that’s great, that will cover the bill’. More so than ‘Oh, I’ve chosen hospital as a conscious choice. This is my preference or I feel safer.’ None of that seems to go into the majority of Medicaid hospital birthers, it’s just like, ‘I’m just following along with what’s the normal thing to do, and this is all I know, so that’s what I’ll do’. So I think the Medicaid home birthers distinguish themselves because to get there in the first place, they’ve had to do a little bit more work.

Xenia also described how the Medicaid home birthers made that effort to research their options, and added that many of her Medicaid clients were perhaps low-income because they held non-traditional jobs like being artists, but that they were also more involved in their communities:

I almost want to say [those Medicaid clients that seek home instead of hospital birth] it’s a personality type, like self-educators, critical thinkers, people who want to take things into their own hands more so than – I want to say there’s almost an education level, because my clients seem to be so - many, many Medicaid home birthers are college-educated but many are not also, but they’re self – they’re researchers and thinkers and they seem to just do things their own way. So many of my clients are artists and musicians and people who have projects going on in the community. They are community activists. That seems to be my crowd. Of course, every midwife is going to attract a different type of client so that’s just who I’m getting.

Olga added that she did not think that pregnant women on Medicaid were truly aware of the out-of-hospital birth option:

I think for the most part it’s just they’ve become aware that it’s here, I think most of them, probably a lot of the Medicaid women, they don’t know that it exists. I’m
sure there’s some that would choose a hospital birth but I think for a lot [of Medicaid women] they’re just not aware that there are options.

Additionally, participants described the best parts of giving birth at home. Essentially all of the moms described how much they appreciated ‘being able to just stay in my own bed’ especially after the birth. Additionally, they all agreed that ‘not having to pack a bag’ and ‘not having to go anywhere’ were comforting aspects of the home birth. Faye said:

Well I went into labor really quickly and it just sort of came on me all of a sudden, and I was really glad that [my husband] and I were just able to sit on the couch and wait for [midwife’s name] to arrive. We didn’t have to get in the car, and get packed up and, you know, have a baby, the stress of driving to a hospital when I was feeling like I could barely walk. It just seemed more relaxed than it would have been otherwise, and I think for [my husband] and I it was just a less stressful situation. We were able to focus more on having a gentle birth for the baby as well, because I knew that if I was stressed out then it was going to be like a stressful birth for him, so I didn’t want that.

Helen also noted that birth at home was where she considered herself to be safest:

It’s being safe, really, just kind of having that comfort of not having to go anywhere, not having to pack a bag, not having to get anyone to watch your kid for you…and it was just nice to have everyone there. And then, when I was done, to get up and walk to our bedroom and it was just nice to be on the bed and sleep in our own bed for the first night and just be a family. So, I would do it again, a home birth, and I would love if everyone else could do it too.

Most participants also described how happy they were to ‘eat my own food’ ‘eat and drink when I wanted’ ‘use my own shower’ and ‘go to the bathroom when I wanted.’ Several specifically described this autonomy they had in the home setting, but Becky perhaps stated it most clearly:

The best part of giving birth at home is I got to set up my own environment. I got to decide where I wanted to do it and what was going to be around me…My birth essentially was completely up to me. I made the decisions, [the midwife] didn’t even ask me questions…It wasn’t that I wasn’t informed, it was just that everybody was following my lead because I’d already been informed [during prenatal care and through research]. See, when you’re in the hospital and you’re in labor they say, ‘Oh, the baby’s heart rate is going down, so we should do this and that and that, is that okay?’ That’s not how it worked in a midwife’s model. It was I decided and ‘You know, I think I don’t want to birth in the tub after all, let’s go this way.’ And everybody’s like, ‘Okay, we’ll go that way.’ It was about having complete autonomy of my own body and my own choices and everybody there trusting that I knew what I was doing and trusting that the baby knew what he was doing and that birth is natural and normal and nothing to get excited about.
Two participants also described how they felt safe during their home births, as discussed below. While several of the women described how much they enjoyed being at home because their families were there, and that their newborns just ‘became part of the family here’ only Debbie specifically discussed how the best part of home birth was the instant bond with her baby:

The recovering at home and being able to have my baby right away, that was huge. He wasn’t like whisked off somewhere else.

Two participants mentioned that part of the comfort of being in their own homes was the ability to be naked if that felt appropriate. Becky stated:

When I first went into labor, I thought that I wanted, I had an outfit picked out that I was going to give birth in and whatever. Yeah, I was like, ‘You know what? I’m going to be naked’ [laughs]. Can you do that in the hospital? I don’t think so!

Jessica expressed the best part of giving birth at home as:

Gosh, all of it. How in-tuned I felt with my body and my baby and getting to just be comfortable in my own house. If I have to walk around naked because the water broke and my skirt was all wet, I have no qualms about that. The comfort of going into my own bathroom - it’s clean, it’s not an unfamiliar place….Definitely pushing her out and then getting to just go in my bed and have breakfast with my family, it was just way cool. It didn’t feel like I just gave birth. It was like, ‘Okay, here’s your new family member now’ and just stay, it was just wonderful.

Clearly, aligned with how the midwives described their perceptions of women’s desires for home birth being primarily related to their desire for autonomy, these respondents described the ways in which autonomy played significantly into both their decision for and their satisfaction with home birth.

**Concerns with Home Birth**

Alternatively, only two of the thirteen participants expressed any concerns about home birth. Ann, who had a previous cesarean, stated:

I think my husband was more stressed out about if an emergency came up than I was, so, that was, you know, there’s always a concern that you’re not right in the hospital. And that if something goes wrong, that it takes longer to get to a hospital. But we prayed about it and just felt like everything was going to be OK.
Jessica, who stated that she lived about 45 minutes away from the hospital, which was a major factor in her choice to give birth at home (related to her concern about getting to the hospital in time), also expressed a concern for “what if I needed to transfer to the hospital” but her main concern with home birth was:

I just thought it might be dirty, I just didn’t want to ruin my sheets, I know that’s a weird thing, but I just didn’t want to get bloody, I didn’t know how nasty it would be.

She was also the only respondent who was concerned that the birth might possibly scare her son, which contrasted to several others who felt that one advantage to being at home was to include their other children in the birth process. However, Jessica stated:

I was also really concerned about my son, being in his environment, and you know, [him] seeing me in pain.

She went on to say she was concerned about:

Not having room to walk around, I just didn’t know if I really wanted to be birthing in my house. I didn’t know if I would be as strong as I could be, you know, birthing in my own house.

Interestingly, she had stated that she had not decided to have a home birth until she was nearly 34 weeks pregnant. In the end, she described her concerns about home birth as “really, just little things” and it turned out that she labored so quickly that her midwife did not actually arrive in time for the birth. Instead, her sister, a labor and delivery nurse, was there, and the midwife arrived shortly thereafter. Despite this, Jessica made it clear during the interview that she supported home birth and stated she wished more women could choose this option.

Unlike the concerns about the distance to the hospital raised by Jessica and Ann, two respondents specifically mentioned their relative proximity to a hospital. Chris, who had previously given birth at a birth center in a state where home birth midwifery was considered a felony, expressed that she had no real concerns about home birth, and stated:

We live about a mile from a hospital that my midwife would have rights to. So, I knew if anything, you know, went terribly awry, then I could easily be transferred. I knew I had [given birth] once before and everything went fine. And I was just trusting in my body and the process. I knew I wanted to be home, I didn’t want to
have to worry about packing a bag and packing food and driving anywhere. You know? I just wanted to be in my bed and be able to stay there.

Irene expressed a similar sentiment:

> We live 10 minutes from a hospital and our midwife was very adamant about if anything were to have happened we would have gone straight to a hospital. I feel really comfortable with how far away we live from the hospital and the basic knowledge the midwife had. I trusted her judgment very much.

Among the 11 respondents who did not express any concerns specifically about birthing at home, several other concerns related to home birth did emerge. As Gloria, whose first birth was in a hospital, stated:

> My worst fear when it came to home birth was having to transfer to the hospital. I was just like, ‘Please, please don’t let it happen’ and with the whole pregnancy, I was just praying that everything would go well and I wouldn’t be forced to go to the hospital because that was like my biggest fear, was having to transfer.

Earlier in the interview, Gloria had expressed how much easier her home birth had been than her hospital birth, and how she ultimately felt that her second baby was much calmer and healthier because she had the opportunity to fully bond with her after the home birth in a way that she had not experienced with her son’s hospital birth:

> My bond with my baby was just supported and nurtured rather than, like in the hospital I feel like I had to fight to bond with him because they kept on taking him away from me [laughs]. It was like, ‘That’s my baby. Come back with my baby.’ You know, they’d take him to the nursery and check him for this, check him for that, this and that. I was like - with her, I mean, she never left me. She just went right to me, like right to my chest. We waited for the cord to stop pulsing before it was cut, which I didn’t know about that when I had my son, but she has just been so hearty, and so healthy and so, like textured, like an angel baby. There’s just been no issues with her, and I think that’s partly like just her temperament but a lot of it probably has to do with the environment where she was brought into the world and the environment that like, our home. Like she was at home, so she wasn’t being like taken from nurse to doctor, like across the hospital like, she wasn’t, like, we didn’t go anywhere except for to the doctor and then right back home. So it was just a very calm and nurturing environment. She and I both just flourished. Like, she never lost any weight. When we went in for her two-day check-up at the pediatrician’s here, she already gained two ounces. By the time she was two weeks old, she had gained two pounds. Everything has just been so much easier and so much better.

Trust in one’s own body was also mentioned. Faye, one of the two nulliparous respondents, stated:
I read a lot about it and I just, I wasn’t really worried. I think I thought it would, that everything would go smoothly and fortunately it did.

Becky, the other nulliparous participant, a teacher who got laid off and also found herself as a single parent during the pregnancy and who ultimately received care from a home birth midwife due to her difficulty in accessing care elsewhere, stated:

My only concern was where I was going to live…I wasn’t sure if the midwife would still accept me for home birth because I had been laid off, and I had an apartment but could not afford to keep it. So I wasn’t sure where I was going to have it [the home birth].

She ultimately gave birth in the home of her new boyfriend’s mother, who wasn’t supportive of the choice to birth at home. In fact, Becky asked her boyfriend’s mother not to be present at the birth.

In addition to concerns about home birth, participants were asked what the worst part of giving birth at home was. Five women stated that there were not any worst parts, that they could not complain or think of anything at all bad about their home births. Lauren said:

I can’t really say there was a worst part. My labor was a lot easier at home than it was at the hospital. I mean, I wouldn’t really say I was in pain at any point during it which I wasn’t expecting, because I had a really bad back labor with my daughter, but there wasn’t really a worst part [laughs].

The notion that the home birth was pain-free compared to previous labors was not echoed by other moms. Jessica in fact stated that in reality, the pain had nothing to do with the birth site, but simply with birth in general the worst part was:

I guess the intensity of the contractions, it didn’t really have anything to do with a home birth, it just had to do with the delivery itself, the intensity of the contractions and not being sure whether or not I could do it.

Gloria agreed that the worst part of her home birth was the pain, but again, this was more related to childbirth in general, and she even described the pain as a “good pain”:

[The worst part was] probably the pain of childbirth…it hurt a lot, but in a way, the intensity of the pain was probably more heightened because it was kind of fast and furious, it was just a 30-minute period where I was just like, I’m going to die, and I had to tell myself, like, ‘I’m not dying, I’m just having a baby.’ Because it was very painful, but it was a good pain. It was kind of like pain with a purpose, as they say.
For Helen and Jessica, a drawback with home birth was wondering if the midwife would arrive in time, a fear that proved true in Jessica’s case. Helen and Irene also expressed the challenge of keeping enough hot water to fill the birthing tub. Both described the process of boiling water on the stove to bring to the tub because their hot water heaters couldn’t work fast enough, and Irene joked that:

> Our water was freezing so we had to boil all the water by hand on the stove. I know that is totally silly and it is not what you would probably expect me to say, but that was honestly the worst part about [the home birth].

Several women were concerned about whether their homes would be clean enough particularly to welcome others in during the birth, such as the midwife as well as any others that might have been taking care of their older children. Chris stated:

> I guess being stressed about whether or not your house was picked up before everybody came [laughs]. It was like, ‘Oh God, are the dishes done?’ and ‘Are there clothes on the floor?’ and that was the worst part. And then, by the time you are in labor, you don’t care about that anymore.

Debbie and Jessica were the only two participants who associated the “worst” part of the home birth with what they in turn did not receive because they were not in the hospital. As Debbie, who previously had two cesareans in the hospital, stated:

> I think the thing that I did kind of miss was when they would take the baby [laughs] when I was in the hospital. Yeah, that was kind of like, ‘Ah, I do miss somebody taking the baby, changing their diapers or given me a couple of minutes to breathe’ but I’ll take, I’ll let that one go [laughs].

Jessica, who had a previous hospital birth, missed some of that care and pampering in the hospital and also discussed the samples and freebies that the hospitals provide new moms:

> Maybe the worst part of having a home birth was not having like the cool perks of having the nurses take care of you, and the overnight stay and the free meal. I don’t know, the little goody bags they give you, the free Pampers?

In addition, Eve, who had a hospital birth, followed by one at a birth center and then a home birth, echoed this sentiment that the hospital can provide the advantage of some respite, that the nurses can provide some of the initial newborn care while the mother recovers, but she also
mentioned that she weighed this slight advantage against what was for her and her husband the much larger advantage of being able to just remain in the comfort of their own home:

With the third [the baby that she had at home] like a couple of times I dreamed about going back to the hospital because there is that, you know, your meals are just brought to you and you can send the baby to the nursery, but my husband continually reminded me of it, you know, we really didn’t want the stress of having to go through triage and just being a number at the hospital versus the low key of having it at home. He was able to be my cheerleader to remind me of what we really wanted.

Risk Perspectives

Inevitably, respondents discussed concepts of risk while responding to the interview questions and telling their home birth narratives. Likewise, midwives also discussed risk constructs, despite no definite question related to risk. Some of the participants’ risk narratives emerged when they were discussing their concerns with home birth. Gloria’s perspective on risk drew more from her overall philosophy of the daily risks we face:

My concern about home birth was no different than my concerns about like going for a walk this morning. I could get hit by a car, or I could fall down and, you know, there’s always general risks that you take with any decision you make. Like when I get in my car and go to the store today, I could get in an accident. And so, I mean I feel that honestly there are always things that go wrong in any situation, but I had a much better sense of calm and peace about being at home than I did about going to the hospital [to give birth]. If anything, my worst fear when it came to home birth was having to transfer to the hospital [as described earlier in this chapter].

For Chris, risk and safety relate to state laws and public perception. She drew on her experience deciding to pursue out-of-hospital birth with her first pregnancy when she was living in another state where it is a felony for a non-licensed provider to attend a home birth and where Certified Professional Midwives are not recognized or legal:

Well, [for my first birth] I was in [another state] where home birth is technically illegal, there are lots of people that do it, but you have to get in with kind of an underground network, you know, and find midwives who are willing to do it. I didn’t have those kinds of contacts there, so I would have to be kind of cold-calling people and trying to see. And also it’s my first [birth], so there is some trepidation and fear and, you know, there’s still the perceptions that you get from society that it’s dangerous and it’s not [accepted] like, ‘you’re going to try to have a home birth?’ I don’t know, it’s going to be like the 1800s and you’re going to die on your own bed [laughs].
Alternatively Eve perceived very little risk. While she was describing the best part of her home birth, she discussed how:

I never really felt in danger. I think it kind of went fast, but it was just sort of like we knew what my body was doing… and it was just really a non-event of having a child instead of a big deal of driving to the hospital and labor and you know, having lots of people checking on you and taking vitals all the time, when, yeah, we were back in my bedroom, having breakfast.

She went on to say that she did not have any concerns about home birth because:

I knew they’ll be bringing equipment and because I already had a birth and sort of knew what was normal for me, and all the testing that I did during the pregnancy, that as long as I maintained a low-risk status, I knew that there was really no reason to be alarmed to have it at home.

Kate derived a sense of safety from being able to reach her midwife, especially if she was not able to arrive for the birth given her distance:

[I asked her,] ‘So, what if you’re not able to make it?’ Because she was in [name of town about 45 minutes away]. And she said, ‘You put me on speakerphone and you have a baby’ [laughs]. Anyway, this was oddly comforting.

The one CNM that was interviewed discussed that one of the risks she felt existed with Licensed Midwives attending home births is the fact that they do not have hospital privileges, which may preclude them from transferring the mother to a hospital in labor because they will ultimately “lose” that patient (and the income that birth would have brought). She described how she viewed their perspective on home birth as the only alternative:

[Home birth is the] only option we have – so this is what we’re committed to, and we’re going to make it happen, no matter what….there’s a, at a certain point birth can become traumatic when we – keeping the woman hostage at her house because we don’t want to have to transfer her, because we don’t want to disappoint her, we don’t want her to have a C-section. Well, guess what? She wanted a C-section 10 hours ago [laughs].

This example describes how there can often be competing interests between the midwife, the laboring woman, her family, hospital providers, even emergency services personnel when a woman chooses to birth at home. This also speaks to the need to better integrate planned
home birth into our overall maternity care system so as to either diminish these competing interests or at least to have had dialogues and plans about issues that might arise during a transfer prior to any one transfer in particular.

**Future Birth Plans**

Participants were also asked where they intended to give birth in the future. All but one (Ann, as described below) stated they would never give birth at a hospital, unless a complication arose. All but Ann also were emphatic about having another home birth, with three respondents using the word “absolutely”, five using the word “definitely” and one stating, “Oh, heck yeah.” Reasons for not pursuing hospital birth include those shared by Irene, who chose home birth mostly because by the time her Medicaid was activated at 20 weeks, she was unable to locate a provider other than her home birth midwife. She stated:

I would never plan another hospital birth unless there were extreme complications, if something were to ever go wrong, if there was a breech baby or if anything like that, then the hospital birth would be able to do the surgical means or whatever. But, for me, that would be a very, very, very last resort.

Jessica, who did not decide to have a home birth until she was 34 weeks pregnant, stated:

I would only have a hospital birth if it was medically necessary, and not just because the doctor told me but because I knew it was medically necessary and I had talked to a midwife, then of course that’s what I’d have to do, but I wouldn’t plan on going to a hospital. I might do it if it was a beautiful hospital, like an amazing birth center, where I could do it all natural, then maybe, but other than that, no, I’m pretty cool with my house.

Lauren emphasized the sentiment:

No, I would not have a hospital birth unless it was an absolute emergency, you couldn’t pay me to have a hospital birth again.

Debbie, who had two C-sections and then two home births shared:

I had thought of possibly using a birthing center, but I mean there’s really no need, unless you’re in a really small house or something, I don’t think we, I wouldn’t even do a birthing center, just like you have to go get in the car and drive home [laughs].

However, this is somewhat irrelevant, as according to Florida state law, she would not be eligible for a birth center birth given her history of cesarean section.
The only participant who would not consider a home birth again was Ann, one of the two women who had a previous cesarean birth. Her decision was somewhat complex, based both on the fact that she did not plan to bear further children and that her previous pregnancies had proven difficult to both her and her husband:

Well, we are not going to have any more children. Well, actually, I shouldn't say that. We may adopt. But we’re not going to have any more of our own, just because all of my births have been very tough, and pregnancy is not the easiest thing. But, if we were to have more children, we would probably not have another home birth, and not because we are like home birth is dangerous or we are against home birth, we’re actually very much for home birth. But for us, I know my husband at this point, he was already kind of nervous about the last one, so, just for one, to ease his stress, I wouldn’t want to put him through that again. I know that he would be more comfortable just doing a hospital birth, and because, just the last birth was a really tough birth, and you know, I would want to try to do another VBAC, but I would feel more comfortable at the hospital, for us, for us, but in general, I would always encourage people to do a home birth.

Therefore, this decision remains a very personal one that balances several factors from her family’s situation, but she does not discount the option of home birth altogether for other women.

**Best Part of Prenatal Care**

Beyond the experience of home birth itself, participants were also asked to identify the best parts of receiving prenatal care from a midwife who would attend their birth at home. Every participant stated that the best part was establishing a personal relationship with the midwife and several specifically described how this led to trust. Three of them referred to the relationship as though the midwife became a “friend” and Lauren described it as “a motherly type of connection.” In addition to developing the relationship and ‘just getting to know the midwife really well’ half of the participants described how the prenatal appointments never felt rushed, that the visits would often last for an hour. As Ann put it:

We weren’t just being shuffled through an office.

Irene shared:

I would walk into the office and she would greet me by name, not a number, and I loved that.
And Gloria stated:

I felt just like I was seeing a friend that cared about me.

Kate also described the importance of incorporating her other children into the prenatal visits, particularly in the context of allowing her daughter to form an opinion of birth as normal:

It was very family-oriented. [The midwives] let my two little ones go back in the room and whenever she [measured my belly] or [listened to the] heartbeat, she always let them use the jelly and let them palpate and made them very much a part of it. The midwives had a lending library where they let us borrow books from to explain what’s going to happen and it just made it a very natural, normal process for my girl so hopefully she won’t have to go through everything that we have gone through because it will be socially and societally accepted as normal again [when it comes time for her to have children].

In addition, three participants appreciated how they were able to reach out to their midwives at any time of day or night, and actually reach them. Debbie described this as:

You can call up your midwife, and you have their cell phone number. [I could call and ask] ‘Is this labor or not?’ and she was the one who answered the phone as opposed to like a random nurse, or you know, coming, her coming to the house.

Lauren related this ability to reach out to her midwife as a measure of quality care:

The quality of care is definitely there. I mean, if I had any question, even if it was 4:00 in the morning, I could text her and she would text back whenever she got it.

Ann contrasted the personal care from her midwife to what she likely would have been asked to go into the hospital triage department, which she stated would have been difficult with her two other children in the middle of the night:

One time I wasn’t feeling well, and then I didn’t feel the baby moving, it was like in the middle of the night, and I was really upset, and [midwife’s name] came to our house in the middle of the night just so I could hear the baby’s heart beat. You know, that’s pretty good service.

Finally, two participants discussed how the prenatal care they received from their home birth midwives empowered them to make truly informed decisions. Jessica related that beyond the “personal, cozier” nature of the care provided by her midwife, she felt more:

Attuned with her, like she knew more about my body, and it didn’t feel so clinical. It made pregnancy feel, not like a condition, but it made it feel like, you know, this is a really cool thing. I just felt very comfortable with her. I mean, the lady I saw
at the Health Department was nice but it was kind of like, you’re in, you’re out. ‘This is what you’re going to do. Okay, here’s your next appointment.’ It just wasn’t as personal.

Some of this “personalized” care was also discussed in the context of how their midwives made participants feel as though they could be more active regarding decision-making in their own pregnancies. This, however, will be discussed in more detail in Chapter Eight.

**Discussion**

The overarching themes that emerged about motivations for home birth, both from the midwives’ as well as the mothers’ perspectives, included: desire for autonomy and decision-making, desire to remain in the comfort of their own home, including issues related to actually getting to a hospital in labor, the desire for personalized care, particularly of developing a relationship with their birth attendant over the course of prenatal care, and avoidance of what were perceived to be unnecessary procedures routinely performed in the hospital setting. While a few midwives found that clients who were self-pay or who received share-of-cost Medicaid might have been seeking home birth for financial reasons, and while several of the mothers spoke to the potential for cost savings if out-of-hospital births were more promoted by both Medicaid and by society in general, a financial incentive for home birth did not appear to hold true for the women interviewed. While this chapter provided an overview of these women’s motivations for home birth, the following chapters describe in more detail issues related to accessing home birth and the concepts of autonomy in childbirth decision-making.
CHAPTER 8: ACCESS

This chapter describes how women found out about their options for midwifery care and home birth, as well as the ways that midwives perceived that Medicaid-funded women find out about these options. It details the process that both midwives and pregnant women undertook to enroll in Medicaid, either as a provider or as a recipient, highlighting the length this process took for pregnant women. Generally, this chapter reports on whether being on Medicaid allowed women to access a home birth they otherwise would not have been able to have. From both the mothers’ and midwives’ perspectives, it also highlights what additional services Medicaid allowed the participants to access or alternatively blocked access to. A discussion of access to vaginal birth after cesarean (VBAC) is presented from both mothers’ and midwives’ perspectives, and frequencies from within Florida vital statistics are also reported. Finally, and perhaps most salient to the contemporary shift to HMOs for all Florida Medicaid enrollees, results of midwives’ perspective of the challenges of working with Medicaid HMOs, particularly the barriers HMOs construct in blocking women’s access to care, are presented.

Knowledge of Home Birth Option

Participants were asked how they found out about the home birth option while on Medicaid, and midwives were asked how they thought that Medicaid recipients became aware of the option. Midwives were also asked if they did any specific recruitment or advertising to Medicaid recipients. Although six of the respondents reported that they found out about having a home birth while on Medicaid from their midwives, none of the midwives mentioned that they saw themselves as a source of information about Medicaid funding of home birth. However, most of the midwives did describe that their practice websites either detail that they accept Medicaid and/or provide links to Florida Statute 467 which details the mandate for insurance reimbursement for midwifery care in all settings. Some of their practice websites also offer to
assist women in applying for Medicaid, and encourage women to come into care regardless of whether they have already secured Medicaid or other insurance or whether they need to create a self-pay plan. None of the midwives specifically advertised to or recruited Medicaid clients. They all described general marketing activities, which included maintaining their websites, but none that specifically ‘marketed to Medicaid’ recipients. Olga described her strategy to increase her position within a Google search:

I use a third party marketing company that puts my ad up there on the top when people do certain word searches, but it’s not specifically targeted for Medicaid, so no, I don’t do anything specific for Medicaid.

All but one of the midwives stated that the MomCare program, a free program located within County Health Departments that reaches out specifically to pregnant Medicaid clients and helps ensure they are linked up with a care provider, was a significant source of information for women regarding all of their pregnancy care options, including the option for home birth. Three midwives, Zoe, Susan and Quincy, described how moms would find them based on the MomCare provider list. As these midwives stated, the women were not necessarily seeking out midwifery care or home birth, but rather would get turned away from other providers on the list, and eventually, by ‘going down the list’, would come upon the midwife’s practice. Susan described that:

MomCare will refer them, sometimes they will find out because they will call several of the obstetricians and they are no longer accepting Medicaid, and they’ll just keep going down the list….I think they stumble into [home birth] because other doors are closed, because they’ve called several of the OBs and find out they’re no longer taking Medicaid, so I think the MomCare moms stumble on it.

Rose described how Medicaid insured women find her and stated:

So, they have their little book [of Medicaid providers, or rather, the MomCare list provided by the county] when they sign up for Medicaid, they’re told they’re eligible and they get a little booklet and I’m in there. And that’s really most of the time how they find me.

Rose stated that this “free advertising” to Medicaid clients was one of the advantages of the Medicaid system.
Despite the fact that all but one of the midwives cited MomCare as the main way Medicaid enrollees find out about home birth, only one of the participants stated that she found her midwife based on this MomCare list. Irene admitted that she was not planning on having a home birth, but she became pregnant while living in another state and waited to apply for Medicaid until she moved to Florida because of the experience she had with Medicaid in that state:

The Medicaid people at the DHS [in another state] told us just to go ahead and schedule an appointment [for prenatal care with her first pregnancy]. And so we did, and they said that Medicaid was going to cover every cost because it was prorated or something and it turns out they didn’t and then it went bad on my credit. So, I did call around with our daughter [her home birth in Florida] and everything was just not really working out that well with the whole Medicaid thing so we decided to wait until after the Medicaid was completely finalized [to start care].

Thus, Irene did not seek care until she was twenty weeks pregnant, primarily due to concerns about finances. This is unfortunate not only because Medicaid does promote “presumptive eligibility” to help women access care while their Medicaid is pending, but especially so because Irene had experienced pre-eclampsia with her first pregnancy, and by not accessing care, might have developed undiagnosed complications when it was too late to try to intervene. She went on to describe how she chose her midwife based on the fact that the OB providers would not see her since she was “too far along” in pregnancy by the time her Medicaid was active:

We moved to Florida in April and then we immediately applied for Medicaid and it took two and half months to be approved. By then I was roughly four months pregnant, and by then no doctors would accept me because I was past the 18-week mark and my only options were, it’s one specific doctor that did not have great reviews and then there was [name of her midwife]. We decided to go with [name of midwife] instead of going with the doctor. And, once we scheduled our first appointment with her, everything was falling into place so wonderfully we just decided to stay with her.

When asked what the worst part of Medicaid was she said, “The fact that it took so long to be approved” but that, “at the same time, it was kind of a blessing because we might not have been in that same position to actually have the midwife. So it is weird.”
However, the MomCare program really only becomes part of this process once a woman has been identified as pregnant by the County Health Department and begins the Medicaid application process. As Irene discussed, a gap exists between when women try to initiate prenatal care and when they are enrolled in Medicaid during which time they are actually unable to access care. As Penny describes it, her clinic (which other midwives referred to during interviews as her “easy access clinic”) will initiate prenatal care with any woman regardless of pregnancy risk factors or payment source. Therefore these women are not necessarily seeking midwifery care or out-of-hospital birth, just prenatal care:

Most of the reason these women come to me [is] I’m it, I’m the last safety net in [my county]. There’s nowhere else now now where you can go and get prenatal care if you have not got your insurance or your money. The Health Department wants to charge you, if you don’t have the Medicaid yet, they don’t want to start your care. You know, it’s drama over here….We won’t turn you away initially. My goal is to get people in and triage them immediately, and see where they need to go from here, whether it’s a high risk OB, stay with me, make the payment plan [establish a sliding scale payment plan], you know, whatever. And we also try to help expedite the Medicaid, which is another nightmare. So, all of that helps to encourage folks, if you will, to come in, so they’re not even interested in midwifery at this juncture, they just want to start prenatal care….It’s not the same thing as, ‘I made this conscious choice, I’m a Medicaid recipient and I decided I’d like a midwife.’ So, [among the 70% of my patients that are Medicaid] maybe, let’s just say half of those women thought about midwifery care before they got here and the other half had no clue.

Vera further confirmed Irene’s experience of not being able to access care with obstetricians when care is not sought in the first trimester:

A lot of times women fall through the cracks. Either they waited too long and they can’t find a physician and whether or not they really wanted a home birth or not, but they find that midwives are more susceptible to take them on for the prenatal care because they want to help them. [The OB practices are closed at that point to them] especially if they’re Medicaid, they definitely will tell them. If you’re not 14 [weeks], if you don’t come to us, if you try to transfer in at 16 weeks, you’re on Medicaid and you’ve not had any prenatal care – no.

She went on to describe that some of these women would continue their prenatal care from the midwives but plan for a hospital delivery with whoever was on call at the hospital when they went into labor. Midwife Rose described how she had felt used when these Medicaid recipients received prenatal care from her but all along they were
planning a hospital birth and never told her, as discussed in Chapter Six, though Quincy described how some of these women ultimately decided that having a home birth with her as their midwife made more sense than going to the hospital as they had originally planned.

Only one of the midwives specifically expressed a belief that Medicaid or any programs supporting Medicaid promoted or shared the option for home birth with recipients. In Penny’s words, women found out about their option for home birth on Medicaid via:

> Word of mouth, typically, from other home birth mothers, not word of mouth through any state or health department effort. It was simply through mothers that they may have come across who had already had a home birth and had Medicaid, too, or knew that they could at least refer to the midwife and the midwife would say yes or no to it, or they’d accept Medicaid. All the home birth clients pretty well are educated and self-referred, typically through word of mouth.

Two participants stated that Medicaid or other government programs were certainly not responsible for them finding out about the option for home birth. As Jessica said:

> That was on my own. Medicaid didn’t send me a list of near-by possible midwives that accept their insurance [Medicaid]. They didn’t give out that option, I had talked to a friend who let me know that this particular midwife and her facility accepts pregnancy Medicaid and that’s how I was able to choose her. The Medicaid plan was pretty much XYZ, black/white, you go to the Health Department and stay there until 32 weeks, and then you go to A or B OB-GYN to deliver at A or B hospital, and that’s what would happen. So, I don’t think Medicaid helped me at all in trying to choose a home birth or finding my midwife.

Becky concurred by stating:

> I did not find out that home birth was an option from Medicaid. I found out because I talked to the midwife who told me that she accepted Medicaid. I would never have known otherwise. I mean there’s definitely nothing in their literature or anywhere that says, ‘You can even have a home birth’ [laughs]. Or a birth center birth.

This speaks to the geographic range of outreach that exists across Florida, where some counties have robust MomCare programs that reach out to pregnant Medicaid recipients to help pair them up with care providers while others simply funnel them through a pre-arranged system
and are not forthright in informing women of their range of options. Midwife Yvette expressed
this as:

Actually, I think it depends on the area that they’re in because some of the
Medicaid offices or the Medicaid workers are really good about giving them all of
their options, from home birth up to hospital birth, and giving them names and
phone numbers of all those providers.

Faye had not really considered whether Medicaid covered out-of-hospital birth, and just
assumed it would be an option for her:

I think I just sort of assumed [home birth would be an option on Medicaid]
because I knew I wanted to do a home birth and so I think when I applied with
Medicaid I didn’t really have to specify what kind of birth I was going to have or
anything. I think it was later on when I was talking on the phone with DCF then I
asked, I told them that I was having a home birth but it never really seemed to be
an issue with DCF, they didn’t really care.

Gloria described that during her first pregnancy, which was covered by Medicaid, she
“had no idea that I could have a midwife on Medicaid,” and that after her birth:

I remember hearing it for the first time after I had him that midwives take
Medicaid and I was just shocked. I was like, why didn’t I know that?

She started her second pregnancy covered under her husband’s high-deductible health
insurance plan, and described how she initially petitioned this plan to cover a home birth, but
also how she came to realize that she could qualify for Medicaid:

My husband had us on his insurance with work and it was really, really expensive
but it wasn’t really covering much. And I knew I wanted to have a midwife and a
home birth. And, so with his insurance, I couldn’t find a midwife that they would
cover, so I went through all of these hoops to try to find a way to get them to
cover the midwife. So I thought there’s a law that states that you have the right to
choose where and when, and what manner you’ll give birth. So I wrote a letter to
the insurance company and said, you know, ‘according to Florida law, I should be
able to choose where I want to give birth’ and so in that process, we were kind of
doing the math of how much everything was going to cost us because we had a
very high deductible. And we realized that if I were to go off the insurance and
just pay out-of-pocket to see a midwife, it would be less expensive than paying
every month to keep me on [his insurance] and then pay the deductible and then
pay on top of that whatever was not covered. So we finally got approval from the
insurance company for me to have the home birth, but since it was cheaper
anyway, I decided to go off of the insurance. And then my husband had heard
something about the income levels being raised for people who qualified for
Medicaid. So he was like, why don’t we just apply [for Medicaid], and then if we
don’t get it, fine. If we do, great, because we could really use the help. So then I
applied for Medicaid and I got approved. I knew my midwife took Medicaid. After that I just started seeing her.

Becky, who had lost her teaching job (and therefore her insurance) in the beginning of her pregnancy, was grateful that her midwife took Medicaid because she had been told by the Health Department staff that she was “too obese” to be cared for them and would have to see an OB, which she couldn’t do until she had Medicaid. She ended up finding her midwife and receiving care from her even before her Medicaid became activated. As someone who only relied on Medicaid during pregnancy, she described her perception of the lack of knowledge about the option for home birth among other Medicaid recipients:

I feel so badly for all these women who are on Medicaid, because…a lot of people who are on Medicaid have been poor their entire lives. They have had very low income their entire lives, which often means that they don’t know people who can afford midwives. So, they don’t have any friends who are saying, “Yeah, have you thought about home birth?” So they really don’t know [home birth] is an option. They definitely don’t know that it’s a better option.

However, this contrasted with Marie, the only participant who had been on Medicaid prior to getting pregnant, who stated that when she heard the word “Medicaid” she thought of, “midwife.” Having been on Medicaid prior to the pregnancy might indicate that rather than having an income that only allowed her to qualify for Medicaid during pregnancy, she might have been one of the women that Becky described as “being poor their entire lives.” Also, Marie described herself as “American Indian” and this might point to the historic availability of midwives among communities of color that were often excluded from care by physicians.

Penny discussed how many women were surprised to find out that they actually qualified for Medicaid, and that this mostly happened due to their family size, described in detail in Chapter Five. Midwives also cited word of mouth and internet searching, including through Facebook, as ways women found out about the option of home birth. Only one midwife, Xenia, discussed how home birth is part of a growing movement of women looking for alternatives to traditional maternity care. As she stated, Florida is perhaps more progressive than other states because of its long standing availability of birth alternatives, particularly Licensed Midwives:
I think it's word of mouth, and it's a little bit of a movement, and in Florida we're really lucky because we have a big midwifery school in Gainesville [the Florida School of Traditional Midwifery], so I think it's more prevalent here. People might know their options more because we have this big school and a few freestanding birth centers.

Midwives also discussed that some women came to them uninsured and only because the midwives themselves suggested it the moms found out about the option to apply for Medicaid. As Zoe put it:

You have women that are uninsured that really want to do an out-of-hospital birth that are coming to me to find out what their options are. And we say, 'Well, try for Medicaid.' But that isn't as common as people coming in knowing that Medicaid will support an out-of-hospital birth.

Several women described stories that concurred with several midwives' views that women who seek out home birth will find the way to pay for it. Eve stated:

We knew we wanted a home birth, and we knew we wanted to use our pediatrician for the baby. So, we looked at Medicaid, or asked them, and they said that we could still do a home birth with the Medicaid, so we kind of went backwards.

Lauren described the process involved in her case this way:

Well, at first we were just going to pay out-of-pocket, we were going to sell what we had to, do whatever we had to make money because we knew we were definitely doing a home birth. I mean there wasn’t an option otherwise. And then my midwife was like, ‘Well, you know I take Medicaid and since you’re pregnant you already qualify that way.’ So I’m like, ‘Oh, bonus, ok we’ll try that.’ And it just happened to work out.

**Perspectives on MomCare: Medicaid Recipients**

Because MomCare seemed to be a significant source of information and referrals related to home birth while on Medicaid, participants were asked during interviews what types of care, counseling, or referrals they had received from MomCare. By far, the women either did not have contact with MomCare, or had relatively negative experiences with them. Six of the participants did not engage with MomCare at all, or as Ann said, “Oh, that sounds really familiar. I think that they offered it but I think that I didn’t take it.” Among the seven women that did have some level of involvement from MomCare, only Irene actually got help with locating a home birth.
midwife from MomCare, as was described above. Jessica had somewhat limited interactions with them and discussed how MomCare did not help link her to home birth midwives. Instead, they seemed to link her only with Health Department resources and hospital-based providers:

Yes [I had contact with MomCare]. At the Health Department, they didn’t refer to anything, I guess because I was in [name of County], there’s no home births really, here. I never was referred to, I mean, they referred me to midwives, but never anybody for home birth except the midwives for hospital birth, or you know at 32 weeks and you'll be transferred to this doctor who’s an OB-GYN, who will deliver your baby at this hospital, but there was never any mention of, ‘Do you want to do a home birth’ or, you know, ‘What’s your plan?’ If I wanted to do a midwife, I could have, but it was a midwife under the care of the OB-GYN at a hospital.

Kate, who became pregnant while working as a peer breastfeeding educator alongside MomCare staff at her local Health Department, discussed how she felt that the services that MomCare could provide were beneficial, but not necessary in her case, and therefore she preferred to leave them open to others who might need them more than her:

I did [have contact with MomCare]. They kept trying to get me to come and listen in on one of their breastfeeding classes and I’m like, ‘I can teach your class [laughs]. I’ll go, if you just need somebody to fill a seat [laughs], but I think I got this one down.’ We got referrals for Healthy Start but I didn’t have nor did I feel that I needed, being in the birth community, the extra assistance from MomCare. Like if you don’t need it, then I’m not going to use the services or take the services up when somebody else might really need.

Eve was another participant who had an overall positive experience with MomCare, though she did mention that her contact was somewhat limited and focused only on resources related to post-partum depression that she still battled from her previous birth. Her story also describes some of the challenges that women face enrolling in social services when they move from one state to another:

[The MomCare staff member] was able to tell me about the free counseling service for post-partum depression which, already being more on the lower income with getting Medicaid is definitely helpful, as well as breast feeding support as well. Because I was on medication for the post-partum depression with my second, I was concerned about being able to breastfeed and stuff before my third. So, they were able to point me towards people who could help me to get that under control, as well as how we’re talking with my midwife about what my decision, what was going to be the plan if it were for that….I’ve been trying to get. When we first moved back to Florida – we’d been here and moved away for ten months - and came back and I had post-partum depression, when we had
switched our WIC to Florida WIC from [another state] WIC, I tried to ask at the WIC office -- because they're a place of contact where they deal with pregnant women and children and children after birth. They actually snapped at me [when I asked for] the information for post-partum depression help, which kind of surprised me and aggravated me. So there was actually -- pretty much I was trying to get help and they weren't too overly helpful at all, they just pointed me to whatever agency and that's where Mom Care was.

Helen described very limited contact with MomCare, but did not have any real complaints. In fact, she was one of four respondents who described that MomCare had 'called me once, and that was about it'. Perhaps, as Helen describes, being that most of the respondents were not first-time moms, they did not feel that they needed the extra support or advocacy from MomCare:

I only got one phone call from the lady [at MomCare] but she was -- I explained to her when she called and all, that like, I didn't really need much of anything and kind of, you know, that I wanted, and had done this before, that kind of thing. So that was it. I only had one phone call contact from a lady from the MomCare. There were a couple of letters that I got from MomCare but it was pretty much just like that they were going to call me and check up on me and see how things are going or something but I - there was just wasn't much to it.

Chris spoke most emphatically about how, while she appreciated the contact from MomCare, she ultimately felt that MomCare 'talked down to her' because she was on Medicaid, and in fact, became slightly intrusive related to 'all the things they wanted to evaluate'. What she described were the interactions that she likely had with the MomCare staff either in person, on the phone, or via their educational materials:

In the beginning, getting onto Medicaid was difficult and complicated. And there's a lot of -- it's almost like when you're on Medicaid, they assume that you're just some poor trash. It feels like people just think that you are ignorant and you're poor and if you don't have proper insurance and you have to be on Medicaid then you have to be treated that way. And you have to be told not to you know -- they didn't do this per se but the way it comes off, the way it feels is that they're basically telling you not to smoke crack while you're pregnant. "They" being the literature that comes from Medicaid [via MomCare]. The pamphlets, the different things that come from the Department of Children and Family Services, Medicaid. You get assigned a case, I guess a case -- I don't want to say a worker but -- you know somebody who's in charge of your Medicaid case. And they call you and they check in on you and they say, 'Have you gone to your prenatal? Are you taking vitamins? Are you aware that you applied for WIC?' And I think, you know, the call is nice. They are very friendly, and they are trying to make sure that everyone knows what options they have available to them, 'Feel free to
call if you have any questions,’ that kind of thing. But the pamphlets that come in the mail are the ones that really kind of talk-down to you, I think. Also, there seems to be some sort of – it’s like a Healthy Start survey thing, which I ended up not doing. The midwife was like, ‘Oh, you don’t need to do that.’ But, there’s all different kind of things that they want to evaluate. Again, I think they don’t want people to be smoking, they want people to have good nutrition, to know that they have to have car seats, to know they can’t shake the babies, but it just felt like I was being talked down to.

Debbie also described this same feeling of being ‘talked down to’ but it was during her first pregnancy, during which she had Medicaid and was much younger. Her specific age at that pregnancy was not asked, but she had four babies at the time of the study and stated she was 28-years-old. She described what happened during her first pregnancy:

So it was awful with my first one, it was kind of like, oh shoot, like I didn’t know anything about pregnancy, or I don’t know if it was just because of my age or whatnot, and I felt kind of very bullied, especially knowing now [laughs] what I know, it was kind of like, ‘Oh, you have an ache and pain. Oh, well, sorry,’ kind of, ‘get over it.’ It was like – yes, I was put in with the health center - I guess the women center, their OB/GYN, because I didn’t really have an OB/GYN, so I didn’t know where to go or she accepted Medicaid or whatnot and so it was just kind of – I felt really pushed around like, ‘Oh, well, you don’t know anything’ [laughs].

In this pregnancy, Debbie tried to get questions answered from the MomCare staff, particularly related to what Medicaid covered during pregnancy, and described how challenging it actually was to reach the staff:

I would call the office several times to say, ‘Is this covered? Is this not covered? Can I have a doula?’ or ‘You keep telling me to turn in the papers to say this is my OB/GYN,’ but I have a midwife and I would hear from nobody and I was getting really, really frustrated. With this [pregnancy], I just kept calling them and [they were like]…‘Oh, if you don’t tell us by such and such day…who your care provider is, then we’ll provide one for you.’ So I would call them, and I would leave a voice message…but nobody would call me back [or] they’d call me back much later as if they never got my message, and it was just really frustrating…I was calling MomCare because that’s who they had told us…that any questions I have to contact them, but I…didn’t hear anything from them. They were trying to figure out who my provider was and I wouldn’t always be able to answer the phone, because [they would call from a] random number, and I would listen to my voice mail, and I would call them right back within minutes of hearing that…and I would get their voicemail…Then they’d call me back a week later like they never got my message, and then I just kept trying to call them. Finally, I answered the phone one time and I was like, ‘Hey, this is who my provider is,’ and then they’re like, ‘Okay.’ But when I tried to call to see [what was] covered…I had to find out
from my midwife that I could get the chiropractor [laughs]. Whereas, I couldn’t get a hold of anybody from MomCare, so I just sort of wrote them off [laughs].

This experience trying to actually get a live person on the phone was quite similar to the descriptions of many participants that spoke of trying to get in touch with someone regarding their Medicaid applications: they would call, have to leave a voice mail, eventually get a call back but from a “blocked” number and that person would not leave them a valid call back number, and the vicious circle would continue.

Many of the midwives expressed concern for their Medicaid recipient patients because they witnessed and observed just how challenging the application process can be. Susan described that some women find the process so challenging that they intentionally start care with a health center that can help them with the Medicaid application but then transfer their care to her once the Medicaid is approved:

I think the process is becoming a bit more, it’s challenging for women to actually apply. I keep saying, why don’t you go to the office, why don’t you, most of the time they have to try to sit on the phone, and you know these women are home all day and have nothing else to do. Ha ha. You know I’m just saying that. You know they’re at the mercy of calling, and you know, hoping someone will answer and calling and calling and calling and eventually getting frustrated and like, you know what, this is what it is and so, these women, one of them has to pay out-of-pocket. The process needs to be a lot easier. I have some people that will go to some of the federally funded clinics first because that will streamline their process, they know that they’ll get Medicaid if they go through the clinics, and then, they’ll pay for, I think they have to pay for the first visit or something. Go through the process, they’ll get the Medicaid and then they’ll transfer their care [to me].

More detail about the women’s experience with the Medicaid application process is provided below.

**Challenges with the Medicaid Enrollment Process: Midwives**

Among the twelve midwives that discussed the process of applying to be a Medicaid provider, eight described it as difficult while two described it as easy. The remaining two midwives stated that their applications were handled by someone else, so they did not feel that the process was particularly easy or hard. One of these was a CNM whose Medicaid provider
number was established when she was part of a larger group of CNMs and OBs, which actually led to some challenges:

At my first practice as a CNM I got a Medicaid number, so that goes with you [when you change practices]. Then [in my own practice] it was just a matter of setting up my group and PI number….But, initially [Medicaid] sent my first paycheck to my previous employer and then they made me get that money from them instead of canceling the check or getting it back from them and paying me.

Among those who stated the process was hard, comments made included, “It was a pain in the ass” “It took me forever” “It was confusing” “There’s a lot of paperwork” and “It’s a bit of a headache.”

Particular challenges are encountered by midwives who provide both home birth and birth center birth, or by those who might have their own practice but also work within another group of midwives’ practice, as the Medicaid system seems to have a hard time delineating between an individual’s Medicaid provider number and a practice group number, as described by Vera and her office manager who handles her billing:

As a home birth midwife, in order for you to be a home birth midwife, but practice in a group [which requires a business Tax ID number], let’s say, [name of midwife in practice] goes out and delivers a baby as a home birth midwife, I don’t want [name of midwife] getting paid, I want [name of group] getting paid and then I pay [name of midwife]. So therefore you have to form a group of midwives. So then you have what Tallahassee doesn’t seem to be able to understand, I’m telling Tallahassee, I have these three midwives with their individual provider numbers, but they all come under this group with this provider number and under this tax ID. And that must have taken me eighteen months, and five trips to the area Medicaid office where the lady I saw there actually said, ‘I’ve looked over this application and I can’t see anything wrong with it and yet they’ve sent it back.’ I said, ‘You’re employed by all that, so what chance have I got?’ [Laughs] It is a nightmare.

Among the midwives who did not seem to find applying to be a Medicaid provider particularly difficult, one had gone through the process some fifteen years prior, but the other had only recently completed it. The former, Penny, summed up the process as follows:

It’s an application. Florida recognizes the LM and you apply and you check the box that says LM and that was it. It was slow, but it was straightforward. I
remember it taking weeks, ‘cuz I was waiting on it. I can’t remember how many weeks, I applied probably in 1994 or ’95\textsuperscript{34}, so it was a long time ago.

Quincy, the other midwife who found the process easy did so because she had a mentor to help her:

> It’s fairly easy, I thought. You know a lot of midwives tell me, ‘Oh my God, it took me forever and day to get credentialed.’ But I also had a very awesome teacher, my senior midwife, she’s been practicing 13 years, she taught me all the ropes. She told me to make sure you get everything done, in that packet, get the checklist and check everything off, make sure that you have it, certify it, delivery receipt it, and then keep a copy of it. I did it and I got my credentials within like a month.

Susan also discussed how midwives help each other and provide tips to complete the Medicaid provider application:

> There’s this big thick packet that has to be filled out…there’s a lot of paper work, and…if it’s not filled out completely or correctly it will delay things. What was nice was often the midwives will help each other out…prior midwives who have done the process will often help you through it, so that you don’t delay something…or give incorrect information. And that was helpful…One of my colleagues showed me hers, so for these questions, which are general across the board, all midwives fill out these the same way. Just answer these things in these ways and, it won’t create any [delays].

Several discussed the requirement for fingerprinting and background checks and the potential delays when these are lost or need to be redone. Tammy felt that the process was standard, and that it was the same for any type of provider:

> I don’t think there was anything unusual about [applying to be a Medicaid provider]. I mean, in theory, any licensed professional in Florida is reimbursable by Medicaid. So, we just learned it in midwifery school before we graduated. We took a course on how to bill Medicaid and what Medicaid is eligible for, and then there is continuing education. Other than that than, it was just simply billing, like you would bill for anything else and then, you know, just waiting.

Tammy had been practicing for four years and thus her education was relatively recent. But many of the other recent midwives did not discuss that they learned how to apply or bill Medicaid while in their midwifery training programs. The most recent graduate, Xenia,

\textsuperscript{34} Actually, Licensed Midwives were not able to apply to become Medicaid providers in Florida until 1997.
described her process of applying to be a Medicaid provider as frustrating but ultimately taking only two months:

Oh, my goodness. Well, they have an online wizard that you can follow, and it’s really not that hard, but I have an aversion [to computers]. So, the biggest thing is the wizard kept breaking down, whatever that means. They would say it wasn’t working. So I would get halfway through it and it wasn’t working - they’re always having website problems. So you’d think you are through it – it took a lot of persistence. So every day I would go on there and call up and the wizard is broken but finally – I mean I just got through. This was the funniest part. I had sent in all my documentation. I was waiting for that number [laughs]. I called up and I said, ‘Okay, they sent me a letter saying I was missing all these things but I actually sent them in,’ and this was the funniest part, he said, ‘Oh, yeah. When you send something in, you then have to send us another letter saying that you sent things in, or else we don’t check it,’ and I said, ‘Alright, can I fax that over right now?’ and he goes, ‘Yeah.’ So I faxed over something, and it was literally a piece of handwritten paper that said ‘I sent things in’ and then faxed it, and I thought that was the funniest part. That held me up for thirty days. I didn’t know – they kept saying, ‘You don’t have your…’ and then finally, because you talk to a different person each time, finally they said, ‘No, you have to send us a letter saying I sent in the stuff.’ Anyway. So, not long after that I got my letter, maybe it took two months. If I was even more persistent, I might’ve could have got it sooner. But their website keeps breaking down and nobody knows what’s happening and then it doesn’t save your information. So, it’s like you have to keep applying over and over every day. I already started seeing clients before I had it because I didn’t want them to go without care and I just figured my number will come eventually, and it turns out I was able to back bill to them so that was good.

Echoing Xenia regarding what happens when there is any missing documentation, Rose detailed the delays that occurred when she had to resubmit documents. She also began to see Medicaid clients prior to having a number, and while she did try to retroactively bill once she got a Medicaid number, she did not actually get paid for most of that care. Unlike others who described either learning how to complete the application during their schooling or getting guidance from other midwives, Rose described the process as a “learning experience”:

That was a pain in the ass…It’s a huge application that you gotta fill out. You just have to submit everything that you have…and then you have to pay the money, then you have to wait. And here’s what happened, I forgot something…and then it stayed there. So, they just didn’t do anything. So, my file sat there. So, I waited all the time, 30 or 90 days, I can’t remember. Then I called them up and I said, you know I’m still waiting. ‘Oh, well you didn’t send this in.’ So what I did was I made the mistake, I did a whole new packet, I started all over, and sent another one in. A whole new packet, instead of sending in what they needed. Don’t ask me why I did that. So, now, they were really confused ‘cuz they had
two of my applications there. So, anyway, it took me forever to get credentialed, but I finally did. And, it’s not that bad. I was nervous. You know, at first, ‘cuz I wanted it so bad, I was seeing Medicaid clients already and I wasn’t a provider, so I wasn’t going to get paid for any of that, ‘cuz I didn’t understand the process. It was all a learning experience, and you can only go back and bill retroactive so far, so I was like, ‘I’m not gonna get paid for a lot of these things,’ and I didn’t for a lot of them, but okay, live and learn.

While the question was not asked of each midwife interviewed, the average time the application process took was between one and three months.

**Challenges with the Medicaid Enrollment Process: Medicaid Recipients**

The application process for participants also ranged from easy to difficult. Three women described the process as relatively easy. Lauren was the most emphatic about its ease and stated:

It was really easy, I did it all online. They mailed it out, they called me and asked me a couple of questions, and that was it. It was really simple. I didn’t have any loopholes, they called me once and that was it. I was lucky, I mean, I was surprised at how easy it was.

She stated that her Medicaid was activated by the time she was ten weeks pregnant, which contrasted significantly with the experience of other women interviewed, especially those who found the process difficult.

Jessica also described a relatively easy process that was fostered by the Health Department staff. Ironically, Jessica stated elsewhere in the interview that she did not like the impersonal nature of the care provided at the Health Department, and this contributed to her seeking out midwifery care later in the pregnancy, but at least the staff helped her to complete the application:

I remember being called by Medicaid. I had to go to the Health Department and get confirmation of pregnancy. I had to take a blood test, urine sample, then I had to meet with the counselor, give them documents proving my financial status. Then they sent the application, answered some questions. I think that was about it. That was very early on in my pregnancy…The Health Department took care of all of that for free, so that was a great thing.

Eve also found the process relatively easy, but in her case, it was fostered by her husband’s ability to fax documents from his work place. In fact, this need to submit documents
was the most difficult and frustrating part for the participants who had difficulty with the application, so this access Eve had to fax in documents likely contributed to the ease she described:

I was able to do it all online, which was great for me because I didn’t have to talk to people on the phone. Their [online] system was kind of confusing, but I was able to submit it all online and use the Florida MyAccess website which was really helpful. The first time I got into it and the hang of it, so, it was really easy to do it that way. I did have to scan something but again, it was really easy to do that. I think I had to fax a couple of the forms. So, I had to go to [my husband’s] office, because we don’t have a fax machine at home, to initially start the process and the rest we were able to do on the MyAccess page. My husband was able to fax things in from work.

Eve directly mentioned the system Florida requires citizens to use to apply for all assistance programs, ACCESS Florida, which stands for Automated Community Connection to Economic Self Sufficiency. This system boasts “24-hour online access to benefit information” and does admit that “it may take up to 30 days to process an application” (Florida Department of Children and Families 2013). However, on this website, a link is found where the paper Medicaid application can be downloaded for printing and mailing in, although the application does clearly state that one can, “Apply faster online.” Because Florida had converted to this online system, the DCF offices where applicants had previously gone to apply in person had closed, and some of the midwives interviewed described how difficult it was for pregnant women to apply now that these offices had closed.

Several of the participants discussed how they had managed to get the paper application and avoid the online system. Ann had been on Medicaid for her last two pregnancies, and she had made a point of saving both the paper application as well as the information that would be required. She admitted that:

The only reason I found [the paper application with my first pregnancy] was I think that someone gave it to me at like one of those pregnancy centers, otherwise, I don’t know where you get that application, like it’s not online, you just have to happen to find it from somebody. Somebody told me don’t apply online because it takes so much longer, and you can’t give all the information that way, and they don’t approve it as easily because it doesn’t capture the information as
well. So, I got the actual forms that you fill out, and then I hunted down a fax number to fax it to.

The current version of the application does not list a fax number, and only gives a P.O. Box address to mail the form in, or lists the website where the application can be completed online. However, some of the women interviewed did discuss faxing in the paper form, and one even discussed going to an actual Medicaid office to apply. Irene had moved to Florida from another state and recalled:

We went to the Medicaid and Food Stamp Office and I received a paper form to apply. Then we sent it, we went back with it and we had to fax it in to the call center. And, when we faxed it in, and then after the 45 days [they had said it would take] and we still had not heard anything, I went ahead and called them and they said that they never received the form. So, I had to go through a lot of trouble for them to say that they actually got it. Apparently they did get it and they weren’t looking at the right place for it and that was what took so long. At the same time that we sent in the application, we went ahead and sent in the proof of income and we sent in the proof of pregnancy. That was I believe all we were required to send in them. Whenever I called them to see what the holdup was, they said that they did not receive either one of the proof of pregnancy or income. So we had to, after a few more weeks, go back and send it back in and basically do the entire process over again.

Similarly to the experiences of several of the midwives interviewed that ‘paperwork got lost and they had to apply again’ Irene encountered this, albeit after using a paper form. However, even among the participants who used the online system, the most frequent complaint was that the Medicaid office lost their paperwork and they had to resubmit it. Quincy, who had suggested that the offices open again after witnessing Medicaid lose many of her patients’ documents or seeing women who were unable to submit their documents to Medicaid in a timely fashion, stated:

If [Medicaid] really wants to do it online based, there should be like scanned points where they could upload into their application, ‘cuz I have people that come in through the door with pay stubs, birth certificates, social security cards, that if that capability was in that web portal for the application [that would be helpful], ‘cuz a lot of the girls that come here are like, ‘Well I have ADP from my employer, so I don’t get pay stubs, I don’t even get paper checks ’cuz it gets direct deposited’, so they have to print that out to fax it to them. So, if they really want to make the process easier, there has to be a way where there’s like a button on this to scan the documents and upload it when they’re applying, or, do like a checklist, if you’re applying for this, this is what we need, so instead of
having to wait 30 days to get a letter in the mail saying this is what we’re missing, then wait another 15 days to get approved, and then wait 3 hours on the phone and get someone live on the ACCESS call center....Not everybody has access to a fax, not everybody can afford overnight, certified, receipt return mail, whatever, to send in all that paperwork.

The other major complaint that half of the women who experienced difficulty with the Medicaid application process had was the terrible customer service, particularly the significant delays in either getting through on the line as well as the challenges of actually reaching a live person. Of course, the participants interviewed had all succeeded in getting enrolled on Medicaid or they would not have been eligible for this study. But, several midwives described how they felt that Medicaid made the application process so difficult for women that many would just “give up” trying. Ursula said:

We’re always getting ladies coming in and saying, ‘Oh, I’ve done this, and I’ve been on the electronic site, and I’m trying and I’m trying and I’m trying’. And you just say, ‘You have to keep trying, don’t give up,’ because it’s almost like they’re making it so hard [in order] to lose the people who aren’t dedicated to do it again to get Medicaid. And there are so many obstacles, or they can never get through on the telephone or whatever. For those people who are not desperately in need of it, they just don’t bother carrying on with the application because it’s too difficult for them. It’s too obstructive.

This same midwife described how some midwives likely will just give up trying to become a Medicaid provider because the experience is so difficult for them: “I’m sure they made it so complicated so people give up.” Her biller added that trying to get reimbursed by Medicaid can be so challenging that sometimes it is not worth it to fight for what are in actuality very low reimbursements:

I don’t give up on anything. I will chase commercial insurance companies for a dollar. But Medicaid, I don’t even bother. The system is so convoluted and messed up. It’s just not worth my time.

Kate described the challenge of actually getting through to the customer service line given the usual wait times and the system being overburdened with callers, and then when you can finally get through, the staff are not always helpful:

I got the typical runaround, the, ‘We’re experiencing high call volume, please call back later. Click.’ I’ll wait on hold for an hour and a half, just give me the option
to wait on hold. Then you run into people who either don’t know what they’re talking about, can’t figure it out, can’t answer your question, isn’t your case worker, because you can’t talk to your case worker and say, ‘Hey, listen. I think you added wrong. You know, I’m getting the same numbers. What I submitted was well under it and you’re saying that I’m denied,’ and then it’s an email to your case worker and then you have to follow up a couple of days later to see if they put a note in your file and you can’t access that online. It’s a mess.

Several other respondents described how mistakes made by the Medicaid staff caused delays or, initially, denials. Chris described how she was initially enrolled in “share-of-cost” Medicaid, which she stated her midwife did not accept, but that she was able to get it corrected and get on “pregnancy Medicaid”, although she never could get a clear answer on how they were different or why she had been assigned incorrectly:

[To get on Medicaid] I just called the – I think it is the Department of Children and Families - something, I don’t know. They said you have to get online and… it was a really laborious process [laughs]. We had to get online and we had to submit all of our, you know, financial information and insurance information and I had to have the form from the midwife proving that I was pregnant and everything. At first that came through “medically needy” [share of cost35] and it wasn’t correct and I had to go back. Eventually, I was able to get [pregnancy Medicaid] but I just knew that I was going to need some kind of insurance. Yeah, when I first applied, even though I told them I was pregnant, they put me on “medically needy” which I guess is not the same as full Medicaid. I couldn’t get a clear answer as to why or what that meant. The [midwife name] said that they didn’t accept that kind of Medicaid. They would take full Medicaid but not the “medically needy” kind. But I guess it just ended up being an error on the Medicaid part. They just didn’t enter something correctly. And so once I was able to prove pregnancy then it got switched. It’s very complicated and there were lots of distracting times spent on the phone and on the internet and getting it together. But once it was where it needed to be, the rest of the process was really easy.

Faye also stated that “the first few months were really a pain and then it was all okay.”

She experienced problems because of errors that Medicaid had listed on her paperwork:

I would get all this paperwork in the mail and sometimes it was inaccurate, and actually there was a problem where my maiden name is [states name], and so my name is [states full name], and it’s a pretty common name and at one point, they had the wrong Social Security number on my file at DCF and it caused all of these problems just trying to figure that out. I had to call and call and call, and they put me on hold for hours at a time. A few times it was like I waited and waited, and I called and it turns out they hadn’t received my fax, so I had to go down [to Office Depot] again and do it. Which adds up, it’s like $3 bucks or something to fax things over there. And then there’s a lot that supposedly you

35 See Table 1.5 for a description of the types of Florida Medicaid.
can do online but that depends on if the system is actually working correctly, like I couldn't do a lot of things online because I couldn't access my account on there because of the problem with the Social Security number.

In the end, Faye described her experience as, “just the price you pay for getting the help from Medicaid to pay for the childbirth” but that on the one hand:

It’s a load off your mind that you’re going to get some help paying for it, but on the other hand, dealing with the Medicaid office was really a pain and caused some stress, to be honest. I think it’s going to be that way because it’s, you know, a government-run thing, and a bureaucracy, and there’s just like all the paperwork.

Gloria also expressed that perhaps these hassles were just the price paid for getting on Medicaid, and stated:

It’s never like a walk in the park to get Medicaid, but like I’m thinking, I’m getting free health insurance, so it’s worth whatever time I have to spend to get it.

Gloria also described how it was much easier to apply for Medicaid than it had been with her first pregnancy:

There was kind of a fast track on the website. You can either apply for Medicaid, food stamps, cash assistance, or all that stuff where you have to go through and it’s like a really long process. They also have like – it’s like a quick approval thing for just straight like pregnancy Medicaid. So I did that. I applied for that and I think there was like a phone call or whatever that they ask you some questions. So it was actually – the first time I got on Medicaid, it was such a headache. And this time around it really wasn’t that bad. I remember being surprised that compared to the last time - it wasn’t as arduous as the last time. I remembered it was being like I wanted to die [laughs]. Who knows if I was just doing it wrong or what, but they’d like send you a letter saying, ‘Hey, call on this day. If you don’t call on this day, then you’re not going to be approved.’ Then you call and you can’t get through and you’re like, ‘I’ve been calling all day. Please don’t deny me.’

Several of the respondents discussed how it was not only the quantity of information required, or even the difficulty of actually submitting the information, but that the types of information being asked for felt somewhat invasive, such as number of household members or employment details. Helen described how the application required lots of documents and personal information, but that after getting everything submitted, she never heard back whether it had been approved or not. She described the process of applying for Medicaid as:
Oh, not fun [laughs]. They wanted every kind of – all your information. They wanted your Social Security numbers and how much you make, how many people are in the house. You know, it was a lot of work, I would say, to give them all the information, but it was the initial output of information and then after that, it was fine. It was hand W-2’s in and, self-employment stuff. It was like you give them all personal information that way too. I applied for it and hadn’t really heard if we’d gotten it or not. I’d assumed we would because we were in the right money income bracket…then we went for our first prenatal appointment at 10 weeks along, they billed Medicaid assuming that I had it at that point, but I didn’t actually know for sure that I had it. I never had to do anything about it after that.

Becky described how her application was delayed because of a denial and then the need to resubmit:

Well, first I just applied online which is what you do; you go on the website and you send the application. What took forever was that they would send back paperwork for me to fill out. Just like with any government thing you apply for, you have to prove stuff, and you have to cross your T’s and dot your I’s and send it again and wait another month or two until they get back to you [laughs]. So I’m not really sure why it took until December for it to kick in, but I think the first time they sent the paperwork back, I missed a page or something. And then a month later, I would get them saying, ‘You’ve been declined, try again.’ So I think I was declined once and I had to reapply. I’m not sure why it took – what the delay was after that. It made a stressful life.

Kate also described potential clinical implications of this delay in Medicaid approval:

[Even] if you’re just doing the simplified pregnancy, it’s a short form that you’re filling out for everything. So, I got all that turned in and then it’s still 45 days almost before you get any [response]. So you have a mom who let’s say has low progesterone and has to go on suppositories or cream almost immediately to even keep her pregnancy, and she can’t do anything until [her Medicaid is approved at] 16, 18 weeks? And she loses the baby because she couldn’t physically get the help that she needed which would have been a viable pregnancy had she been able to get the progesterone?

It became apparent after the first few interviews that the timing of Medicaid activation was crucial to these women’s access to care providers. Table 3.3 details the gestational age of respondents when their Medicaid was fully activated, and also lists their insurance status prior to and after the pregnancy. This helps contextualize the experiences and frustrations of these women, such as those who went through the “stress” of not knowing their Medicaid status until the late second or even third trimester. The table also highlights the fact that most of these women were no longer insured after their pregnancy Medicaid ran out post-partum.
Increased Access Due to Medicaid

When asked what services Medicaid allowed them to access that they otherwise would not have been able to, three participants specifically referred to simply being able to access midwifery care and/or their midwife. Two referred to how Medicaid allowed them to access prenatal care at all. As Becky put it:

Other than the fact that I was able to get care from [midwife name] for so many months without actually having 100% certainty that I had Medicaid, if I hadn't had Medicaid, I wouldn't have been able to take the pregnancy test that confirmed that I was pregnant because I didn't have money for that stuff either. If I hadn’t had Medicaid, I wouldn’t have been able to pay for any of the tests or the sonogram. There was a blood test for checking for all the parasites and other things that could cause, that can damage your baby, the urine test. Yes, I wouldn’t have been able to pay for anything without Medicaid so I would have been totally screwed.

This sentiment was echoed by Faye:

Not really anything except for just the basic, the care of going to the midwife and getting all the necessary tests and everything. That's it.

Specific to this home birth population, several women referred to the access Medicaid gave them to a hospital, just in case they needed it. Knowing that the possibility of transfer to a hospital would be a financial burden, several respondents expressed relief that Medicaid would be able to cover a hospital transfer if needed. Debbie expressed this as:

I think if we had any complications that it would have been very difficult to do without Medicaid. Like if we had to have gone into the hospital or we needed something for the baby afterwards and I think that would have been really tough.

Debbie understood the true financial implications of hospital birth, having delivered her first two in a hospital, with both being C-sections. Her detailed account of the finances associated with her repeat C-section is provided in Chapter Six and demonstrates just how expensive maternity care is, as well as the incredible benefits that women can reap if they can get Medicaid for pregnancy.

Jessica discussed that Medicaid did somehow act as a conduit to midwifery care, but that Medicaid may actually act as a barrier to accessing an obstetrician. Unlike how Debbie
described that by the time Medicaid was activated, she could not find an obstetrician that would accept her into the practice, Jessica spoke more broadly about how some obstetricians simply do not accept Medicaid clients. Comparing this pregnancy to her first, during which she had a private, commercial insurance plan through her full-time job, she described that Medicaid did not necessarily change her access to midwifery care, but that it likely would have changed her access to OBs:

I wouldn’t say so much the whole midwife option, but I would have more choices maybe as far as OB-GYNs go because they often seem to look more favorably on private payments since there might be more money involved. With my son, I remember, with my insurance I was getting through work at the time, there were more options as far as OB-GYN physicians. So I do think private insurance thinks differently.

Regarding other services that participants were able to access because of Medicaid, five of them specifically mentioned accessing chiropractic care that they otherwise would not have been able to, as described by Jessica:

I was really thankful that I was able to get chiropractic treatments through my Medicaid… I probably wouldn’t have been able to afford that, as that’s kind of more of a – well, it’s not a luxury, I think it was very needed - it helped me out a lot. But I wouldn’t think that it’s medically necessary for pregnant women so I definitely probably wouldn’t have been able to afford the chiropractic treatment if I had to do it based on a co-pay. So I definitely am grateful to Medicaid for that.

Chris described her experience with the chiropractor as:

I did get chiropractic services and Medicaid does cover prenatal chiropractic. I think they covered the first five appointments and then after that there was a $1.00 copay per session – I’m like, ‘A $1.00? Okay’ [laughs]. Yes. And again, it wasn’t some – you know, any yucky Medicaid doctor. It was the nice chiropractor that a lot of people in town that I know go to and that the midwife recommended. So that was covered which I’m surprised because it was like, ‘Really, that’s covered?’

Two moms mentioned MomCare as a perceived benefit of being on Medicaid. Irene discussed how MomCare helped her to access midwifery care:

I was able to have the MomCare and that did help us a lot with selecting [name of midwife] because once I called a couple of places and they were all like, ‘Oh no, you can’t come to us. You are already past your mark.’ So, I think MomCare was definitely a benefit of Medicaid.
Eve described how MomCare provided her with resources she had not experienced in her first two pregnancies:

Somebody called me from MomCare early on in my pregnancy and that was a new service that I never had with any of my other pregnancies. I think somehow it got dropped at the end my pregnancy. I never heard from her again. Um, but just having that extra advocate, for the first time, it was new and really helpful since I was doing things differently with the Medicaid and stuff, and she was actually even able to point me in the right direction for post-partum depression help which I had with my second and was still overcoming when I became pregnant again.

Chris discussed how Medicaid allowed her to access additional social services, although no other moms specifically discussed how Medicaid also allowed them to access other services like food stamps or WIC:

Well, I guess that the food stamps would be one of those because when you apply for Medicaid you’re going to the same exact system and so you’re applying for food stamps as well. And, you know maybe we wouldn’t have done that. We wouldn’t have necessarily gone after getting food benefits, but when they saw what we’re making, which was nothing, they gave us quite a bit. And it ended up being – you know, it relieved a huge burden. I was able to eat healthier and buy lots of fruits and vegetables and things that maybe would have been more expensive and we might not have bought and might not have eaten as healthy.

Participants were asked if having Medicaid allowed them to have a home birth they otherwise would not have been able to have. Overwhelmingly, the answer was no - ten of the thirteen women stated they would have had a home birth regardless and “just found a way to pay for it.” However, while those ten women admitted to that in so many words, several also suggested it would have been a financial hardship and/or caused additional stress. Eve, remarked:

For us – we would have made it work to have a home birth [based on] our previous experiences, but it definitely relieved a lot of stress and tension and in our marriage – it was one less thing I had to worry about. During my pregnancy, I actually was put on bed rest at the end of my pregnancy, and I really would not have the stress of any of this financial stuff or, ‘Will things be covered,’ or whatever. I knew if we went to [name of hospital] for triage, which we did do, I wasn’t worried about how much it would cost. I was just able to focus on making sure that mommy and baby were healthy. That’s what I needed to do.

Gloria echoed this:
We would have been able to do it but it would have been like *such* a hardship financially. We would have…buckled down that whole time, but it would have been very stressful [and] when you have a baby coming you’re already kind of stressed about making sure that…baby is provided for….But, if we had been paying out-of-pocket for the midwife, that would have just added so much more stress which I don’t know if you read the studies but if the mother’s stressed out when they’re pregnant, it affects the baby’s health.

Chris, who had a master’s degree but during this second pregnancy chose to primarily be a stay at home mom, discussed the actual way that her family would have ‘found the way to pay for the home birth’ if Medicaid had not done so:

I was pregnant, either way we were going to make it work. If Medicaid hadn’t come through, because we had both been in professional positions before, we haven’t been poor forever, we did have 401Ks and other things like that at our disposal. And so, we had discussed specifically cashing out the 401K to be able to pay for the homebirth. Having not had Medicaid and had complications, or had to go to a hospital, that wouldn’t have been an option just because the price point is so much higher. We would have had to declare bankruptcy or something without insurance if I had to have an emergency C-section or something. So you know, [Medicaid gave us] peace of mind.

Lauren actually planned to pay out-of-pocket, but received Medicaid, and stated:

It definitely helped a lot because, if not, you know, we were planning to pay out of our pocket, which would have been *stressful*. [But] where there’s a will there’s a way.

Faye seemed aware that while Medicaid covered her birth expenses, it may have been at reduced rate from what the midwife typically charged. She commented:

I don’t know if what she billed Medicaid is cheaper than what it would have been without Medicaid, I’m not sure what the cost difference would have been, but probably I would have had a home birth anyway.

Along the lines of “finding a way to pay for it”, the midwife Wanda, who no longer accepts Medicaid based on a “purely business decision,” spoke about previous clients who would likely seek to hire her again for future pregnancies, and said she imagined that they would simply start saving in order to be able to pay her the cash, self-pay fee she charges:

[By choosing to stop accepting Medicaid clients], it shifted the people I could provide care to, and yes, there were clients that had Medicaid births with me in the past and they now know I don’t take Medicaid, and they’ve been saving up their pennies so that they could come and have a regular, full [pay] birth with me.
Alternatively, some participants stated that Medicaid did allow them to access a home birth they otherwise would not have had. Irene, one of the women unable to access care with an OB once her Medicaid became effective (at twenty weeks of pregnancy), stated:

Yes, actually, because I do not think we would have ever even really considered the homebirth before the Medicaid and then the contacting MomCare, and then, it all just really settles back to the order of everything that took place.

Becky, who was financially struggling after being laid off from a teaching position, found her midwife after being turned away from the Health Department because she was “too fat” and it was her midwife that encouraged her to apply for Medicaid. Becky stated that Medicaid allowed her to have a home birth primarily because it was the fact that her midwife continued to provide her prenatal care despite her Medicaid not being activated until she was 32 weeks pregnant, and in a way her path to home birth was mediated by both her midwife and Medicaid:

I decided that I wanted a homebirth when I realized that Medicaid would cover my midwife.

Jessica had been receiving prenatal care at the Health Department, and when, at 28 weeks, they referred her out to a community obstetrician for delivery, she instead found a midwife with whom she began to plan a birth center birth, but ultimately chose a home birth with that midwife. She stated:

Well, I would have paid out-of-pocket, so maybe having Medicaid was how I got with the birth center originally, and my home birth experience was really nice. So maybe, if without the stress like that, that’s how Medicaid helped me, but if we didn’t have Medicaid, I probably would have to work full time and just go with whatever my insurance would have allowed me to do. So, I’m thankful for Medicaid because I was able to just work part time, and get that coverage, insurance coverage, that allowed me to explore more options. So, yeah, you’re right, I’m thankful for having the Medicaid for that.

For Debbie, who had two previous cesareans and one previous home birth, and was still paying off the debt she and her husband had incurred during the second cesarean birth, financial factors weighed heavily on her decision to have a home birth.

I think if we didn’t have Medicaid, I would have definitely still done home birth, because it would have been cheaper, because we would have had to spend thousands of dollars on another C-section, not even wanting another C-
section….I think it would have been kind of difficult to pay for it…and if I would have had to go to an OB, I would have waived, for instance, the glucose test [because I would have had to pay for it].

Only Kate discussed that without Medicaid, she would have still had a home birth, but it would have been without the assistance of a trained birth attendant such as a midwife:

That’s a tough one because we would have had to pay out-of-pocket because, I mean, the baby has to come out [laughs]. So did it mean – did [Medicaid] mean me having an attendant versus going unassisted? Yes, because that would have been my other option.

Unassisted home birth represents an extreme measure to which some women will resort if they are unable to access or pay for the care of their choice.

**Decreased Access Due to Medicaid**

The majority of participants (eight of the thirteen) stated that there were not any services that they wanted during their pregnancies but were unable to receive because of having Medicaid. However, two stated that they wanted to access dental care (which is actually covered by Medicaid) but they were unable to find a dental provider that would accept Medicaid.

Jessica stated:

I had heard that dental care is important to pregnant women, but I couldn’t find a dentist that was available and that took Medicaid. I mean, I had one office that accepted Medicaid and they were 45 minutes away from my house, and I would call, and call, and call, every week until finally, they called me back and said they were busy and they were not accepting any more Medicaid patients. So, I never was able to get dental care done during my pregnancy.

Gloria seemed to be referred to a particular dental practice because of her Medicaid status, but then found out they also would not provide her care:

I tried to go to the dentist and the one I had to go to didn’t take Medicaid. They were saying that some dentists do take Medicaid but that particular one that I was like – the one I go get my teeth cleaned while I have Medicaid, but they didn’t take it.

While many moms described how they were able to access chiropractic care, Debbie stated:

I think the chiropractic care was the hard one; they wouldn’t accept [Medicaid]. We had done it before when there were a lot of chiropractors that were doing it
with baby number three, but that was baby number four [laughs] and [the chiropractors] no longer took Medicaid.

All of these examples point to services that theoretically are covered on Medicaid, but that these women could not access because the providers had stopped accepting Medicaid, perhaps as a result of what one of the midwives stated that ‘eventually you just give up with Medicaid.’ In particular, these examples resonate with the one midwife that was interviewed who was no longer accepting Medicaid. In this midwife, Wanda’s, eyes, midwives who accept Medicaid are generally those who are trying to get their practices established:

Yeah, you get lots of clients, [Medicaid] is a great referral source if you are trying to broaden the base of your business, and do more numbers.

As described earlier, Wanda had chosen to stop accepting Medicaid because when she calculated out her costs, she realized she was getting paid “less than minimum wage.”

Among the other services that moms felt Medicaid perhaps blocked their access to, Faye was the only mom who mentioned that “Medicaid didn’t pay for my childbirth class, but the instructor did give me a discount because I told her we were on Medicaid.”

Ann discussed how Medicaid only covers one ultrasound during pregnancy, which was a common response among the midwives when asked if there were any services that their Medicaid clients had difficulty accessing, but that only Ann and Becky mentioned from the women’s perspective. Because Ann had a previous cesarean, and because she went past her due date, her midwife referred her for an expanded ultrasound called a bio-physical profile. Ann described this process:

I’m not sure why they didn’t cover the bio-physical profile because you know there is a medical reason to do that one, it’s not like you’re just doing that one to see your baby. It’s medically necessary.

Ann ended up paying for this out-of-pocket which was a significant and unexpected expense. Midwife Olga further discussed the issue of Medicaid only paying for one ultrasound in pregnancy, as well as the clinical implications of this practice:
One of the things that we have been encountering recently is the ultrasounds. Medicaid only will cover one ultrasound in pregnancy unless there is a medical need. Well, we have a lot of moms who have irregular periods or they didn’t have a period or whatever, we need to have a date, a due date, right up front, we need to get that as soon as possible, so, you know, we have to try to like pull diagnosis codes out of our butt to get it covered and then you know if it’s the wrong diagnosis code, or in some cases where the ultrasound place puts the regular pregnancy [code] for that ultrasound so then their twenty week [standard, mid-pregnancy anatomy scan ultrasound] wasn’t covered and the mom had to pay out of pocket for it. It’s frustrating for us, I’m sure it’s frustrating for the imaging center as well, but I think it does potentially compromise the care of the patient, because yeah, a lot of my patients don’t want a lot of ultrasounds, but, you know when sometimes things look borderline and you’re not sure, to be able to check with ultrasound and not worry about it being covered, that could potentially you know find things that could be problems and prevent them.

Therefore, some midwives were able to find ways around this “one ultrasound” provided to Medicaid recipients, but as Olga’s statement describes, it is not only the midwife who primarily cares for the Medicaid client that can impact how other services get billed within the pregnancy. Another example of this that was discussed by other midwives was that Medicaid recipients are allotted only 10 routine prenatal visits in the pregnancy. Therefore, when some recipients transfer in to a home birth practice in the second or third trimester, many of these 10 visits have already been billed for by and paid to another provider, which ultimately results in the midwives not getting reimbursed for some of the care they provide.

Ann also discussed how Medicaid did not cover her newborn son’s circumcision, and further describes the challenges she had with a primary care concern during pregnancy:

I got sick with my second pregnancy like with a sinus infection, and I could not find a doctor to go to, that would just see me for that, without being like my full OB. And it was impossible to find a primary physician just to go see. I ended up not even seeing anyone for it, and just trying some herbal remedies to get rid of it, which actually did work, thank God, but it was very challenging and I mean, I definitely had something really bad going on, you know, but I called around to some OBs to try to see them, and they were like, no, you would have to come and become an established client and all that. And so, like, well, I really don’t need an OB, I just need a physician, you know, and no one would take Medicaid. I tried. I called my old primary and they were like, no, we don’t take Medicaid, and I called around, no one would take Medicaid for that. And as far as the OBs, they would take Medicaid, but they wanted you to become like their own [patient]. So, I was kind of stuck there. So, I went to a walk-in, which I didn’t want to do that, because they wouldn’t take Medicaid either. And, that’s you know, kind of pricey to go into a walk-in too.
This inability to write prescriptions was discussed by the midwives, although it was more in the context of medications related to the pregnancy itself. Specifically related to prescriptions for prenatal vitamins and iron supplements, which are both covered by Medicaid if filled at a pharmacy, Ursula stated that Medicaid clients do ask for a prenatal vitamin prescription:

Especially clients that transferred in from an OB. ‘My prescription’s nearly ran out, can you give me another one?’ ‘Uh, no. Sorry.’ Or, if they get to like 30, 34 weeks and their iron’s down in their boots and you say, ‘I need you to get this supplement’ and they say, ‘I can’t afford it.’ That’s why we’re making a loss on them [because they provide the iron supplements without charging].

Tammy elaborated on the “grey area” that Florida Licensed Midwives fall into regarding medications that are considered standard of care to utilize at a birth, for instance in the case of a post-partum hemorrhage.

We don’t have prescriptive privileges but we can carry medications. And so, we generally carry, Pitocin and Methergine. We give Rhogam shots and Vitamin K shots, so we would get them from a physician who can kind of, ‘I’m doing this for you, but don’t tell anyone’ kind of deal. So we could get the medications from physicians and administer them, we just could not prescribe them.

[Interviewer: So, kind of if you were a nurse, you were following an order, you were just carrying out, essentially those were ordered by somebody else, and you were just administering them?]

No, because they weren’t technically ordered. But, it’s kind of a weird grey area. It was legal for us, actually we were expected to carry them, but we were not allowed to prescribe them, which kind of requires this sort of, you get them from somewhere and it’s your own clinical judgment as to whether or not you “order” them and “administer” them, but you cannot write the scripts for them.

This is one example of how the laws that govern Licensed Midwifery practice in Florida are not necessarily aligned with the realities of the practice of these midwives.

Olga discussed how women with Medicaid that are receiving care from a Licensed Midwife do not always have easy access to obstetrical consults when problems in the pregnancy arise. Additionally, based on the Florida Statutes for Licensed Midwives, if a pregnant woman needed to obtain an OB consult for a risk score greater than three\textsuperscript{36}, not all of

\textsuperscript{36} As detailed in Table 1.6 - the Florida Statutes clearly delineate a risk-scoring system for Licensed Midwives in regards to conditions that require consultation with an obstetrician. Each item has a “score”
the obstetricians with whom the Licensed Midwives consulted accepted Medicaid, which would result in the women having to pay out of pocket. Zoe discusses a specific instance regarding this consult required for women who have had a previous cesarean section below. Olga described that when a more acute problem arises in pregnancy, she is often left to refer women to the emergency room because it would take too long to arrange an OB consult:

If they have an issue I pretty much have to send them to the ER, because I can’t get them in to a doctor’s office quick enough to take care of whatever it might be, even if it’s not necessarily an emergency situation, that seems to be the only way I can get them to be able to get the care they need, and then to get them referred. I do think that the care is compromised.

She described an instance in which she was unable to schedule a timely outpatient appointment with the regional perinatal referral center, so she had to refer the patient to the ER of a tertiary care hospital. She described that hospital as being wonderful to work with, but also described how clients with commercial insurance could get in to be seen in the private practice of that academic medical center but that Medicaid clients could not:

Say you need to go through the [regional perinatal referral center] but you know it’s going to take them too long to get in for whatever it is that they need, whether it’s maybe an external version for a breech at 37 weeks. Well you need it right then, you can’t call up [the referral center] and make an appointment. So I just have to give them their records and say, just go up to [the tertiary care hospital] and ask for an evaluation. But that’s all we can do, and that care has been good, [the tertiary care hospital] been absolutely wonderful for anything Medicaid or not Medicaid. They’ve been very, very good in taking good care of any transfers or anyone that’s become high-risk through the pregnancy, but the non-Medicaid we send through [their private practice] but then the Medicaid go to [the tertiary care hospital].

Thus, several midwives discussed that women’s Medicaid status acted as a barrier among clients who needed referral for a “risk consult” or for other complications that might arise in a pregnancy. This might not be specific to home birth as even among obstetrical practices that see Medicaid clients, those who need perinatal consults might have difficulty in getting seen by these specialists and they too might have to refer Medicaid patients to the emergency room for

and if the total "risk score" exceeds three, then the LM must document the recommendations from the OB consult in the pregnant woman’s chart.
a perinatal consult. One potential difference, however, might be that a physician-to-physician (e.g., obstetrician to perinatologist) “professional” consult might occur over the phone, with the obstetrician consulting essentially on behalf of a woman on Medicaid, but it is possible that perinatologists might not want to provide such “informal” consults with Licensed Midwives, besides the fact that LMs need documentation of such “consultation”. This then, could represent a barrier for both the Medicaid-funded women and their LM providers.

**Vaginal Birth After Cesarean (VBAC)**

As discussed in previous chapters, the rate of surgical delivery in the U.S. has increased dramatically. Women who have had a previous cesarean delivery encounter significant challenges in locating both a health care provider as well as a health care facility in which they can attempt a trial of labor after cesarean (TOLAC). While collecting data for this dissertation, VBAC was available to women under the care of Licensed Midwives, assuming the birth was planned to occur at home (not a birth center) and if necessary, an obstetrical consult was obtained.

Data from Florida birth certificates (2005 to 2010) showed that among planned home births 5.4% of women had experienced a previous cesarean. Of those, 100% had a successful VBAC (although any transfer of care for a women with an attempted TOLAC at home to the hospital setting is not counted within the birth certificates). Of the 277 women that had a planned home birth after cesarean, 258 (93.1%) had one prior cesarean, while 17 (6.1%) had two prior cesareans and 2 (0.8%) had greater than two (one attended by an LM even though this is not technically permitted based on the Florida Midwifery statutes, and the other was attended by an other attendant). Among the 277 women that had a planned home VBAC, none were attended by physician, 7 (2.5%) were attended by a CNM (of which all had one prior cesarean), 241 (87.0%) were attended by a LM, and 29 (10.5%) were by another attendant. These similar to the birth attendant rates among all planned home births (Physician 0.3%, CNM 3.5%, LM 86.9% and Other 9.3%).

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Looking at rates of VBAC in the total hospital sample (1,360,202 births from 2005 to 2010), 13% of births were to mothers that had a previous cesarean section. Among these, only 4.8% were given a trial of labor, and only 1.1% had a successful VBAC. Therefore, 98.9% of women with a prior cesarean had another cesarean. The total cesarean rate in the hospital sample was 37.3%, compared to 62.6% vaginal births (and 0.1% unknown delivery route). Of these 507,923 cesareans, 66.9% were primary cesareans while 33.1% were repeat cesareans. Among all cesareans, 28.1% had attempted labor, 69.0% were apparently scheduled without a labor attempt or performed emergently without a labor, and 2.9% had unknown status regarding labor attempt. These rates represent something different from a TOLAC and instead report among women that had a cesarean that only 28.1% had labored at some point prior to the cesarean. This is surprising considering that nearly 70% of cesareans were primary cesarean (i.e., the mother had not had a prior cesarean) suggesting that many primary cesareans are scheduled for reasons such as “suspected macrosomia” or “unfavorable biophysical profile” without giving the woman a chance to even attempt a vaginal birth. Of course, some of these would include cesareans for the absolute cesarean indication of complete placenta previa, but this is a rare (0.5% reported rate) complication. These also can include cesareans scheduled for breech presentations (at least 9% of cesareans were for non-cephalic presentations) and multiple gestations (7.0% of cesareans involved multiple pregnancies). These figures demonstrate the rationale behind both why women with previous cesareans are fearful they will not be able to achieve VBAC in a hospital and also the fears among women that hospital birth will increase their likelihood of having a cesarean.

Nine of the thirteen midwives interviewed mentioned VBAC in some capacity during the interview, while six of the women specifically mentioned avoiding a hospital birth for the fear of a cesarean section. However, only the two participants that had experienced a previous cesarean mentioned VBAC specifically.
One midwife, Xenia, tied home VBAC or at least home TOLAC, to increased VBAC success. Although she had reservations about the women who chose home birth after VBAC simply because they felt it might be the only setting in which they would achieve a vaginal birth with this pregnancy, she did support these women and found they were often successful in having a vaginal birth, even after transfer from their homes to the hospital, as partially reported earlier:

Some women, like the VBACs in particular, I worry about them because they just want a home birth because they don’t want another cesarean and they feel like maybe I’m the only option for that. So, I worry about that because they don’t want the cesarean but they don’t necessarily really want a home birth. So I’ve seen transfers [in labor to the hospital] just because of that reason. But they’re fine to transfer because at that point they still get the vaginal birth because they’re getting ready to push before they transfer so they get their VBAC [in the hospital after transferring].

Xenia went on to describe how these women seeking VBAC often seek to transfer their care to her home birth practice late in their pregnancies, after they realize they are not likely to get the VBAC they hoped their provider would at least attempt:

Some of them are saying that [their providers are telling them], ‘If you come to me, you’re going to have another C-section.’ Some clients, this is what I find the most, is that clients come to me late to care saying, you know, this guy told me he was going to give me a VBAC but as I’m getting closer to delivery, I can tell what he’s doing and I can sense that he’s going to cut everything he’s saying and he’s leading me into cesarean’. They can kind of tell that. I’ve had that many times actually. Well, I have one wanting to come in to care now at almost 37 weeks. I have another one that just came in to care yesterday, she’s 32 weeks. I had another one come in at about 30 weeks. I have another one, another one, another VBAC, same thing. She felt like her doctor said he was going to do a VBAC and then now she’s 30 weeks and coming into my care. Yeah, I have five due in June. And I think four of them are because of those reasons.

Among midwife respondents, seven also attended births in birth centers. Among these midwives, there was consensus that some women were forced to birth at home (rather than at the birth center with them or at the hospital with a physician) because they were VBAC clients. Tammy described the process of getting the required consult for a VBAC patient to have a home birth as tricky and tenuous:
When we did a VBAC at home, we would have to have a physician quote-unquote “sign-off” and that was always a tricky process. I mean, in theory, that’s a good idea to have collaboration about a patient who is in theory higher risk, so that’s a good policy, it’s just in practice, with the politics between obstetricians and midwives, you know, we were fortunate in that we would have obstetricians who would look at the clients and give us a verbal OK, but they wouldn’t necessarily write that down for the record in case they got sued. So we kind of had this under the table, ‘Yeah, we don’t have any problem with you doing home births, you know, VBACs at home, but don’t literally make us put that in writing.’

Olga further described the challenges posed when a VBAC client is also a Medicaid recipient, given that not all of the physicians that are willing to “sign off” on VBAC patients are Medicaid providers:

Recently we did find a doctor who could do some consults for us, like for our risk assessments, who is a Medicaid provider, but up until then, for a risk assessment, like, say if a mom wanted to have a VBAC and we’d have to consult with an OB, she’d have to pay $225 because that provider wasn’t Medicaid.

This amount, given Medicaid recipients’ status as low-income, can therefore restrict access to VBAC among Medicaid clients.

Zoe further described the business nature of the “consultant” relationship required for midwives, as well as the significant financial implications for patients:

I’ve been fortunate because I came from working with someone in a birth center that already had [obstetrician] backup…[who] supports a lot of the local midwives because he really is a business owner, and gets that there really is no liability to do that. That he also just makes money when we walk in and say we need a C-section, and have for the most part very healthy clients that are very well-educated. So he has a very good business mind…He “lets me do VBACs” but my patients have to pay a $2,000.00 cash medical management fee to him because he has to come to the hospital and hangout while they’re having their baby. So for Medicaid patients he actually makes more on that delivery than I do.

This speaks to the fact that while pregnant Medicaid clients cannot be charged a co-pay or be asked to pay for services that are covered by Medicaid, a “management” fee like this that is not a Medicaid-reimbursed service is technically legitimate. Zoe further went on to describe how she had recently curtailed access to clients who desired to have their prenatal care with her but ultimately planned for a repeat cesarean section, citing her own financial and time constraints:
I will tell you something that I recently stopped doing, which was I had people that had like two C-sections, and they came in for a repeat [cesarean], they couldn’t do a VBAC, so they’re going in for repeat C-section. So I would see them prenatally, and then [visit them in the hospital] and then come back and have them continue their [post-partum] care with me. But I realized that… it’s just unfortunately not worth my time anymore.

Wanda, the only midwife respondent that was not currently providing care to Medicaid recipients, described the VBAC situation in her part of Florida, and in essence is sharing that Medicaid recipients in her area do not have access to VBAC:

The VBAC situation sucks. I am the only VBAC provider for 100 miles around here. That’s criminal. It is absolutely criminal. I’ve had people drive and rent a place over here [even from other states where the practice of CPMs is illegal] to have a baby after a cesarean… but that’s just absolutely crazy. It’s just crazy not to have a provider.

The respondent mothers who had previously given birth by cesarean and were now opting for home births corroborated with the midwives interviewed in describing tenuous access to VBAC in the hospital as ultimately what drove them to pursue home birth. Ann, whose first birth resulted in a cesarean for the true medical indication of a placenta previa (a condition where the placenta is covering the cervical os and precludes vaginal delivery) and who had already had one successful home VBAC, expressed concern about having a hospital birth for her third pregnancy because:

I knew what labor looked like, and it’s already intense, and I just felt like the most comfortable place I could be would be in my own home. And I didn’t want the epidural, and so, I just knew that I would be going through a lot of pain and I would want to be at my own home to do that. Just that it’s not a place that you’re, you know, you’re just, it’s not a place you’re always in, so it’s not home, it’s not the most comfortable place for you to relax and have a child, and then also I felt like I could be pressured into having a cesarean, whereas even… if it ended up that way… it wasn’t pressure right off the bat.

Debbie discussed how after having her first successful home VBAC she became a support person to others who were seeking home VBAC, and that she viewed this role positively:

I’ve had a lot of people who have said, ‘Oh, you know, so and so really wants to do a home birth and I’ve given them your information.’ So, then I go and talk to other people who had C-sections before and were told, ‘Oh,
your body’s broken and you can’t do it at home’ and being able to kind of like help them out and put them in the right direction has been, it’s really neat to see. They’re scared or they don’t know all the right information, so it’s been really kind of neat to be able to help other people out with that too.

Clearly, the issue of access to VBAC is important for women planning to birth in any setting. Helping to ensure that women are able to choose the birth site they feel most comfortable in after a cesarean, and where their desire for VBAC will be supported, within reason, represents an important area for policy at the local, state and national levels.

Medicaid Health Maintenance Organizations (HMO)

As discussed earlier, when midwives, or other Medicaid providers, begin to feel that the benefits of being a Medicaid provider begin to be outweighed by the difficulties of working with the Medicaid system, particularly as it relates to getting reimbursed for the services they provide, they may simply choose to stop accepting Medicaid clients into their practices. There is nothing illegal in doing this, and there are no rules put forth by Medicaid that mandate that a provider be willing to see every Medicaid recipient that requests their services. Therefore, some of the midwives discussed how they will cap their practices to only accept 25% Medicaid clients, or others described only taking Medicaid clients with whom they had a previous relationship from an earlier pregnancy. Those midwives who described 75% of their practice as Medicaid recipients were in fact providers that had limited experience and were therefore trying to build up their practices.

Regardless, every midwife, without being prompted within the interview script, discussed the challenges of working with the Medicaid Health Maintenance Organizations (HMO). Several forms of Medicaid exist, as described in Table 1.5, and within pregnancy most women are enrolled into “straight pregnancy Medicaid” which in essence covers all services without co-pays for the woman enrolled (including for prescriptions). When women have “straight pregnancy Medicaid” their enrollment can be verified on the Medicaid web portal, and providers submit
electronic claims on a fee-for-service basis directly to the Florida’s Agency for Health Care Administration (AHCA) that administers the Florida Medicaid program. Providers who submit electronic claims generally receive reimbursement one week later, and payments are made per prenatal visit (up to ten routine prenatal visits) as well as for the birth itself.

However, some women either choose to or are automatically or inadvertently enrolled in a Medicaid HMO plan. Like commercial HMOs, Medicaid HMOs (e.g., Amerigroup, Humana Family, StayWell, Molina, etc.) receive a set amount from Florida Medicaid each month, known as a capitated payment, to provide all of the care for each enrolled patient, regardless of actual care utilization. In turn, providers bill the HMO for the care they provide, rather than billing directly to Florida Medicaid. Coverage is based on the month-by-month status of any enrollee, and changes to an enrollees’ status occur on the first day of each month. Health care providers must complete credentialing applications with each HMO, which is beyond or in addition to the credentialing application they completed directly with Medicaid. Unlike the electronic fee-for-service billing that midwives utilize with straight Medicaid, Medicaid HMOs reimburse for services in the same manner as commercial insurers, that is, through a single, “global” payment that covers all prenatal visits, the birth, and post-partum care. This is reimbursed after the pregnancy, and in some cases several months later. Whereas midwives stated that a key benefit of accepting Medicaid clients is that Medicaid reimbursements provide a steady, weekly, stream of income that can help to cover monthly expenses like rent or electricity, with Medicaid HMOs this benefit disappears. Additionally, where the midwives enjoy being able to verify eligibility for services on the Medicaid portal, as well as the status of claims, when a patient is enrolled in a Medicaid HMO this access decreases and reverts back almost to the way that providers verify eligibility and coverage through commercial insurers.

Therefore, although providers are able to check the Medicaid online verification system with relative ease to determine what type of coverage a pregnant woman has, when women are switched from a straight Medicaid plan to a Medicaid HMO without their knowledge or consent it
makes it challenging for the midwife to keep up. As Vera described it, because changes happen on the first of the month, but births can occur any day of the month, regardless of whether or not it is a weekend, sometimes services, including birth attendance, may be provided to a patient who has been switched to a Medicaid HMO:

The fear is, for example, April 1 falls on a Saturday, and my [office staff] don’t check the Medicaid list until Monday and you’ve delivered on a Sunday and they’ve been switched to StayWell [one of the HMOs on the 1st, Saturday]. It’s a huge issue, and then we obviously don’t end up getting paid.

Therefore, midwives actively encourage their patients to stay on top of their Medicaid status, to help ensure that the midwives are credentialed with that plan, and some midwives also tell their patients to request that Medicaid re-enroll them in straight Medicaid. As Olga described it:

We tell [patients], if you get that letter stating HMO, call us right away ‘cuz you’ve gotta let them know which one you want to select, ‘cuz they will assign you to one that’s not good, and won’t pay us, and then it’s difficult to get changed.

Vera also stated:

You really have to kind of prepare women, like, ‘Don’t let them switch you to an HMO’, you know, pay attention to your mail and if you get switched to an HMO, then you have to call and get switched back [to full pregnancy Medicaid].

Nancy described that women often do not know about or have a choice in getting enrolled in a Medicaid HMO:

What I’ve heard from many, many clients is that they are automatically enrolled in an HMO and aren’t aware. And the way HMOs work, if you don’t provide the proper notification as a provider, that you are providing the care and get your authorization ahead of time, you know they affect their cost savings by managing the care, so if you haven’t been approved then you don’t get paid at all. And I’ve done billing for other home birth midwives where they found out at the very end of the pregnancy that their client had been in an HMO all along and they’re just out [of that reimbursement], they never got paid...You should be able to look up somebody’s eligibility and know they’re on an HMO but it’s not always there ahead of time. And if you don’t check it on a monthly basis then you don’t have any notification.

Rose described this in detail, and also described how she ultimately had money withheld from her reimbursements because she had received payment from “straight” Medicaid on a client that
was actually enrolled in an HMO, which she ended up never getting reimbursed for and in fact had to pay back what she received from (straight) Medicaid:

I never got paid a nickel for that because it was an HMO, and I didn’t know it was an HMO and Medicaid hadn’t told me about the HMO, and they ended up not paying me for it. Period. I got paid [by Medicaid] and then I had to pay back all her prenatals because they did pay me for the prenatals but then they took it away from me afterwards. I lost about $3,000 last year because Medicaid decided, ‘Oh look, she had an HMO’ but they paid me, though, even though it was an HMO I just billed it, I didn’t know, so I just billed it as regular Medicaid and they paid me and put it in my account. Well, then they did an audit and they actually took it away from me, they said, ‘Here’s what you owe us, keep billing us and we’re going to keep taking until you’re paid off’ the $3,000, which is a lot of money. It was devastating. It was at a really slow time for me.

She then detailed what was just described above regarding the weekly Medicaid payments keeping the midwives afloat until the global fee insurance reimbursements come in with large sum payments, as well as how she will not accept Medicaid HMO clients any longer:

My Medicaid clients I bill on a weekly basis, you know, per visit. And you get paid like that. I like Medicaid because at least I know I’m getting paid. It’s something that holds me over….But I will never take another HMO. Ever. [Because you get the pre-authorization] and you’re supposed to get paid, but you don’t…If I want to do something pro bono I’ll do it pro bono, but I’m not going to do a pro bono when I have an understanding that I’m going to get paid. [I can look up to see what type of Medicaid they have] but there’s different codes, like the MMP37, full Medicaid, MEA, and I don’t know what all these codes mean, and I don’t have time.

In addition to all of the midwives bringing up the topic of the Medicaid HMOs, they all discussed how they had eventually hired companies to handle the billing because it just took up too much of their time. Vera’s example above clearly depicts both how laborious it can be to stay on top of Medicaid enrollee’s status as well as how these somewhat “hidden” shifts to HMOs can block reimbursement for services that midwives legitimately provided. Clearly, this is through no fault of the midwives or even the Medicaid enrollees, and is another example of what

37 See Table 1.5 for types of Florida Medicaid. From these terms used by Rose, only “full Medicaid” is relevant here. MMP stands for “Medicare-Medicaid Plans” which are for dual-eligibles (those that are both low-income and disabled or elderly). MMA stands for managed medical assistance, which is the term used to describe Medicaid HMO plans. MEA does not exist.
Rose described as “providing pro bono care without the understanding of providing pro bono care.”

Wanda summarized how challenging it was to work with the HMOs, as well as how they tended to pay less than regular Medicaid. Her experience in even trying to become credentialed as a provider sounded a lot like the experience of the pregnant moms who were trying to enroll in Medicaid:

I tried to apply for the Medicaid HMO when they only had one of them and they consistently lost 3 certified packets of paperwork to become a provider, for a Medicaid provider who’s [already] in practice anyway. But to be a provider through the HMO, you have to do their paperwork, and I’m talking like 40 page applications, character references, BS, just total BS. So, I literally applied for the one HMO that was starting to cover this [geographic] area, three separate times, mailed the packet in the first time, they lost it, they changed addresses and I mailed the packet in a second time and they lost it, I mailed it in certified mail a third time, they lost it again. This is now over almost a three year time period. I basically said, screw this. If you’re that incompetent getting the providers on board, I can’t imagine what a nightmare it’s going to be to work with the clients, and to try to get reimbursed for services. So I just said I’m not doing that. I’ll do straight Medicaid, I encourage my clients to sign up for regular Medicaid, avoid the HMO…because they reimbursed you at a rate even lower than what the Medicaid rate, which sucks anyway.

As Wanda stated, another HMO challenge midwives discussed were the even lower reimbursements the HMOs paid compared to even the already low reimbursements allowed by Medicaid. Because Medicaid is paying the HMOs at the rate they would be reimbursing the providers to cover all the care any given pregnant woman would require, the HMOs actually pay the providers even less than straight Medicaid because they are trying to skim their own profit off that same rate. Susan detailed this as:

The Medicaid HMOs want to pay you less than the Medicaid rate. That’s one thing I just can’t understand, how they can be allowed, and, be able to do that? If Medicaid contracted with them, they should pay Medicaid rates, which are already low…and it’s like we tell women now, do not allow yourself to be put into an HMO. We try to get women to just stay on straight Medicaid, but they just have to be savvy, and in [name of] County, I’ve heard that women now don’t have a choice, they have to go into an HMO.

This statement makes reference to the pilot program Florida conducted within several counties during the timeframe of these interviews that was examining the feasibility of
transitioning all Medicaid recipients onto HMOs. Unfortunately, all of Florida Medicaid has now transitioned to a HMO model and therefore the benefits midwives used to have regarding these prompt weekly payments in real time are now gone. Florida Medicaid underwent a reform process beginning under Governor Jeb Bush. In 2006, this five-county pilot program was launched where some Medicaid enrollees in those counties were converted onto “managed care” (HMO) plans that were administered by third parties. Despite significant problems, a three-year extension to this pilot was granted by the federal Centers for Medicare and Medicaid in 2011. That same year the Florida Legislature approved to expand this “Medicaid Reform” and mandated statewide managed care to be rolled out in phases, with all Medicaid enrollees shifted onto Medicaid Managed Care plans by August, 2014. Apparently, this is fully completed and there is no turning back.

Thus, while all of the midwives interviewed expressed difficulties in working with the Medicaid HMOs, to the extent of stating that they would not accept Medicaid clients on HMOs, now that there is no further “straight” Medicaid, these midwives will have to choose whether they will stop providing care to Medicaid recipients altogether or if they will accept both the lower reimbursement rates and the increased hassles (including the one global payment at the end of the pregnancy instead of the weekly payments provided by straight Medicaid) that the Medicaid HMOs represent. It seems quite possible that this shift to Medicaid HMOs will actually serve to eliminate home birth access to Medicaid recipients. As Rose said, if the Medicaid system shifts entirely to HMOs, then she will no longer participate as a Medicaid provider:

Well, then I won’t accept Medicaid. I won’t. Unless they’re Medicaid full. If everyone’s an HMO, I won’t do it. Unless they make it easier for, for you know, not unless they pay me. Why am I going to take care of these clients? It’s not the client’s fault. But I’m not going to get screwed.

Furthermore, it remains to be seen if Medicaid enrollees would have a choice to change providers during pregnancy, as this might ultimately lead to one or the other provider not getting paid at all by the HMO. As Wanda had chosen to stop providing
care to Florida Medicaid recipients based on their low reimbursements, it will remain to be seen if more Florida Licensed Midwives will stop accepting Medicaid clients, particularly now that they are all going to be enrolled in Medicaid HMOs.

**Discussion**

A key access issue among Medicaid recipients has nothing to do with midwifery care or home birth. Instead, it revolves around basic access to prenatal care particularly when they have not yet completed the Medicaid enrollment process. Among this sample of women who had a home birth while on Medicaid, the range of gestational age when their Medicaid was fully activated was between eight and thirty-two weeks; however, the importance of asking the participants when they began the process was not appreciated until data analysis commenced. The gestational age when they saw their first provider in this pregnancy was between four and twenty weeks. This variance is due in part to the fact that some women were able to begin care because: a) they were able to be seen at a Health Department clinic, b) they were still on a private insurance plan when they became pregnant, or c) a home birth midwife was willing to see them before their Medicaid was fully in place. Among these thirteen women, only one had full Medicaid prior to her pregnancy, and one was on a Medicaid share-of-cost plan (see Table 3.3). Therefore, all but one of the participants had to apply for pregnancy Medicaid once they became pregnant. Among the six women that had private insurance at the start of pregnancy, one excluded maternity care and two had either only major medical or such a high deductible that prenatal care was not covered in a practical sense. Two other participants started with private coverage but lost it through their own or their husband’s loss of employment. One maintained her private coverage while Medicaid ‘kicked in’ as secondary insurance and covered deductibles and co-pays. Five women had no insurance coverage prior to the pregnancy. Therefore, most women had to apply for Medicaid once they were pregnant, and as they described, this was an arduous process.
with frequent delays that contributed to Medicaid not being active until well into their second, and for one, third, trimester of pregnancy. At that point, many participants found that the only providers that would still accept them into care were Licensed Midwives.

Women therefore came to know of the option for home birth under Medicaid either by the midwives that had accepted them into care prior to their insurance status with Medicaid being finalized, through word of mouth, or from MomCare lists. However, MomCare programs vary from county to county and while some programs openly shared the option for home birth and care provided by Licensed Midwives, others apparently are primarily shuffling pregnant Medicaid applicants to the Health Department where they will not receive the highly personalized care that they receive from Licensed Midwives.

Having Medicaid allowed some women to access ancillary services such as chiropractic and dental care, but for other women in this sample, such care was not accessed because there were no providers that would accept Medicaid recipients. Again, this variance seems primarily geographic. While none of the women in this sample, by nature of the eligibility criteria for the study, had to transfer to the hospital, women in this study felt a sense of relief that Medicaid would allow them to access and pay for a hospital birth, if that became necessary. While this provided a sense of back up and financial security, all but three respondents stated that even if they had not received Medicaid, they would have had a home birth and “found a way to pay for it.” One of these women stated that without Medicaid funding she would have had an unassisted home birth.

Two of the respondents were able to access VBAC services with these home birth Licensed Midwives, and several of the midwives discussed that some of the women that are seeking their care do so simply because they feel that their only chance of having a vaginal birth is in the home setting. VBAC is a contentious issue at both the state and national level that deserves further research. It is notable that as of this
writing, Florida Licensed Midwives have just been confronted by the reality of their liability carriers discontinuing their coverage for VBACs. It remains to be seen if another carrier will pick up these policies or if VBACs attended at home by Licensed Midwives will become essentially impossible to access.

Another contemporary issue that is arising in Florida is of the Medicaid HMOs. While, during the data collection phase of this research the vast majority pregnant women in Florida could be enrolled on “straight” or “full” Medicaid, Florida Medicaid has now instituted a 100% HMO program, for all Medicaid recipients. As referenced in Chapter Six, what were considered advantages for the midwives to accept Medicaid, such as the weekly payments and the relative ease of checking patients’ eligibility via the web portal, are no longer going to be in place. Medicaid HMOs act much like commercial insurers and pay one global fee after the birth, so the steady income stream midwives had been able to count on from Medicaid will no longer be there. Furthermore, HMOs are commercial enterprises in the business of making profits. They take a capitated payment for each “covered life” from the State Medicaid program and from that pool of money are expected to pay for any services that enrollees’ require. Inevitably, the HMOs are going to try to profit some of the $1,800 that the midwives had been making for the entire course of prenatal care, delivery, immediate newborn care, and post-partum care. Midwives already felt that the Medicaid reimbursement rates were too low, and with HMOs trying to take some of that, it will remain to be seen if midwives continue to provide care to Medicaid recipients, particularly given the increased resources midwives will have to place in filing claims with the HMOs. Future research could examine the extent to which the shift to Medicaid HMOs restricts access to home birth care to Florida pregnancy Medicaid recipients.

The following chapter will discuss the ways in which home birth among this Medicaid-funded population offered opportunities for autonomy, informed consent, and
decision-making. It will also describe the ways that Florida policies impact Licensed Midwives’ ability to provide care.
CHAPTER 9: EMPOWERMENT

Throughout the course of the interviews, a key concept that emerged was that of the maternal empowerment that arises when women are able to make informed, conscious decisions regarding their birth experiences\(^3^8\). Midwives felt that the main reason their clients sought home birth was to have autonomy over their birth and to have their decisions respected, although the participants mainly described their motivations for home birth as seeking to have a relaxing, natural experience. Some did make the decision to have a home birth because they had a previous disempowering experience in a hospital and they did not want to experience that again. This chapter reports on the perspectives of both the mothers and their midwives regarding issues of the informed consent process, decision-making, and autonomy, as they relate to an overall theme of empowerment. The chapter begins with descriptions provided by both the women and midwives regarding how prenatal care provided by home birth midwives engaged mothers in a more robust informed consent process. It continues with a description of who helped these mothers make their decision to have a home birth, followed by their descriptions of the types of reactions they had from family and friends to their decision to have a home birth as well as how they dealt with those reactions. As a function of autonomy, the women describe the extent to which they felt in control and supported during their labors, and how home birth has changed them. The chapter concludes with a discussion, primarily from the point of view of the midwives, of how Florida laws and policies promote or constrain home birth, particularly as it relates to Medicaid.

\(^3^8\) This use of “informed choice” or “informed consent” is not the same as what researchers generally refer to during an “informed consent” process that is undertaken during research subject recruitment. Instead, here the term “informed consent” is used by both midwives and women interviewed in reference to the process of making educated choices about aspects of their care, and in particular, the process in which these midwives engage clients in understanding their care options and then the care recipient’s making their own, autonomous choices.
Informed Choice

Both the midwives and mothers interviewed cited the process of informed decision making as being at the core of the type of care they provided or received. Unlike the previous experiences several participants had in hospital birth settings where decisions were made for them and procedures done to them, in the home birth setting, and during the course of prenatal care with a home birth midwife, a significantly more interactive and empowering process of true informed choice was encountered.

Kate stated that the main reason that she did not want to have a hospital birth was:

Just the lack of informed consent. I mean, it’s ‘We’re going to break your water.’ ‘No, please don’t.’ ‘Oh, we just ruptured it.’ ‘What are you talking about?’

Having had a negative and disempowering experience with her first birth in the hospital, Kate later became a supporter of midwifery care and promoted natural birth among her friends, and went on to have a birth center birth and then a home birth. She discussed how, during the course of prenatal care, her home birth midwife never forced her into any decision, and instead would provide her with options from which Kate would be able to make an informed choice.

Kate described this process as follows:

We were on the same page with almost everything and when I brought up something, vitamin K for example, I said, ‘I’m pretty sure we’re refusing vitamin K, but I’ve heard about the liquid. Can we get the liquid?’ She said, ‘Yes. We’d have to order it from Canada but we can get it and get Medicaid to cover it.’ Then she said, ‘But, I personally,’ she said this that and the other, and she gave me the reasons why she didn’t even think that it was needed, but she said, ‘obviously you have to come to your own conclusion. We’ll support you whichever way you go.’ But to know that she was already ahead of my thought process and I’d already done my research, I was just trying to finish out my research for my husband who’d be like, ‘We’re not doing this.’

This interaction describes how Kate had clearly done some of her own research prior to discussing the use of Vitamin K with her midwife, but how she felt supported in her ability to make an informed choice as opposed to being rushed into a decision without time to weigh her options. However, thinking back, Kate did recall how her midwife interjected her personal opinion that she might not think something was necessary, though still allowed Kate to make her
own decision. While this might just reflect Kate’s recall, perhaps this description does not demonstrate a truly unbiased informed consent process on the part of her midwife.

Becky also described how her midwife engaged her in a process of informed choice, and per Becky’s recall, this midwife did offer a more unbiased approach, particularly to whatever test or procedure the midwife herself may not have agreed with:

I’ve learned so much from [my midwife] because she didn’t just tell me what to do. She explained every little thing, even the things she didn’t approve of or things she didn’t recommend, she explained them to me and asked me what I wanted to do before she told me that she didn’t usually recommend it. So, there’s definitely more consent. She did that very respectfully. She told me what the government recommends or what the standards [are]. She told me why people do it and then asked me if I want to do it. I was like - for some things I saw no point whatsoever, and other things, like I wanted to get a sonogram [laughs]. She asked me what I wanted to do.

When midwife Nancy was describing why she believed that her Medicaid-funded clients sought midwifery care and home birth, she described that women sought to engage in care that would respect their decisions, and that would provide a true informed consent, not to present biased information and expect women to just follow along. Nancy specifically addressed that for “true” informed consent to occur, the information must be presented in a way that is both thorough and unbiased. She further spoke of how the women just wanted to make decisions and then not have to fight about them:

Well, certainly it goes into that whole idea of having their wishes respected, not having to fight for what it is they believe is right or the way they want things done. You know if they say they don’t want vitamin K injections for their child, they don’t have to wage a battle about it, they just want to say it and have it be the way it’s going to be. A lot of them have done their own research, or are very open to, or I should say are open to a less biased presentation of, the facts. I think informed consent is all about how something is presented, there is a way to present information and be thorough and unbiased, or you can present something and say that really only gives one option. Whereas really informed consent you give all the options and they make choices for themselves. I think those that choose homebirth really want that true informed consent.

Midwife Quincy in particular discussed how the women who come to her that have had experience with birth in traditional maternity care settings are surprised when she asks them to weigh their options and to make informed decisions during their pregnancies:
If they’re multips, they’re like, ‘Wow, I have to make the decision? You’re not going to make the decision for me?’ I’m like, ‘that’s right. The only time I would make a decision [is] if you’re unconscious and your life is threatened, that’s the only time I’ll make a decision for you, but if you’re alert and awake and you’re here with me, then you need to make your own decision.’ I even tell them like a couple of visits before hand, like, remember, I’m going to talk about this next visit, so, go do some homework, some research, so when I start talking about it, you can say, ‘I don’t want it’ or ‘It’s this, I do want it.’

Wanda spoke of a “raising of consciousness” related to the birth paradigm in the United States that is being fostered by increased lay media attention. As she stated, “You see water births on television and you see home births on television, and *Call the Midwife* show,” adding that people are beginning to seek care that allows them to participate actively and to make informed decisions:

On the one hand you can get on the little conveyer belt and go into the hospital and have a McBirth, is what I call it, because you come out with a baby in a plastic box at the other end of the conveyer belt, and it’s basically done the way they want to. Or then you have these more educated clients that are taking this opportunity to improve their knowledge base and their level of education about their own body and this process, and they’re wanting to take more responsibility for those choices, and that is the advantage of having the midwifery [care]. If you don’t want the policies and procedures as they exist in the hospital, then you can personalize that experience more for them, and that’s basically why people tell me they come to me, they want to make those choices. Informed consent is what my practice has been based on since [I began practicing over ten years ago].

Therefore, while the concept of “informed consent” differs from the way the term is used in research, here the term refers to how pregnant women are able to truly “consent” to the care they desire, or “refuse” care they do not. For instance, if they do not “consent” to an episiotomy, one should not be performed. Or, if women do not want their baby taken away to a warmer or the nursery, they should be able to have that choice respected and the baby remain with them. Both the midwives and the women described how they felt that home birth gave them the greatest chance of having their informed choices respected, including describing that philosophically the women and midwives were “on the same page.” Alternatively, while women may sometimes be “on the same page” with their midwives or physicians caring for them in a hospital setting, it can be the hospital policies or the nurses working in and employed by the
hospital that can completely tear the page out of the book and subject women to procedures, such as artificial rupture of membranes, that are against the wishes of the pregnant woman. Staying at home to give birth, then, empowers women to have their voices heard and their choices respected because rather than being at the mercy of hospital policy, in fact, they are the “rulers” of their own home environment. This leads directly to the next topic: empowerment.

**General Empowerment Discourses: Medicaid Recipients**

Throughout the interviews, while answering various questions that might not have directly related to concepts of autonomy or empowerment, respondents described how they either felt that home birth could offer them more autonomy or how hospitals restricted their autonomy. This autonomy allowed them to build self-confidence, and therefore become more empowered. Lauren described why she thought that her home birth had been so much easier than her hospital birth:

> I think it was the confidence that I had in my birth team, and I was in my own environment, I wasn’t stressed about unknown people coming in, coming out, poking, prodding, that type of thing. I was just in my home, if I wanted to go lay in my bed I could go lay in my bed, if I wanted to go walk into my kitchen to get a drink, I could do that. So, I think it was just being in my normal environment where I’m relaxed and you can just go with the flow and that helps a lot.

Marie, who had never given birth in a hospital but had both of her children at home, discussed her impressions of the hospital birth environment as being unsupportive of “the way God made us, to give birth” and instead to apparently serve the needs of the hospital staff:

> That’s why God made us the way we are, to give birth. And by the fact of going to the hospital, I mean, if you don’t have the baby at a certain time when these doctors want you to have a certain time, it’s like, already, let’s go do the C-section, let’s do the C-section. And by them giving you the epidural, it makes your baby’s heart stop, it puts your baby in distress, and that’s when them [sic] are like, ‘Oh, that’s why your kid is in danger, we need to hurry up and do an emergency C-section.’ It’s because of them they [are] making your kid an emergency C-section.

To be clear, an epidural does not stop a fetal heartbeat, but Marie is voicing what many supporters of home birth believe: that iatrogenic risks associated with hospital birth are worsened by being put on the time frame of the hospital and its staff, not on the natural time...
frame of the maternal-fetal labor efforts. Furthermore, she poignantly describes what is referred to as the “cascade of interventions” (Tracy, et al. 2007) where once one labor intervention is applied (e.g., an epidural) the risk for additional interventions (e.g., a cesarean) also rises.

Kate discussed how difficult it can be to overcome the power differential with hospital staff, particularly doctors, and how this can ultimately impact birth outcomes. She said:

It’s a lot harder to sit there and argue with a doctor in labor with nobody to advocate for you, especially being a first-time mom and having a husband who’s scared to death of birth.

She went on to describe how she had advocated for her brother’s wife, who she described as having a “lower IQ”, when she was admitted to the hospital for a labor induction because she had reached forty-one weeks of pregnancy and had not gone into spontaneous labor. The physician placed a Foley catheter39 (Kilpatrick and Esakoff 2013; Lewis and Collins 2008) that successfully opened her sister-in-law’s cervix to four centimeters, but when labor did not ensue, the doctor was looking to employ additional induction techniques. Kate describes her interactions with her sister-in-law and hospital staff after the Foley induction:

I asked her what they were doing and she’s like, ‘I don’t even know.’ I’m like, ‘Look, it’s your body. What’s worse is it’s the most private area of your body. What do you mean you don’t know what they’re doing to you?’ She’s like, ‘Well here, talk to the nurse.’ So I’m sitting there talking to the nurse and I was like, ‘No, see if there’s something else that they can do.’ They don’t need to be doing this, that, and the other. I found the doctor and said, you know, ‘She’s not dilating well. Can we put her on a birth ball? I will go and get my birth ball.’ [He said]’Oh well the midwife is in there right now.’ So I went in to go to talk to the midwife to see if we can put her on a birth ball. ‘Oh, well, I just ruptured her water.’ ‘Why? She’s at four centimeters. You’re putting her on a clock. She sat four centimeters overnight.’ And I’m like, ‘She’s going to end up with a C-section because you guys put her on a clock.’ So she ended up going [having a vaginal birth] – but she ended up with fourth degree tears through her sphincter because she said, ‘I’m pushing’ and they said, ‘No, you’re not’ and she pushed anyway.

39 A Foley catheter is normally used to drain the urinary bladder, and after it is inserted through the urethra, it is held in place by a “bulb” or “balloon” that is inflated with saline. The same device can be applied as a labor induction aid when it is inserted into a woman’s cervix, after which the balloon is inflated with saline to provide a gentle pressure to the internal os of the cervix that can help the cervix to open, or dilate. The Foley bulb will expel once the cervix has dilated beyond the diameter of the bulb, usually at 3 to 4 centimeters. This cervical pressure can also induce prostaglandin release that further helps with cervical dilatation.
This example speaks to how the hospital staff does not trust that women know what is happening with their own bodies, which leads to the staff essentially telling the women what to do rather than engaging them in the birthing process. This also represents an instance of how some respondents felt there were midwives who acted more like doctors, or “medwives”, as was discussed in Chapter Five.

Gloria also discussed how her wishes were not respected during labor, particularly when she was pushing, during her first birth in the hospital. She had educated herself regarding optimal physiologic positions for pushing, but she was not allowed to make the choice of what position she pushed in:

When it was time to push I asked [if I] could be put up on an incline. They wanted me to lie flat on my back to push and I said, ‘Can I be propped up? I don’t want to lie flat.’ They’re like, ‘No, that’s just fine. You’re fine. This is how things, this is how it’s done.’ And I knew from doing research like, it is not good to push when you’re flat on your back. You’re going against gravity and being propped up will help the baby make like a smoother entrance. And so there were just so many times when I was told, ‘No, no, no, no, no.’ And I was like, ‘Why? Would it hurt being propped up?’ Like, No. The baby was fine. He was never in distress. He was never – his heart rate was always good. Like, there was never any problem. It’s like they constantly wanted to monitor him and I’m like, ‘He’s fine. He’s fine.’ If anything, everything that they were doing to try to keep things under control was making things worse, and causing me more stress. So, I tore really, really badly when he came out and I think that’s partly because I was flat on my back.

She went on to sum up why she had chosen home birth for her second baby:

Once you get to the hospital, like they take over, and you don’t have any control over what happens. I feel like birth is really personal and really a beautiful thing and very, very empowering. And, so they take that away [in the hospital]. It’s a big loss for a woman to have that experience taken away.

In addition to the comments that respondents made regarding autonomy during the course of the interviews, after the fifth interview it became apparent that adding the question, “How do you think home birth has changed you?” would likely elicit poignant responses. Therefore, this question was asked of the final eight women that were interviewed. Invariably, this led to descriptions of how these respondents felt “empowered” by their home births. Gloria described her first birth, a hospital induction, as:
It’s almost like dehumanizing, to be honest with you, like you have no dignity, and you don’t feel respected. You don’t feel like they trust you to make sound judgments, sound decisions for yourself, but you’re an adult. It’s your body and your baby and like they’re telling you like can’t have any control over what’s going on.

She then essentially described this disempowerment as criminal, in that it robs women of their own experience:

When a woman is in the hospital and the control is being taken away, and other people are interfering in what should be very personal, it’s just like robbing her of this like amazing experience.

Gloria went on to say that, “even with all the horrible things that happened” during that hospital birth, she experienced a “really dramatic change” just by “being a mom.” So, when she thought of how her subsequent home birth had changed her, she replied:

I’m trying to answer your question without sounding like a cliché but it’s really hard because the clichés are true [laughs]. It was just very empowering and just gave me faith in my body and faith in what it was made to do. I just have a lot of joy when I think about my home birth and it changed me as a person. I think it just made me more confident, and I’m just really glad that I did it.

Gloria had gained this “confidence” partially because she described that during her home birth she:

Didn’t ever feel like unnecessarily – like I was being forced to do things that I shouldn’t have to, or that wasn’t good for me, or something like that.

Kate, who had her first baby in the hospital and later worked in the birth community as a peer breastfeeding educator, also described how home birth had contributed to her sense of empowerment. She related it to:

Knowing that you are in complete control of your body and its function, that you’re not broken, especially having, not a failed induction by any means, you know, each person’s definition of failure resides in what they believe it is [pause] knowing that I was, I’m empowered, and it’s all up to me and that I could do it.

Irene had not originally pursued a home birth, but because she could only receive care with the home birth midwives by the time her Medicaid was activated, she decided to do that. It appears that she overcame the general views around her that home birth is dangerous, but that
even being relatively young (21 at the time of the interview, after the birth of her second child) she gained strength and confidence from her home birth:

Well, [my home birth] really opened my mind to the fact that – a lot of people see homebirth as a bad thing and I think it is just because people are scared of the consequences. It is really nothing that anybody should even be afraid of because people have been doing this for thousands and thousands and thousands of years. I feel like it definitely made me a stronger woman, and more confident.

Jessica described empowerment as pride in her accomplishment, and has become a promoter of home birth:

[Home birth has changed me] completely, yeah! As far as, like I want to do it again, I wish I had done it the first time. I just can’t stop talking about it to people, like people know how great it is or how convenient it is. It’s like how you feel about yourself after, like a pride that you get in delivering a baby naturally, but also doing it in your own, in the comfort of your own home, that you established and built and gotten ready for your baby, it’s just – it feels so natural. It just makes the birth so beautiful, but as always I encourage people to do it. A lot of people think I’m crazy, but at the same time that high that we get after, it’s amazing.

Helen also described how her experience has transformed her into a role model for others to consider home birth, which made her feel good:

We had a bunch of friends that were pregnant at the same time that we were, and so by us doing, choosing, a home birth, it made a lot of our other friends then think about doing the same thing, who had never even considered it before. And, it kind of like made me feel good, like it was like I became a role model without planning on it because we had so many other friends that just like, ‘Why did you do that? That was so great. Now, I want to do the same thing.’ So it gave me that feeling of like, I did what I knew what’s best for us and for our baby, and it just spurred on other people to want to do the same thing. It made me feel good to think like maybe I started a pattern, you know, other moms wanting to give home birth as well.

Lauren described how the home birth of her second child helped her to heal from the disempowerment she experienced during her first birth, which was a planned birth center birth that ended up transferring to the hospital in labor:

It has definitely healed a lot from my daughter’s birth, that went against my wishes and made me feel un-empowered, I guess I feel a lot better after that, a lot stronger, a lot more confident.
Faye, who gave birth to her first child at home and therefore did not have to overcome any disempowerment from a previous birth experience, described how her home birth empowered both her and her husband as well:

It made [husband’s name] and me more - feel more empowered or something maybe, because we felt like we were like contributing to the whole process, you know it wasn't something that like, removed from us, you know. Since we're able to really be there and pull the baby out of the water and there wasn't a doctor doing it, it was our child, you know, so we felt, maybe we feel a little bit stronger for it or something.

Gloria was describing what the best characteristics of her midwife were when she spoke about how her home birth experience allowed her to express her autonomy much more than she had been able to in her previous hospital birth:

I think the main thing was just me being allowed to be involved and have a say in my birth experience, which really, should actually just be the normal, but when I was having to go to the hospital, there were so many things that I was like, ‘Well, can I do this?’ and they were just like, ‘No.’ They’re like, ‘You have to do this’ and I was like, ‘I don’t want to’ and they were like, ‘Well, too bad.’ You know, it was just like, you kind of feel almost like a child or like they’re not trusting you to know what’s best for yourself, or to know your body and like what’s happening.

Indeed, these are the very stories of autonomy that both midwives and respondents cited as their main motivations for pursuing home birth in the first place.

**Empowerment vs. Medicaid**

Some participants described the ways in which being a Medicaid recipient felt disempowering. Others described the process of supplying very personal information during the Medicaid application process as intrusive. Chris described how although she was eligible for WIC, she could not bear the humiliation of having to meet with WIC staff in order to receive this benefit, which ultimately she felt was not going to allow her to make her own decisions about the best food choices for her family anyway:

When you do the Medicaid enrollment, you have to submit all of your financial information. It’s the same as the food stamps enrollment. And so, they say, ‘Oh, you’re pregnant, you have a three-year-old, you have no income, have some
EBT[^40] [food stamps] too. And I possibly I could have made that go further [by applying for WIC], but I knew that to get WIC I had to go down to the office, and I didn’t want to go sit in the office and have to meet with somebody and feel humiliated. Again, it’s the stigma. And also they don’t cover a lot of the foods that I like to feed my family. So a lot of the organic – free-range eggs and organic milk and – that’s not covered. It’s like with WIC you can get the most basic of these things. You are not allowed to even get brown eggs.

As several participants had described related to their experiences with pregnancy Medicaid, they were surprised that they did have choices to make despite being on Medicaid, such as who their care providers would be. When Eve was asked if she had any final words at the conclusion of the interview, she said this:

That it’s possible to use Medicaid, to not financially have a lot of money and to still be able to choose your birth and to have the option of a home birth. I mean usually, if you go on Medicaid, then your choices are going to be made for you, and have less choices, but in Florida we’re lucky to have that option, that we’re able to still have those same choices and it doesn’t limit all your options.

Eve had experienced birth in another state, and in fact she and her husband chose to return to Florida for the last birth partly because they knew they would have the autonomy to choose a home birth, both based on the legality of home birth midwifery per Florida Statutes, but also because of the availability of Medicaid coverage of home birth. Thus, in Florida, she and her family felt that to an extent having Medicaid contributed to a sense of empowerment, even though Chris found being on Medicaid to be disempowering.

**General Empowerment Discourses: Midwives**

Midwives also shared examples of ways in which they found that women were seeking home birth as an expression of their autonomy. While these were home birth midwives, some had experience as health care providers in the hospital setting. Yvette, a Licensed Midwife who has also worked as a nurse in a hospital labor and delivery unit, described how she saw the doctors treating patients at that hospital, and how for some women this has become an accepted, unquestioned part of our birth culture:

[^40]: EBT stands for “electronic benefit transfer” and is the manner in which many states have shifted from paper WIC vouchers and food “stamps” to a card that works much like a debit card that recipients can use at stores that accept it.
The way I see some of these doctors treating these patients, you know, ‘You will do what I tell you to do’ and, ‘This is not a discussion’ and, ‘You are going to kill your baby, and this is what we are doing’ and literally no discussion, they [the pregnant women] are not a part of the decision, ever. And, I am appalled that women accept that and that they are OK with it. It just reminds me of a bunch of sheep who are just falling off the cliff.

This is clearly in contrast to the way that the participants described the informed consent process in which they engaged with their midwives. However, Yvette went on to describe how some women, particularly clients of hers who have experienced home birth, will try to engage other women about their birth options, and thus almost perform tasks associated with informed consent. Yvette acknowledged that only when consumers demand alternatives will change to the routine birth paradigm begin to occur. She described an interaction she’d had the week prior at the grocery store with a former client:

[The client] said, ‘You know what? I still to this day, if I see a pregnant woman, I’m going to bug her to death until she at least says she’s going to look at [options for out-of-hospital birth]. I don’t care what they decide to do, but as long as they look at it, and you know, at least talk to somebody.’ And I thought, you know that’s a really interesting perspective. I have a lot of clients that do that. They don’t like to push, but they like to educate. And I think education is the key. And that’s going back [to when the laws regarding midwifery practice in Florida were passed]. I have heard that [lay] people were involved with the insurance, or involved with the legislation [for Licensed Midwives in Florida in the 1990s]. A lot of the stuff gets voted today by the consumers. If the consumers get together and they demand, you know, the options, then, it will happen.

Wanda also spoke about how “consumer demand” is key to changing the birth landscape:

As a midwife, we can rail the system all we want to. We don’t have anywhere near the numerical or economic impact as the clients do. They’re the people that need to grab that birth power and put that hand up in the air and go, ‘You’re not doing this to me.’ ‘I’m not going to let you put me on the conveyor belt.’ ‘I don’t want to birth like everybody else.’ ‘I’m demanding that responsibility. Do not [take that from me], give it back to me.’

Tammy discussed autonomy in the context of those women who seek home birth based on conditions such as mental illness. She described an encounter with one patient who felt that her mental illness would preclude her from being treated respectfully in the hospital setting, so she sought home birth care:
There was some talk that [the women who sought home birth] felt that it was safer, but I really think for most of them it was the issue of control and being treated with respect. We had a client who had some mental health issues, for example. She had bipolar disorder, and she was concerned that she would be given drugs in the hospital and treated like a psychiatric patient first, rather than [a pregnant woman], so it was all about the control and the respect for them.

In this way, women who seek home birth might be considered marginalized in different ways than groups that are traditionally marginalized, such as the mentally ill.

**Home Birth Decision-Making Process**

The decision-making process regarding their home birth seemed relatively straightforward in that when asked who was involved in the decision, respondents primarily gave only a few words to answer, and primarily gave the response “me and my husband.” The overwhelming majority (eight of thirteen) of participants responded that their decision to have a home birth was made solely between herself and her husband. One additional woman stated that both her husband and her midwife were involved in the decision to have a home birth, while another one stated that the decision was made between herself, her husband and a friend. One participant stated that the decision was taken between her, her fiancé and his brother. Only one mother (who was married) stated that the decision was reached with one of her “good friends” as well as her own mother. The one single mom in the study stated that the decision was hers alone. Thus, while respondents may have found out about the home birth option from sources such as MomCare or have referenced the growing out-of-hospital birth movement due to media portrayals such as *The Business of Being Born*, when it came to make their own decision about birth place, the decision was made primarily between themselves and their spouse, with significant contribution as well from their provider, the midwife. While some women likely had the choice between a home or birth center birth, interviews did not focus on why the decision was for home over birth center birth, except for with Jessica who stated that she chose home birth because of the long distance to the birth center.
Reactions to Home Birth

Among the thirteen women interviewed, six primarily faced negative reactions to their decision to have a home birth, while two had primarily positive reactions, and five faced mixed reactions. Participants generally reported the experience of cultural dissonance between their decision to birth at home and the overwhelming societal norm to give birth in hospitals, which was generally reported as a reaction of “are you crazy?” when they would tell others about their home birth choice.

Among those who had primarily negative reactions, concerns for the baby’s safety seemed to be the most common. Faye had posted her decision to have a home birth on her Facebook page and then described the reactions she received there:

A few people who aren’t really friends, they’re just acquaintances, who were like in the older generation, they were pretty critical of me. They left comments that I was going to endanger my baby’s life, and you know, just concerns about safety.

Gloria recalled how she received emails from her family “begging me to reconsider” and telling her that she “didn’t understand how dangerous” home birth was. She further discussed the cultural dissonance between her choice and the societal norm:

I mean, there’s such a stigma about home birth that people don’t realize that it’s getting more and more common. And people don’t realize that a lot of what happens in the hospital is so detrimental to the mother and the baby. People don’t understand that like it’s actually not normal and that hospital birth is actually a pretty recent thing in history. Like, it hasn’t always been this way and that it shouldn’t be this way....Some people have that mentality where they, like ‘you’re just going to die if you aren’t in the hospital.’ Like, no, not really. Like how did the human race survive for thousands of years before there were even hospitals like the ones we have now?

She further described the reaction that one of her friends had faced regarding his family’s home birth choice:

A guy we are in a community with, he and his wife had a home birth, and he said people would say to them, ‘Yeah, we’ve thought about having a home birth, but we wanted our baby to live, so we decided to go to the hospital.’
In addition to being seen as “dangerous”, several moms reported that the concept of home birth was viewed as “odd” “unusual” “crazy” or “weird.” Several discussed how surprised others were with their decision, as Helen stated:

Some friends were a bit skeptical when we told them that we’re going to have a home birth, they were like, ‘On purpose? Are you sure?’ It seemed like it was really, most people think of it as a weird thing or like it’s not the typical norm, so some people’s reactions tend to be like, ‘Wow, good for you!’

Several other moms also described that even if they faced negative reactions to their decision, people were “amazed” by them and found them to be “brave.” Jessica, who received both positive and negative feedback, described the negative feedback as “very, very malicious, very opinionated” which was likely related to the fact that while many were “amazed” and thought that her home birth was “really awesome” others “thought we were very crazy and irresponsible, what if something had happened?” She directly related to the cultural dissonance of home birth in modern society by revealing the reaction of her father that, “People don’t do that like that anymore.”

Among the two participants who only had positive reactions, Lauren stated:

They were all pretty on board with it. My grandfather was kind of blown away at the idea, but by the time we were actually doing it, he was prepared, he was informed.

Kate’s response to “what reactions did you get to your decision to give birth at home?” offered her interpretation that “reaction” was something negative, so that when she stated, “No, not at all” she meant that all of the reactions she received were positive. She stated that her mom was “very supportive” and that home birth is:

*Normal in the group of friends that I hang out with. So, for me to have had a hospital birth would have almost been like what hospital birthing people think of us home birthing people.*

Similar to Kate, both those with only positive reactions as well as those with mixed reactions, the reality that out-of-hospital birth was normal within their social circles provided some of their best support. Lauren, who had only positive reactions, simply stated “In my circle
it’s normal.” Ann, who had both positive and negative reactions, particularly because she was having a home birth after a cesarean, stated:

My in-laws, they were very kind, but they weren’t really that into having a home birth….Most people are surprised, the norm is to go to the hospital, and they don’t really understand why you wouldn’t. I am very blessed that I have a lot of friends that do home birth, you know, I told you all the negative, but I do have a lot of friends that are very supportive and positive…encouraging and just praying for me and giving me the support that I needed. But overall the general community is always very surprised when you say you are going to have a baby at home. And, they’re kind of confused, like ‘What? What do you mean?’

Despite some of the negative reactions people received, several participants described that family members did not express their concerns until after the birth. Chris described how “my mother-in-law probably did [oppose the home birth] but she bit her tongue.” Ann had also said that her father “never said anything to me, but I heard later that he wasn’t really in favor of a home birth.” Jessica shared that:

My dad was actually out of the country at the time, so when I finally did talk to him and told him the story [after the birth], he was not very happy, he thought it was kind of irresponsible of us.

The women were then asked how they dealt with the various reactions they received to their decision to give birth at home. Four of them showed research to their skeptics, including Faye, a first-time mom, who stated that:

I posted a few articles on Facebook that I found about home birth, about its safety, you know, posting statistics just to try to educate those people on Facebook who were concerned about it.

Faye went on to describe how she had minimized the negative reactions she got from some people by restricting their presence at her birth. Specifically, with her mother:

I just talked to her about it, I tried to reassure her that it will be okay, but she still wasn’t totally happy about it until it was over, until she had a grandson, that she accepted it. But she wasn’t there during the birth or anything. It was my choice, actually, because I thought maybe it might add some tension.

Several other moms described how they simply ignored or otherwise avoided people with these negative reactions. Jessica stated:
Oh, I let it roll over my head. The cool people that ask questions, I answered and we talked and you know I gave them all the facts, but those that had stronger opinions, a couple of people told me ‘that’s crazy, I would never do it that way’ but I just let it roll off my back.

Becky stated she “kind of formed my own bubble” and “devoured books” on childbirth. Helen further described how she used research to support her decision and in her responses to others:

I would say [to them], ‘it’s kind of the norm for me. We did all the research on it and it seemed like the best choice for us, so we’re going to do it.’ We weren’t obsessed about it, it’s just like if you go and do something and you have done your research, and if you’re educated about it, it’s not like you’re just making decisions blindly. If you really do your research on it, people tend to respect it, I would say, more so. You’re not just going along with the cattle herd and doing what everybody else does.

This comment seconds that of midwife Penny, who criticized the American prenatal care delivery system by saying, “Herding people like cattle into a building and calling it care is not actually so.” In this way, choosing home birth was a function of the women’s autonomy and their ability to overcome significant societal stigma and make a choice to birth at home despite that most experienced negative reactions from their family to their decision.

Control and Support in Labor

During the interviews with women, two of the elements within the validated 10-item Birth Satisfaction Scale (Hollins-Martin and Martin 2014) were assessed in an attempt to elicit greater detail than simply women’s ratings on a Likert scale. Control and support are key concepts related to maternal autonomy and empowerment, and asking about control and support allowed for an assessment of autonomy and empowerment without directly using those terms which might have swayed participants’ responses.

Three participants specifically stated they were “100%” in control, with a fourth stating that she was “110%” in control. Another five respondents stated they were either “very” or “absolutely” in control. Two women shared their belief that “God is in control” with Gloria stating:
My view on life is that control is really just an illusion. Like, God is the only one that is ever fully in control of any situation, like we think we can control XYZ but there are things that can happen at any moment to let you know, actually, you’re not in control.

But, she went on to say that despite this worldview, in relation to her labor:

As far as just like being empowered to make my own decisions and being empowered to like say what I want and go after that, definitely. I didn’t feel ever that I was being forced not to do something or to do something….So I don’t know if you can say I was like fully in control of my moment or something but I didn’t ever feel [like I was being forced to do anything].

Chris described that during the height of labor when the “contractions wouldn’t stop coming” she felt like, “I need a break, why can’t I control that they won’t stop for just a minute?”

Nevertheless, prior to that she had felt a lot of control:

Before that, I felt like I was very much in control. I could choose when I got in the tub if I wanted to, where I wanted to be, what position I wanted to be in, if I wanted to eat, everything about it. Whereas, in a hospital, you’re kind of strapped down to the bed and machines and everyone’s coming and going and if you have an epidural you certainly can’t walk around.

Chris also emphasized how much she felt in control of her birth by describing how she was able to reach down and deliver her baby herself:

[The midwives] helped me to catch him and I kind of felt like I delivered him. A doctor didn’t deliver him. The midwife didn’t deliver him. She was there, she made sure we were healthy. She made sure his heartbeat was good and my blood pressure was good. Otherwise, she just made sure we were okay [and I felt like I delivered him].

The ability to choose how her labor unfolded also contributed to Eve’s sense of control in her labor. As she described it:

I was very in control with what was going on, and they were able to tell me at first and made suggestions but it was really – everything was really my choice. We did a water birth and so when I got in the water, or if I got out, or walking around – all of that was very much – everything was suggested to me and it was really very much my choice what we did when, or what I felt helped to progress things, which was wonderful to do, to have that control over what was going on versus I felt out of control with my daughter’s hospital birth. Which was kind of being done to me and, ‘this is procedure and this is what happens’ versus having a lot of say in what went on.
Debbie, Helen, and Marie all described how being in control was a function of allowing their bodies to do what they needed to do in order to give birth. Debbie, who had had a long labor with her one previous vaginal birth after having had two scheduled cesareans without any labor, initially doubted what she was feeling her body do, but ultimately settled into knowing that her body was doing what it needed:

I guess I kind of didn’t trust my body at that point, I kept telling my husband, I think I’m going through transition, I think this is what’s going on, I could feel [my baby] turning into position and everything, but I didn’t really trust myself, I guess because the last [labor] where I was like, it’s so long. But then [the midwife came and checked my cervix] and she was like, ‘You’re at eight centimeters,’ and I was like, ‘Okay.’ Everything I was feeling, like I knew right then, like, ‘Okay, I’ve got this [laughs]. I’m really in control on this one.’ So I just kind of went with everything that my body was telling me to do and then she came out wonderfully.

Helen specifically related her feeling 100% in control to trusting her body to do what it was naturally designed to do:

I would say [I felt] 100% [in control], like it’s kind of like trusting your body to know that it will do what it needs to do, and if you do that, I feel like everything just falls into place. It’s a natural thing. People have been doing it for thousands of years and it’s a natural thing and so I felt like everything was under control. I didn’t feel like anything was off at any point and it was a very quick and successful birth and that.

Marie described a sense of gaining confidence and becoming stronger in general, starting from when she chose out-of-hospital birth to begin with:

I felt like I was in control when I chose the midwife instead of doing it at a hospital….I just let my body do what my body do [sic], I felt power when I was pushing and afterwards because, Oh my God, it’s tiring, but in the end I actually did it without no meds, no nothing, and it feels real good.

Irene simply responded that she felt “absolutely” in control and that “I feel like it definitely made me a stronger woman, and more confident.” Jessica felt “very” in control and compared her experience to her first hospital birth:

Oh man, I felt very in control. I could feel all the contractions. I knew what was coming and felt very informed this time around. The first time around, I did not feel very informed, so this time around, I felt in control and knew what was going on. I was telling everybody when my water was breaking. I would tell everybody when her head was coming out, so it was just like, I’ve never been more attuned with my body. It was amazing.
Becky, the first-time mom who had been turned away from the Health Department because she was too obese, stated that while she was only 90% in control because her son was in control the other 10%, she described that:

It wasn’t like I felt out of control. It was just like, ‘Wow.’ I got so much more respect and love for my body. I was blown away in awe of my body because of what it was doing, how powerful it was. How much, it just, I felt so strong and so much like a goddess really.

Some of this control may have stemmed from the high level of support that participants described they felt during their labors. The descriptions of the extent to which they felt supported in labor made these births seem much more festive and also relaxing than what is traditionally described of birth in our culture. Eve described how she had not even screamed out in labor:

I was supported a lot. I labored really – kind of, not screaming – and just really low key and just, I had to tell everybody when there was a contraction because I was in carrying on with everyone. But I had a lot of support between the two midwife students, the midwife, and my husband were all here, so it felt like quite a party when I was definitely free to do whatever needs to be done and to support me, to encourage me when I needed it.

Helen discussed how the water tub and the support from her midwives made the birth very relaxing:

My husband was right there, in the tub and stuff and there was definite support in that way. And the midwife and her birth assistant, they were very positive, you know, in the background saying like ‘you’re doing a great job’ and ‘everything’s going so well.’ So there was definitely a lot of positive around me. So that made the whole birth very relaxing and just it was empowering and knowing that everything was going well.

This certainly contrasts to scenes of panic and chaos often found on episodes popular TV series such as TLCs A Baby Story.

Becky’s description most significantly contrasted with the typical American birth narrative, in that she felt so supported that if felt like she was at a spa:

Completely, I felt like a goddess in a spa during my labor. My midwife – first off, I was in a birth tub which felt like a warm bath. They were putting fresh oils in there so the aromatherapy could help out. I was getting my feet and legs massaged
and my shoulders massaged. I had a cool cloth on my face when I needed one. They were giving me drinks through straws so I could sip cold water with lemon [laughs]. It felt like I was in a spa. That was the most cherished, the most pampered, the most precious I ever felt in my entire life. I had a whole team of people just there for me, and I was the focus of attention.

This quote comes from the same woman who at the onset of her pregnancy was turned away from the Health Department for being “too obese” to receive care there, and who felt that if she had gone to a hospital for her birth she surely would have had a cesarean section because ‘that’s what doctors do to women who are obese.’ Instead, she clearly experienced a pampered birth in which rather than the focus being on her obesity and the potential health challenges related to that, she was treated like a ‘goddess’ and honored for the ability of her body to give birth.

**Florida Policies as Promoting Home Birth**

The midwives were asked how they felt that Florida policies promoted or alternatively constrained the practice of home birth, both generally and in particular with Medicaid. Two midwives flat out said, “no,” that Florida policies have not promoted home birth. Five midwives discussed that they did not think that anything currently supported it, as they felt that no real promotion of midwifery or home birth had occurred since the 1990s. Ursula, who had experience as a practicing midwife in another country where she experienced greater autonomy, responded to the question, “How have Florida policies promoted home birth” with the statement, “That’s a good joke.” Her midwife partner Vera went on to say that,

Well, I think when Governor Lawton died⁴¹, that was probably it. That was one of our last big advocates, at a high level.

Yvette also stated that she did not think there had been any true promotion of home birth and midwifery since the 1990s, and also referenced Governor Chiles as the man many Florida midwives see as their champion:

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⁴¹ Lawton Chiles served as Florida’s governor from 1991 to 1998, after serving in the U.S. Senate from 1971 to 1989. During the first of his two terms as Florida Governor, he instituted significant reforms to Florida’s health system. Governor Chiles died of a heart attack in the Governor’s Mansion in 1998, 23 days before his term was to expire.
In the ‘90s, yes, [but] I would have to say in the last few years, no. Promoting it I think in the sense of Lawton Chiles helping us to pass a law and saying that insurance companies, to do business in the state of Florida as well as Medicaid, is required to cover it. I think [that was] a huge hurdle for us.

Despite these relatively negative views, five of the midwives expressed their views that Florida is considered a “model” state compared to other U.S. states when it comes to the practice of midwifery for Certified Professional Midwives and for home birth in general, or Medicaid coverage for home birth. Wanda, who had moved to Florida in 1998 in order to be able to practice in a state where home birth and non-nurse-midwifery were legal, stated that:

The Florida law governing Licensed Midwives is the tightest in the country. It’s based on the Washington State law, which is one of the better ones. But, [it’s] very comprehensive, very nit-picky, and we’ve operated under it for a good while. It does need to be tweaked some, but [some midwives in Florida] don’t want to open it back up because they’re afraid that [the Florida legislature] will strike it down.

These stringent laws that Wanda refers to are within the Florida Statutes for the Regulation of Professions and Occupations, specifically Chapter 467 (State of Florida 2011a) and the Florida Administrative Code (Florida Administrative Code 2011a), which contains the criteria specifically outlined regarding the rules for non-nurse, licensed midwifery practice, particularly the criteria for Risk Assessment (Florida Administrative Code 2011b) that are presented in Table 1.6. These detail what clinical conditions require obstetrical consult or are considered outside of the scope of a home birth attended by a Licensed Midwife.

Debbie, one of the mothers, stated that she experienced a problem related to these statutes regarding home birth. Partly because she had a previous cesarean, but also because of the Florida Administrative Code requirements regarding gestational age limits for out-of-hospital birth, she became nervous towards the end of her third pregnancy, which would be her first vaginal birth, because she had not gone into labor as she neared the 42-week mark:

I actually had a restraint, because it was like I went well overdue with my third one and I had to – it felt like towards the end, it was like ‘Ok, well, if you’re going

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42 As reviewed in Table 1.6 and referenced in the Midwifery Practice Act, criteria for home birth include gestation being greater than 37 but less than 42 weeks.
past the 42-weeks, then you’re going to have to go into the hospital or have a C-section’ and there was a lot of pressure on that, but that’s not something you could control, but that was, I think, the one thing that I felt like a lot of pressure, I could just go – it was like, okay, go with your body with everything, until you hit 42 weeks, and then [laughs] your body is all of a sudden broken and you have to go in [to the hospital]. So that was very kind of frustrating. Then we had to take castor oil and all of that, so it was kind of, that was not very pleasant [laughs].

Debbie did end up having a successful vaginal birth after cesarean at home, though she did describe a long and difficult labor.

Midwife Olga agreed that Florida and Washington were among the best states in the nation when it came to the practice of non-nurse-midwives in the United States, as well as the insurance reimbursement requirements:

From what I understand, Florida and Washington State are pretty compatible, comparable, and we’re like the top two in the whole nation as far as our, all the way from like the requirements, we have really stringent requirements as far as schooling, and births and clinical [experience], to get[ting] licensed. Then we do have the insurance and Medicaid reimbursement. So I think that Florida is ahead of the other states.

When discussing how she felt that Florida policies promoted home birth, Quincy talked about how the support midwives receive from local agencies (e.g., MomCare, as discussed in Chapter Eight) was actually more related to the outreach the midwives themselves do in those settings:

I would say, because midwives are so proactive in the community, that we go to the Department of Health, we go to those offices that help moms like that, WIC, DOH, the Community Health Centers, they promote it for us. But Medicaid itself, no [it doesn’t promote home birth].

Quincy also talked about how she does not believe there are specific supports for midwifery practice in Florida, though she went on to describe how Florida was viewed as a “model” state:

I think Florida is number one with midwifery and Medicaid combined. Everybody uses us as a model of how to do it in their state, if they were to do it in their state. Like, Illinois right now is trying to pass their laws, and trying to get Medicaid to do that for them, North Carolina has been battling it for years and they use our base model of care, base model of law, base model for Medicaid, to get it in their state. There’s only eleven states in the whole United States that pay for (non-nurse) midwifery care, that is sad. And only twenty-six of those states are legal for midwives to practice in. Ten are only alegal which means it can go either way, and the rest are illegal.
Nancy simply stated that “Florida is probably one of the better states” for home birth midwifery because, “we have that specific language in our insurance statute.”

Six of the midwives expressed the view that ‘the fact that we even have the law is what supports’ midwifery and home birth. Some related this in comparison to other states, as noted above, and it was during this part of the interview that many of the midwives referenced how they provide links to the Florida statutes on their websites. Tammy discussed how Florida is “lucky” but that the only way that midwifery is promoted in Florida is really the fact that these laws even exist:

Well, I think Florida is very lucky in that, first of all, direct entry midwives are legal, and can practice autonomously, which is wonderful, and also that Florida law guarantees that insurance companies, if you do business in the State of Florida, have to pay for midwives. So, I mean, it's lucky that if you are on Medicaid, and you want to have a home birth, and you might have a home water birth, Medicaid will pay for it [laughs], which is fabulous. [But], I don't think so, other than the law saying that all insurance companies have to pay, which obviously is beneficial, I don't think that there's anything else. I mean, I know people who for years have been trying to lobby Medicaid to actually promote midwifery care because it would save so much money but they just refuse to, [it’s] too much of a hot potato politically.

Olga also expressed her view that the fact that these Florida statutes exist serves as the only real promotion of midwifery, and as Tammy discussed, Olga talked about how this directly impacts access to home birth for Medicaid recipients by helping them realize the option exists:

We have our licensure and we do get Medicaid and insurance coverage, so that’s been good, it really opens it up for a lot of women because a lot of time their decision does come down to money. Yeah, I would say our license and the fact that we do get Medicaid and insurance reimbursement, that’s huge, that’s definitely promoted it. I wouldn’t say they’re like advertising us like on a billboard but at least it’s, we can advertise that, we can say, ‘Yes, we take insurance, we take Medicaid,’ and a lot of people have no clue. They’re like, ‘Really, you take Medicaid and insurance? I had no clue.’ So that opens doors for a lot of people who wouldn’t, couldn’t consider it.

Wanda spoke to how the legislation promotes coverage of her services by insurance companies, but she does not actually file the claims, she has the women get reimbursed after paying her directly. Therefore, she thinks it is important that the legislation exists, and
acknowledges that home birth midwifery is much more cost-effective than hospital birth, but ultimately she decided to stop providing care to Medicaid (or any insurance) clients.

I think it’s wonderful that the legislation exists, and I provide complete insurance claim forms for all of my clients that have (commercial) insurance, so that they can get reimbursed to the extent that what their policy says, and many of them do. Frequently I’ll have clients get paid every penny back…I think that’s a great idea. It’s still cheaper to have a baby with me outside the hospital than it is at our local hospital. One of our local hospitals charges three times what I charge for nowhere near the personalized care that you get when you have a midwife. And, you know, if you’re looking at it in dollars and cents, it’s still one of the better bargains around. And you get to have the kind of birth that you want, not the kind of birth that they want you to have.

The only CNM participant discussed how the insurance reimbursement statute helps to promote midwifery, and also how she and her clients have been able to use this law to get women who choose home birth covered through their (commercial) insurance company even when there is not an in-network provider already credentialed:

There’s the one statute that says that Florida law states that insurance companies have to cover midwives. That’s one thing where we have fought to get gap exceptions, not necessarily for Medicaid but from [commercial] insurance companies [by saying], ‘Okay. Florida Statute says you have to cover a midwife. So if you don’t have any midwives in your in-network status, you have to cover me.’ So we do get a lot of gap exceptions with private insurances, which doesn’t necessarily benefit me because that means I am agreeing to take less money, right?

Nancy referred to the state insurance statute as a “saving grace” to midwives. But it was Xenia who most emphatically discussed that beyond the insurance statute that requires midwifery care to be covered, she feels most protected by the Midwifery Practice Act (State of Florida 2011a):

To me, [the law] is definitely protecting me, too. When there’s a thing where I’m sensing something is out of normal, then I feel very glad that the laws are there and [I can] say, ‘Listen. This has been two solid hours of your body trying to do this…we need to transfer’ and it gives me a little strength too because sometimes it’s the client that doesn’t want to transfer.

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42 She is referring to the fact that once the insurance company agrees to cover her services, she has to agree to accept their negotiated rates, which are often lower than the rates she would charge for self-pay clients. So this doesn’t really help “her” but it does equate to insurance coverage and reimbursement for her clients.
Perhaps this relates to her relative newness to the profession, as she said:

Maybe if I...was some famous midwife practicing for 40 years, maybe I might know something that everyone else doesn’t and I would feel that I wanted to do those things that [I don’t personally feel constrained by now].

But she also spoke to how the statutes not only protected and supported her during these sometimes sticky transfer situations, but also served to validate the practice of Licensed Midwives, and in particular home birth LMs, in Florida:

The fact that there are policies and statutes to me is a validation of it. I feel very supported by my Florida LM laws. I feel protected by it and I feel like it’s a good protection for the clients too. I mean me personally – if I was just having my babies and I was seeking this sort of care that was already a little different, that maybe people don’t normally do - to know that it’s on the books and it’s regulated to some degree, even though not a whole lot, which is kind of nice too. There needs to be some room in there to practice what we do, but it would make me feel more confident that things are – I don’t know. It gives us some sort of validation, to me, and maybe it’s completely arbitrary. Maybe it’s just this thing like when people think there’s an LM coming to your home is different with the LM at the birth center, it’s the same but the fact that there’s a building that they go to maybe kind of makes them feel better about it. Maybe it’s the same thing. I don’t know. But I do feel that the fact that there are laws about it gives it more notice. It’s here. These are available. [Interviewer: Do you think this legitimizes it?] In some people’s mind? I do, and so therefore that would be a way of promoting it in some way for example. Just the acknowledgement of it I think promotes it. I mean in some places it’s a legal or illegal and so acknowledging it that we’re here, and that we are practicing, that the State is acknowledging that we are competent basically, to me, that promotes it.

Three midwives spoke about the “trade-offs” that are part and parcel of their laws, or that emerge when one does choose to accept insurance reimbursement. Nancy discussed the trade-off of agreeing to carry liability insurance when Licensed Midwives were added as Medicaid-eligible providers in 1997, though this can certainly apply to other insurers as well:

The tradeoff for LMs [when Medicaid reimbursement came] was that we had to carry liability coverage, so that was one of the challenges...I mean, it’s a two-edged sword, like, once you’re a provider, you’re obligated to take that reimbursement, whereas if you said, no I’m not going to take any kind of reimbursement from anyone but [the client], then, you know, there’s that sort of give and take behind what the clients need to exist and what you as a practitioner need to exist and/or hopefully flourish.

Prior to coming to Florida, Susan had practiced in other states where midwifery was not legal, and she admitted part of her reason for coming to Florida was to practice in a “legal” state.
When she arrived in Florida, the Midwifery Practice Act and Insurance Reimbursement statutes were already in place, and therefore she could get reimbursed by insurance and Medicaid. She also spoke about the trade-off of agreeing to carry liability insurance in exchange for becoming a Medicaid-eligible provider, and how the impact of this has actually changed over the 15-plus years since its passage, as the cost of liability insurance has increased significantly:

Part of getting Medicaid reimbursement, my understanding was that the doctors put pressure on wanting the midwife to have malpractice insurance, and so the midwives were able to negotiate having Medicaid reimbursement tacked on to that, you know that we'd have to have malpractice insurance. And initially, one Medicaid birth covered your malpractice insurance [for the year], so it kind of was that trade-off, but now, malpractice insurance, you need three Medicaid home births almost to cover it, the malpractice insurance. But I think the fact that they, somehow or other, got it mandated, that Licensed Midwives would be reimbursed, were able to be Medicaid providers, I think that that's positive, 'cuz I know in other states the midwives are not able to be reimbursed. You know, there's not very many states where Licensed Midwives are [allowed to bill Medicaid].

Wanda had similarly moved to Florida from a state where her midwifery practice was illegal, and she chose Florida particularly so that she could practice legally. However, over time she chose to discontinue contracts with commercial insurers and with Medicaid and now practices in a low-volume (four to five births/month) home birth practice that charges all clients on a self-pay basis. She also described the trade-offs involved:

It’s difficult, but what I have found in practicing in illegal states and then practicing in legal states is that there is always a trade-off. There’s pros and cons under any situation that you might be in.....I will never participate with insurance. I will not do it. I understand the racket - they want your money - and they’re not getting my money.

Because Wanda had chosen to stop accepting Medicaid, and because she described the Midwifery Practice Act as constraining and nit-picky, she was asked, “If you could rewrite the midwifery law of Florida, now, what do you think are the critical elements that need to be there?”

Her response spoke more to individual freedoms and lack of government interference than what should or should not be included in a statute:

You’re not going to like my answer, but I would eliminate it. Honestly, I believe that the entire power and responsibility for choosing your birth attendant should
come from the mother. She is the only one who has the right to make those decisions. I don’t think the State has the right to legislate these decisions for other people. If they want to stamp it and say, ‘Oh, well, this person has this education, that person has that education, this training compared it,’ it shifts the responsibility for decision-making to the State, and in my way of thinking, the State has no right in the bedroom, and that’s where birth should occur. They weren’t there when it was conceived, it’s none of their damned business. You know, they try to tell me how to do things, where to do things under what conditions. The government is too much in our faces, and if I had my choice, I would be moving to a place where there is no licensing whatsoever, because the responsibility lies fully with the mother. Period. She has the right to make a decision. If she wants to bring somebody in there and take them for their level of training, I mean, you can’t do breeches, you can’t do twins, you can’t do slightly higher risk things, I don’t care what kind of background you have in Florida, you have to conform to the tight legislative [mandates], you know, things that govern how we practice. And they’re telling you how to do it. They don’t tell nurses how to do it, they don’t tell doctors how to practice, they tell midwives literally how many times you have to take heart tones during labor. It’s a crazy law. I understand the pro’s and con’s of negotiating it what they had to put forth, and I feel like they’re protecting the public, but I think the public is smart enough that it doesn’t need protection. That’s my personal opinion.

Thus, ironically, Wanda moved to Florida to practice legally, but now states that she would rather live in a state without licensing in order to avoid the government intervention that she feels is too restrictive. Whereas newer midwives interviewed felt “protected” and “validated” by the Florida midwifery statutes, Wanda, who has practiced longer than most of the other midwives interviewed, feels “tightly governed”. Furthermore, she clearly believes that the role of a government should not be to regulate or ensure that health care providers are ‘appropriately trained’ but rather that women themselves should be able to discern and decide the appropriate caregiver for her birth. Tying this in to comments made by some women interviewed in this study who could not positively identify the type of midwife that had attended their home birth or the credentials that the midwife possessed, perhaps Wanda is a bit naïve in her confidence regarding women’s competence to select their care providers. Furthermore, to become Licensed Midwives in Florida that can practice independently, the requirement is for student midwives to manage only fifty births, a number that may not fully allow new midwives to have experienced the range of deviations from normal and complications that can arise in any birth. This certainly doesn’t relate to the micro-management, as Wanda said, of detailing how often
heart tones should be auscultated in labor, but perhaps because the out-of-hospital setting is not “fully integrated” into the health system and access to emergency services and personnel can be time-sensitive in birth, there does need to exist “laws for protection.” Certainly, this is a hotly debatable topic, and ties into the next section detailing how policies constrain home birth practice.

**Florida Policies as Constraining Home Birth**

Similarly, midwives described how they felt that Florida policies constrain home birth, and if there were any specific restraints for home birth related to Medicaid. Only two midwives felt that there were no constraints. Quincy had actually described that she did not think there was anything in particular that promoted home birth midwifery, either, but stated that “no” there were no constraints. Xenia, who felt that the Midwife Practice Act actually gave her protection, shared:

> I personally do not feel constrained by my laws at all… I feel very protected with my laws. I definitely, I stay within the limits of my laws and I also know how to work within those limits to give people the wiggle room that they may need.

She described how she worked diligently with women to identify an accurate due date, based on multiple criteria such as the woman’s menstrual cycles, when the woman first felt the baby move, when Xenia first heard heart tones, and even ultrasound imaging, so that when it comes down to gestational age criteria that are considered appropriate for home birth, they are working with a solid date, but also having some “wiggle room.” She went on to say:

> I can work within the laws that I have. That’s not to say that I want to stretch them to unsafe limits either. I’m very happy to stay well within those limits but at the same time work [within]…there’s windows I think intentionally within the laws to allow for the art of it or the practice of it and I feel that I’m very good and competent at doing that. So I think when you’re really familiar also with the laws then you can have your sort of art within it but…to me, it’s definitely protecting me, too.

She did, however, speak to how the lack of any formal promotion of home birth midwifery does act to constrain it, particularly among Medicaid-funded pregnant women because:
Maybe they don’t know it’s an option. I have had a few women tell me, ‘I didn’t know this is an option. I didn’t know I could do this.’ They were so grateful that they found out Medicaid paid for that. Some people just searching for midwife find that on my website, that I take Medicaid. They’re so excited. They just didn’t even know that was an option for them. So, I don’t think anything promotes it, and on the same take by not promoting it, then it is a constraint. But we have Healthy Start here and I’m happy to be on that list. I work closely with them.

Among the two midwives who stated that there was nothing specific to Florida policy that was supporting the practice, one, Penny, discussed how the constraints grew out of the low reimbursements from Medicaid, though this was not something particularly new:

I think [the constraints are] only costs, and that’s not new or changed. It would be unfair to say that that’s a constraint, it’s always been that way, everybody’s had full disclosure that it would be that way, so any practitioner that chooses to accept Medicaid would obviously be choosing to accept what is so. And you know, maybe the flip side of that one is that the patient doesn’t often realize or recognize how pitifully [Medicaid is] paying the practitioner. I think there are many people even in my own practice who think, ‘Oh, [midwife name] charges $4,500 for a birth, oh, I’ve got Medicaid, oh, she’s getting $4,500.’ They have no idea that I’m getting you know, $1,200, $1,400, $1,500. No clue. And what’s the point of telling them? They can’t change anything about that, and they’re eligible for Medicaid, so it’s sort of like a moot point. I have to work very hard sometimes to just breathe through that and not be frustrated because it’s not the patient’s fault, it’s the system itself.

Rose spoke more about how the Florida statutes and risk scoring system (detailed in Table 1.6) act to constrain practice because they risk certain clients out of her care that she feels could still be appropriately cared for by her. She cedes that “it’s really OK” but her statement was couched within the fact that sometimes she can continue to care for some of these women because her consulting physician gives her that leeway and supports her. She also agrees with the midwives who said that one of the ways that Florida policies do promote home birth is simply through the very fact that they are allowed to provide home birth. Thus, her response to the constraints that Florida policies place on home birth was:

Some of the Florida statutes and laws and rules I might not agree with, but it doesn’t matter, I have to follow them. And sometimes they can lose me clients because, gestational diabetes, for instance. It’s so treatable, through diet. [But the statutes], they tie your hands, when you know it’s something you can handle. They make it an issue when it doesn’t really need to be an issue. You know, but that’s ok, because, it’s really okay, because. It’s not ok, but it’s really ok because at least we’re allowed to do it. At least we’re allowed to do home births, at least
we’re allowed to take care of these women, and I happen to have a really great consulting physician who makes it easy for me when I have to make a referral or do a consultation, and that’s really all the laws and rules ask. Is that you, you know, if they risk out of your care because of risk score of 3 or more, you just have to consult with a physician, and then it’s up to that physician whether she allows you to continue care, and I have one that will totally collaborate with me, so I’m very fortunate.

From another perspective, Susan described the risk-scoring system as a challenge, partly because of the criteria which require her to transfer a client out, partly because of the need for a consulting OB relationship, but also very poignantly because some transfers of care will occur among previously low-risk clients who have not had to establish a relationship with a consulting obstetrician. These women are then left at the mercy of “whoever is on call at the hospital”, who may or more likely may not be supportive of the women’s choice to have attempted a home birth. She also described how she personally feels attacked if she transfers a client to the hospital that did not also already establish a relationship with an obstetrician who could provide the care for whatever complication has arose. She ultimately describes this tenuous situation as a “back up arrangement mentality” that contributes to dismantling her stance as an “independent practitioner.” Her in-depth description of this “back up” situation follows:

I think one of the challenges is, sort of, obstetrician, the whole sort of back up arrangement mentality. It’s more [so with] a low-risk [mother] who should have no risk factors. If her risk score is less than 3, she doesn’t have to see an OB, but this woman, if her membranes release at 34 weeks, and we haven’t seen an OB, then we’re at a dilemma of whoever’s on call, at the local hospital, who may not be supportive of home birth. I feel fortunate ‘cuz I have a back-up OB that I’ve worked with for many years, and if the woman doesn’t have a risk factor, I always give them the option, ‘You don’t have to see the back up OB because you have no risk factors, and my law says you don’t have to, but if you want to, you can. So, that, if something came up, it’s not a stranger. Especially if it came up when you’re in labor or your membranes released and your 34 weeks.’ My law says I can continue caring for a woman up to 42 weeks, but if she hasn’t gone into labor by 42 weeks and you don’t have a back-up OB, she hasn’t seen one, you are reamed out royally when you go to the hospital.

However, as Nancy and Zoe also described, sometimes the “back-up” obstetrician is either not a Medicaid provider or might require a direct self-pay fee, which could prove to be a financial
barrier to Medicaid recipients, particularly if this consult visit with an obstetrician is more for a “just in case” type scenario than for a true “risk score” indication.

As other midwives had said, Susan stated she does appreciate the fact that she can practice legally, but that these situations when care gets transferred to other providers can decrease the autonomy of her practice:

There’s just this little piece there, that I’m grateful, I feel like I’m an independent practitioner and if they’re low risk I can just care for them, but if something comes up, I think about this for other midwives [that] don’t have either a back-up situation or if this woman hasn’t seen an OB so that you can call the OB and say, ‘Ok, she’s got ruptured membranes, I’m bringing her in’, then it just throws us into the institution that doesn’t really support or know how we know what we are doing and why we do it and how we work and doesn’t support what we do anyway.

She goes on to describe how each Licensed Midwife ultimately needs to create her own transfer plan so that women can continue to receive respectful care:

I think we have to create it, each midwife has to figure out some creative way of creating [a transfer arrangement] so that the women aren’t just left in the lurch if something comes up. I think that’s the main frustrating thing, at the 24th hour you don’t want to be scrambling to find out, ‘Where am I going to get care for this woman, how is this woman’s care going to be carried on?’

Tammy also discussed how the home birth midwives need “to have a physician quote-unquote ‘sign off’ and that was always a tricky process” not just for the ‘high risk’ women, but also for those who might have several risk factors that would tip their score to three or higher and require that obstetrical consult. But she described how even the obstetricians knew that these women would ultimately deliver at home, so this “consult” was therefore just a formality:

There would be a case where maybe this was baby number five, and so theoretically [the pregnant mom] was higher risk. Maybe she had hemorrhaged with a prior birth and so she was high risk. And so you would have to send her to an obstetrician to be signed off. And of course he was like, ‘Well, she had four prior babies at home, of course she’s going to have this one at home, you know, what do you want me to say?’ They know we carry Pitocin and Methergine and [laughs], it’s not going to be a big deal, but we still had to formally send her to the physician.

Ursula and Vera echoed the constraints imposed by the requirement for physician consult, and described that Florida policies are:
Very constrictive. They require home birth midwives to work under such laws and rules that almost makes it prohibitive for them to practice. The requirement for the doctor sign off, the OB sign off.

However, they went on to describe what no other midwives did: that a large challenge and restraint to the practice of Licensed Midwives in Florida actually revolves around the very Council of Licensed Midwifery, the advisory council legislated to monitor Licensed Midwifery practice in Florida. They described in some detail how the Council truly does not understand the practice of Licensed Midwives and that when rules clarifications are needed, the Council will turn to nurses, not midwives. Their comments are presented her in their entirety, as their conversation flowed between them:

Ursula:
I would say the biggest restraining factor is we have people on the Boards and Councils up in Tallahassee that make the decisions that haven’t the faintest clue about midwifery, the qualification, the expertise of the practitioners or what birth centers and home birth midwives do. It’s a recipe for disaster. You have people who know nothing about it, the mind boggles how little they know about the profession and yet they’re the ones that [are] calling the shots.

Vera:
And there’s too many nurses on the Council too. The Council, instead of, as a default, ‘Oh, okay, some things need to be revamped. Let’s go and have some midwives.’ They’ll go and ask nurses.

Ursula:
The Board of Nursing, yeah. So, I would say, overall, the biggest restricting factor is people making decisions who don’t know what they’re making decisions about.

Vera:
I mean I went up to a rule making two years ago, where they wanted to make some rule changes, to birth center law, and of course it was found out very late, so people jumped on the bandwagon and we went up there. The guy leading it was new, but the guy on his right had been a part of the Council [of Midwifery], [or at least] his name has been all over the midwifery world, as far as Tallahassee, for years. [He] didn’t know the difference between an LPN, an LM, a CPM, or an RM. At one point he referred to LMs as LPNs and then he referred to us as lay midwives. Granted, his child was born at home with a midwife who was sitting right in front of him. And he still didn’t know the difference. And that guy is the guy who’s submitting the reg[ulation]s.

Ursula:
Yeah, that’s the guy who heads the desk in Tallahassee. And have you heard of [name of person] AHCA representative who heads the midwifery/birth center
desk? I was having a conversation with her about a year ago over the new Obamacare which states that birth centers should be paid the same [as hospitals], so, [both] a professional component and a facility fee, and she said to me, ‘But [name] you already get the facility fee component because you get the 59430 with the T-hitch modifier’, which [means] we get reimbursed for the delivery and what they call post-delivery/recovery. She goes, ‘But, you already get reimbursed as a facility, because you get the post-delivery/recovery’ and I said, ‘Well if that’s the case, why do you also pay that to home birth midwives who don’t have a facility?’ And there was deathly silence for like 30 seconds. ‘I’ll have to get back with you on that, [name].’

Vera:
But that goes to show the level of ignorance, that lady is running the desk, and that is the biggest hurdle we have, is the rule makers not knowing the profession.

The CNM respondent discussed that the most constraining aspect to her dealt with the requirement for all Advanced Practice Registered Nurses, including Certified Nurse-Midwives, in Florida to maintain written, collaborative practice protocols with a “supervising” physician, unlike the Florida Licensed Midwives (LM) who are only required to have a relationship with a consulting physician who ‘is in current obstetrics practice’ and has hospital privileges. This ultimately ties her hands and forces her to proceed with some caution because she ultimately has more at stake, including the loss of actual hospital privileges that the LMs do not maintain with individual hospital’s credentialing bodies:

[The LMs] are way more under the radar and can do a lot more than what we [CNMs] have to answer to a physician and report to someone, where they can just go to the local hospital [with the patient and from there have no further responsibility to the patient]. I’m not implying anything here, but there is that, ‘Okay, we can push this a little bit more because we’re not going to see this doctor again’ or ‘They’re not going to pull my privileges’ because they don’t have to be supervised.

Furthermore, she discusses that while the clinical practice guidelines are very well laid out and specific for the LMs (which other midwives discussed could themselves represent a constraint to their practice), a similar equivalent within Florida or at a more national level for all nurse-midwives does not exist. Ultimately, this creates a situation in which there are no documented standards, which are keenly important when any liability claim is being weighed. In sum, she said:
As a nurse-midwife, I think the whole supervising physician, that’s [the] biggest thing. I mean, when you look at the Florida Statute - as far as what’s the risk assessment is for Licensed Midwives, it’s crazy what they can do. I mean, it says in there, they can do - having a prior uterine scar is only a risk factor of two\textsuperscript{44}, so they don’t even necessarily have to consult for that. So I use that risk assessment – actually, even though I’m a nurse-midwife - because there is nothing else for a nurse-midwife. Like, I don’t have any kind of State regulations for homebirth...Again, there’s no real standard - that’s the overwhelming thing when you try to set up a practice. It’s like, you don’t want to do anything that’s illegal, you don’t want to do anything wrong, but there’s no real structural guidelines to help you through it.

While Florida has the reputation for being a “model” state for non-nurse-midwifery, Florida nurse-midwives actually have some of the more restrictive practice laws in the country. Certified Nurse-Midwives (CNM) in Florida are licensed through the Board of Nursing as Advanced Practice Registered Nurses (ARNP), and must attest to having liability coverage with each biennial license renewal. In addition, all ARNPs in Florida must file their written protocol entered into with their “supervisory” physician with both the Boards of Nursing and Medicine. Florida is the only state that does not permit its ARNPs to prescribe any form of controlled substance, and considering that CNMs primarily practice in the hospital where narcotic analgesia can be given during labor, this is a practice restriction. Hospital practice is mediated through each hospital’s credentialing process, which is usually controlled by physicians. Additional barriers that are not part of the Florida State Laws governing APRN practice can be applied or used to restrict CNMs from obtaining hospital privileges or to sanction the practice of CNMs within hospitals. As this CNM states, she has to be mindful of a host of factors that Licensed Midwives do not because her hospital practice could be restricted, particularly if she has any untoward outcomes from an out-of-hospital birth. Also, as she discussed, few if any guidelines exist for home birth practice among CNMs that leaves her without some of the “protection” that several of these LMs described. However, a CNM practicing home birth does have certain advantages over LMs in that (s)he can prescribe medications for conditions such

\textsuperscript{44} If a client has had a prior uterine incision but has then had a successful vaginal birth, the risk score is 2, whereas without the successful vaginal birth the risk score is 3. Any score of 3 or greater warrants an obstetrical consult.
as urinary tract infections, and also has increased recognition when referring for radiology or other testing or even perhaps to have “peer-to-peer” telephone consults with providers such as CNMs that practice in hospitals or with perinatologists that could provide more informal guidance when risk factors emerge. That said, if LMs are considered health system outsiders by physicians or by the health system in general, while CNMs are perhaps more integrated, they also face the barrier of being somewhat of an outsider within their own profession, as very few CNMs in Florida or nationwide attend home births. Certainly practice and policy constraints exist for both LMs and CNMs, and much work is needed to help provide women who desire home birth with access to “skilled attendants”.

Discussion

As Gloria stated, the empowerment that women experience after a natural birth can be considered cliché. However, in the context of a Medicaid-funded home birth, the opportunity to become empowered through one’s birth experience should be seen as far from cliché. From the hassles encountered when applying to Medicaid to the notion that Medicaid recipients are “lazy” and that Medicaid recipients can only see “crappy Medicaid doctors,” what could be a very disempowering experience can instead be used to change a woman’s sense of self-power. A striking difference between the way these respondents described their birth experiences and that of the typical American birth narrative is these respondent’s use of terms such as “fun,” “party,” and “relaxing”. Certainly, these experiences offer a greater chance for confidence and empowerment than the typical hospital birth narrative that brings to the front terms such as “painful,” “horrifying,” and “awful.”

These respondents went against the societal norm by choosing to give birth at home, and in doing so, engaged in a process of “true” informed consent. Whereas many had experienced hospital births as ‘being done to them’ they felt as if they were in control of their home births. Rather than the central actor being the hospital machines and the nurses and doctors, the birthing women themselves were the “focus of attention.”
Florida has been lauded within the out-of-hospital midwifery community as a ‘model’ state when it comes to legislation that supports the legality of Certified Professional Midwives and the mandate for midwifery services to be reimbursed by all insurance companies, including Medicaid, for births occurring in all settings. While some of the midwives interviewed felt that the laws “told them how to practice”, many felt that the very fact that these laws are in place helps give legitimacy to their practice and profession and that the law’s existence serves to promote home birth, particularly among Medicaid-funded women. The Midwifery Practice Act, Florida Statute 467, was passed in 1995, and in 1997 Licensed Midwives accepted the requirement to carry liability insurance in exchange for the ability to bill Medicaid. Many of the midwives felt that nothing had been done since that time that helped to promote midwifery or home birth in Florida.

Furthermore, there was not consensus among the midwives regarding whether having the clear-cut clinical guidelines housed within the Florida Statutes acted as a protection, a constraint, or neither. While nearly half of the midwives in this study felt that Florida’s Statutes and laws regarding midwifery care and home birth were among the strongest in the nation, not all midwives felt they were necessary or that they represented the best way to regulate practice. Wanda felt that these regulations should be altogether abandoned, giving women the legal right to make decisions about their “bedrooms.” The CNM respondent discussed the challenges she faces related to the lack of standards or structural guidelines. However, the Home Birth Section of the American College of Nurse Midwives (ACNM, the professional organization representing CNMs) has not reached a conclusion regarding whether such set guidelines are compatible with both their member’s clinical practices and the philosophy and mission of the ACNM (personal communication with Home Birth Section Chair, March 17, 2014). In fact, when an article (Cook, et al. 2014) that offered a template for clinical practice guidelines for CNMs attending home births was published in the ACNM professional journal without the Home Birth Section’s prior knowledge, its Section members felt that the work they had been doing in this arena became
invalidated and they expressed concerns over how these proposed “guidelines” that did not necessarily have ACNM endorsement would be received in the wider midwifery and obstetrical communities (personal communication, March 17, 2014). Interestingly as well, the International Confederation of Midwives, a member organization that represents midwifery associations world-wide, voted at their 2011 Triennial Congress to promote the three pillars of the midwifery profession (education, regulation, and association) among its member organizations (International Confederation of Midwives 2011c). This suggests that at the international level, regulation of midwifery practice and midwifery training should be the standard. However, the ICM spoke in general terms regarding midwives’ “scope of practice” (International Confederation of Midwives 2011a) and did not offer specific guidelines such as those very detailed criteria in the Florida Statutes. Clearly, the global is meeting the local and the face of midwifery is in flux. In fact, when the ICM announced its promotion of the “three pillars” globally, midwifery organizations in the U.S. formed their own organization (U.S. MERA 2013) to address how to advance the very American patchwork of midwifery towards realizing the ICMs vision of a national midwifery guided by ‘education, association and regulation.’ This in fact marks an historic undertaking among American midwifery organizations.

Engaging consumers in birth reform has become a key strategy for the major midwifery organizations in the U.S. Furthermore, consumer groups, such as ImprovingBirth.org and Where’s My Midwife? have emerged and demanded changes to the status quo birth culture. While in this study, midwife Penny questioned, “what's the point?” of educating Medicaid recipients about the issues she struggles with regarding care reimbursement, in fact harnessing the consumer power of birthing women will likely prove to be the most effective strategy to promote change.

Most study participants reported that home birth made them stronger and more confident. To an extent, this grew from their own initiatives to seek out home birth and to be respected within a system of true informed consent. Home birth midwives take very seriously
their roles beyond the provision of prenatal and delivery care - they take on the responsibilities associated with engaging their clients in the transformative and empowering experience of home birth. The empowerment gained through home birth was particularly felt among women that had experienced the stigma of being Medicaid recipients and among those who had negative experiences with hospital births. While other research has documented that autonomy is a key factor within the empowering experience of home birth, this research specifically relates this within a population of both Medicaid recipients and Medicaid providers.
CHAPTER 10: DISCUSSION and CONCLUSIONS

Study Overview and Review of Study Aims

This dissertation set out to explore a relatively rare phenomenon (home birth) within the context of a very common life event (childbirth). In particular, this study looked at the interaction of the Florida Medicaid system with home birth from the lens of Critical Medical Anthropology, highlighting how power differentials impact health policy and implementation and in this case, access to a form of health care that in more recent history has been considered a privilege among women of “means.” While home births represent less than one percent of all births in both the U.S. and in Florida (Martin, et al. 2013a), Medicaid is the payer for nearly half of these births in both locations (Osterman, et al. 2013). Among home birth providers, particularly Certified Professional Midwives (CPM), Florida has long been considered to have some of the most robust laws and policies that support not only home birth, but also insurance reimbursement for it, including through the Florida Medicaid program. Florida therefore is one of only ten of the United States where the Medicaid program will reimburse CPMs for home births. Because of this, Florida offers a unique arena to examine the interaction of Medicaid and home birth.

This dissertation utilized a mixed method approach in order to document the prevalence and socio-demographic characteristics of Medicaid-funded home birth in Florida. It also sought to understand how Medicaid funding impacts access to home birth, particularly among minority women, and to examine women’s motivations for seeking home birth. Furthermore, it set out to document the women’s satisfaction with care, and also to examine how home birth providers in Florida experience and navigate the Medicaid system. Some study data supported findings from previous literature that examined home birth in general, while some data revealed unanticipated and unique results.
This chapter summarizes the results that have been presented in Chapters Four through Nine. First, however, it will discuss how the complementary use of qualitative and quantitative methods contributed to each other and ultimately to the study findings. Next, an attempt is made to directly address the five research objectives that were laid out in the study design. Then, a discussion of emergent themes is presented as an interpretation of the study findings. It then returns to the theoretical foundations of the study to examine how and why Critical Medical Anthropology serves as a vital lens through which to examine the topic of Medicaid-funded home birth in Florida. Study limitations are addressed and tied into recommendations for future research and policy. A dissemination plan is presented at the chapter’s end.

**Compatibility of Mixed Methods**

The use of mixed methods, or the use of both quantitative and qualitative methods to examine a research question, has been said to result in both “number and narrative” accounts of the question at hand. Overall, qualitative and quantitative data supported each other in this study, with little data that contradicted or demonstrated large variance between data streams. Florida birth certificates were used to: 1) describe the population of women that complete planned home birth in Florida; 2) set a sampling goal for qualitative interviews; and 3) conduct bivariate analyses and logistic regression models to assess the interactions between funding source and home birth. The actual demographic data obtained from birth certificates was compared to the views of the midwives regarding their perceptions of their Medicaid clients’ demographic characteristics. Additionally, where themes emerged from qualitative data, such as when midwives identified vaginal birth after cesarean (VBAC) as one key reason women seek home birth, data from birth certificates was able to corroborate that very few VBACs occurred in hospitals, and that indeed VBACs occurred at home. Additionally, during qualitative interviews, women were somewhat unsure about the credentials of their midwives. Data from birth certificates detailing that Licensed Midwives were the primary birth attendant for planned home birth helped demonstrate that primarily these women had received care from Licensed
Midwives. Women also described their motivations for pursuing home birth as resulting from fears of interventions with hospital birth. Birth certificate data corroborated a high rate of interventions in the hospital setting, such as cesarean sections, vacuum delivery, epidural use and rates of labor induction and augmentation, and thereby provided credibility to the respondent's views that hospitals pose iatrogenic risks associated with pregnancy and labor interventions.

The mixed method approach also included the use of an objective scale of birth satisfaction which also complemented the qualitative interviews. The results of the Birth Satisfaction Scale-Revised (BSS-R) are reported elsewhere in this dissertation and in Appendix Q, but the data from this scale certainly echo the qualitative data among the women that their home births were highly empowering and satisfactory. This was further expressed by the women in comments such as, ‘once they got through the hassles of applying and the Medicaid was in place, everything after that was really easy’, and that ‘Medicaid represented the best health insurance coverage they had ever had.’ Interview data was bolstered by objective scale scores and indicated that women were highly satisfied with their care and birth.

Finally, the combination of qualitative data reported in this dissertation from both the midwives’ and women’s perspectives also served the function of data compatibility. The views of both the women and the midwives regarding the perceptions of Medicaid recipients was presented and the experiences of interacting with the Medicaid system was compared and contrasted between the women and the midwives, with each finding both positive and negative aspects to the Medicaid system, and some even giving suggestions for improvement. Additionally, the views of both the midwives and the women regarding the sense of empowerment that resulted from the women’s home births were presented and demonstrated that indeed home birth was empowering.
Study Findings

Research Objective One: Prevalence Data for Florida Home Birth
To document the prevalence and socio-demographic characteristics of Medicaid-funded home birth in Florida

As documented in Chapter Four, the initial analyses of Florida birth certificates provide the prevalence rates of Medicaid-funded home birth, including the socio-demographic breakdowns of planned home birth stratified by payer source (see Table 4.6). While it appears that the overall birth rate in Florida decreased after the 2008 recession, the percentage of women who sought home birth in 2009 and 2010 increased. It is impossible to determine from birth certificates alone whether this increase was related to the changing economic times or if some other factors in popular culture, such as the 2008 release of the film *The Business of Being Born*, contributed to this increase. It is clear from national-level data that the percentage of women giving birth at home is increasing (MacDorman, et al. 2014), and this study sought to determine some of the reasons that women are seeking planned home birth, particularly as this choice relates to their status as Medicaid recipients.

Overall, women who completed planned home births in Florida were diverse, and the specific ways that they compared to the total term hospital population is presented in Table 4.5. Planned home birth was attended primarily by Licensed Midwives (87%) and was most common among white-non-Hispanic women (78%). Over 75% of planned home birth was to women with an education beyond a high-school diploma and 83% of women were over age 24. The marriage rate was 85%. Only 9% of women who had a planned home birth started pregnancy with a BMI >30 (obese). Payer source was split in nearly equal thirds between private insurance, Medicaid and self-pay status. The extent to which these rates differed from women with low-risk hospital birth is evaluated and presented in Tables 4.7 to 4.10.

Compared with the actual birth certificate data, qualitative data collected from midwives describe how midwives perceived their Medicaid clients to be somewhat less “established” in life, employed in lower-wage, primarily service, jobs especially if they were younger. Older
Medicaid clients were mostly stay-at-home mothers who ultimately qualified for Medicaid due to their larger family sizes, and hence these women were of higher parity than non-Medicaid clients. While employment status is not captured in birth certificates, perceptions about higher order parity did not prove significant in the quantitative analyses; however, each individual midwife is obviously referencing her own clientele which likely demonstrate regional variations that are not addressed when looked at from across Florida as was done with the quantitative data in this study.

**Research Objective Two: Medicaid Impacts to Florida Home Birth Access**

To examine how Medicaid funding impacts access to home birth for Medicaid-funded women in Florida, particularly minority women

As described in Chapter Four, it appears that after controlling for confounding factors including maternal age, parity, and marital status, home birth is more likely to be completed by women with Medicaid than by those with private insurance across all ethnicities, although one cannot make the direct statement that Medicaid increases access to home birth among minorities. Simply put, in this cross-sectional study and among women who had a planned home birth, Medicaid status was more likely to be reported among all ethnic groups than was private insurance, and self-pay status was in fact the most common payer for planned home birth. The stratified analyses that took into account the modification effects of payer source and race confirmed that women who complete home birth were more likely to have Medicaid than to have private insurance, and most likely to have self-pay payment status. However, among women that had a home birth, even after accounting for payer source and all the other adjustment variables, all race/ethnicities except Asian were more likely to have a home birth than Black-non-Hispanic women (BNH). Due to study limitations, only one African-American woman was interviewed and no Hispanic women were interviewed in this study, but seeking out the opinions and experiences of these minority groups in particular given their relatively large percentages among all Florida births would be important to better understand the motivations of minority women in regards to birth site.
While the raw percentages of women stratified by race and ethnicity that gave birth in Florida between 2005 and 2010 differed significantly from the subset of women who had a planned home birth (PHB) in the same period, when compared with the raw percentages from a study of nineteen states that report home birth planning status on the birth certificate (Declerq 2010), these percentages of race/ethnicity among total births vs. planned home births showed less steep declines among minorities while maintaining almost the same increase among White-non-Hispanic (WNH). This is shown in Table 4.11. For instance, while BNH represents 17.8% of all Florida births, BNH is only 5.1% of PHB, and thus represents a 71% rate decrease between 2005 and 2010. However, among the sample with 19 states reporting PHB, the overall BNH rate is 11.9% while PHB among BNH is 2.2%, which represents an 82% rate decrease during the six year period. Among Hispanics, the reductions in Florida are only 60% while the larger sample shows an 83% reduction among Hispanics. In a certain way, this accounts for the already disparate race/ethnicity profiles between the two samples. Unlike the similar rate increase among WNH women who represent a larger proportion of the planned home births in both samples, among BNH and Hispanics there is a less steep rate reduction in Florida.

From the crude odds reported in Table 4.7, it is clear that when compared to hospital births, home birth babies were born at higher birth weights, at older gestational ages, and were much more likely to be breastfed. Women who complete home birth were much more likely to be older, married, multiparous, non-smokers who have completed bachelors or advanced degrees, and who did not rely as heavily on WIC. However, age lost its significance when controlled for, and remained non-significant when the interaction between race and payer status was applied. As stated above, there does seem to be a significant interaction between payer status and race, which might contribute to increased home birth access among Medicaid-funded minority women.

Perhaps the most intriguing finding is the manner in which payer status of planned home birth shifted between the crude and adjusted odds. While Medicaid funding, compared to
private insurance, appeared to be a protective factor against planned home birth in the crude odds (OR 0.88), when demographic factors such as maternal age, race, U.S.-born status, education, BMI and parity were controlled for, the adjusted odds of a planned home birth having Medicaid compared to private insurance rose significantly (AOR 4.64). Attempting to understand how these factors interact is speculative, and further research is needed to better understand these interactions.

One important lesson learned from this dissertation is that birth certificates alone may not be able to provide appropriate data to determine whether Medicaid can impact access to home birth. Furthermore, while this research objective primarily aimed to determine if Medicaid increased access to home birth among minority populations that traditionally have not been documented to seek home birth care, the limitations of the qualitative sampling strategy (which aimed to approximate the Florida Vital Statistics Planned Home Birth sample in relation to race/ethnicity, maternal age, parity and education) precluded drawing a diverse sample of women that had completed a home birth while on Medicaid in the year prior to the research undertaking. Therefore, beyond what can be extrapolated from birth certificates in regards to race and ethnicity, the qualitative findings represent a wider range of issues regarding “access” (See Chapter Eight for a detailed description of access-related issues). Key access issues revolved around the women’s Medicaid application process, including how women were able to complete the Medicaid application, as it was not clear whether it had converted to the online ACCESS process or if paper applications were still being accepted. Some women reported completing the online application while others the paper, mail-in system. Regardless, both encountered great difficulty in transmitting necessary documentation to Medicaid during the enrollment process. This was related to the high cost of transmitting documents either by fax or return-receipt mail, to not receiving confirmation that documents had been received, or to the extremely long wait times to get through to a live person on the customer service line. As one respondent stated, the multiple attempts to submit the required supporting documentation for
the Medicaid application “add up” when you have to drive to a commercial business like Office Depot and get charged $3 per page to send a fax. Significant delays occurred because the women had no way to ensure that the documents had been received, and would often only find out the documents had not been reviewed upon receipt of a denial letter which would in turn lead them to have to start a new application and face the same time and financial costs related to the application process. Unfortunately, because this issue emerged during the data collection and was even better appreciated during data analysis, women in this study were not asked specifically how long the application process took or how many times they had to apply, and the women interviewed earliest were not asked how far along they were when their Medicaid became active. Furthermore, this sample clearly only represents women who were ultimately able to complete the application process, as a study inclusion criteria was that women had completed a home birth while on Medicaid in the past year. Therefore, the views of women who were unsuccessful in applying for Medicaid are not represented in this study, and eliciting their experiences could be a worthwhile part of a future investigation into this topic or the broader topic of Medicaid enrollment during pregnancy.

Thus, a key issue with access that was identified related to the timing of the women’s Medicaid enrollment. Despite the “presumptive eligibility” that should have allowed women to receive care while their Medicaid applications were in process, some women decided to wait until their Medicaid was active before seeking care, with one in particular waiting because she had an experience with her credit being negatively affected from unpaid bills that Medicaid should have covered from a previous pregnancy. This delayed enrollment ultimately blocked access to routine obstetrical care among some women in this sample, and if their Licensed Midwives had not provided care to them, many would have first entered prenatal care during the third trimester or not at all. Lack of early access to Medicaid was also suggested by one respondent as a potentially contributing factor to miscarriages among women who need progesterone supplementation in the first trimester, which they cannot afford to pay for out-of-
pocket while their Medicaid is still pending. This all points to the need for a more universal, seamless health care and health insurance system that ensures women do not have coverage gaps, for instance, between pregnancies. Such a system would eliminate the phenomenon among some women of “cycling” on and off Medicaid related to pregnancy status.

That said, this access issue was more broadly related to the women’s experience with Medicaid, not necessarily specific to their pursuit of home birth while on Medicaid. However, as described, several of the women were directed to home birth midwives by the MomCare program that is specifically designed to help women with pregnancy Medicaid access care providers. In this way, Medicaid essentially acted as a conduit to midwifery care and home birth among some women who otherwise would not have considered it. In particular, the fact that Licensed Midwives were open to accepting these Medicaid enrollees, even when their Medicaid was pending or at times not yet even applied for, represents a way that access was opened to these women. Other practices that traditionally accept Medicaid and therefore are listed on the “MomCare lists” were not always willing to accept additional Medicaid clients, which led some women to “go down the list” until they called the home birth midwife that would still accept them into care. Midwives described this more as a social justice function than as a business decision, as they actually receive significantly lower reimbursement from Medicaid than from private insurers or self-pay families.

Medicaid-funded home birth in Florida is at a likely crossroads, given that as of August 2014, all Florida Medicaid has transitioned to an HMO-based system. This will likely lead to reduced access to a variety of services for Medicaid recipients. Chapter Eight details the services to which Medicaid recipients could gain access or, alternatively, be denied because of their Medicaid status, as reported by the women and midwives. For most women, the simple fact that Medicaid allowed them to access their midwives was the greatest thing Medicaid allowed them to have. Thus, for many, Medicaid was a vehicle for the home birth that they already sought out, while among others, the lack of Medicaid providers led them to midwifery
care and home birth that they had not originally intended. Additionally, Medicaid allowed some women to access ancillary services such as dental and chiropractic care, though others were specifically denied access to these same services, suggesting regional variation in access as theoretically these services are supposed to be reimbursed by Medicaid. The problem becomes finding providers who will accept Medicaid, as has also been documented among migrant farmworker children regarding dental care access (Castaneda, et al. 2010). Some of these ancillary providers stopped accepting Medicaid clients due to low reimbursements, and it remains to be seen if Florida Licensed Midwives will similarly stop accepting Medicaid, especially now that HMOs are the only Medicaid option in Florida. If midwives do not credential with each HMO, or for that matter with any HMO, then women on Medicaid who desire home birth will have to make the choice to “find the way to pay for it” as they suggested they would in this sample. Perhaps LMs will offer a discount to clients that they know qualify for Medicaid even if the midwives themselves are no longer accepting Medicaid as payment. It seems that Medicaid-funded home birth in Florida is at a crossroads based on this transition to an HMO system.

Beyond access to some of these ancillary services like chiropractic care, being on Medicaid allowed mothers to access certain additional services that they might not have if they did not have Medicaid during pregnancy. One includes the automatic eligibility and enrollment of the newborn on Medicaid for its first year of life. However, this is also not related to home birth directly but rather to Medicaid at large, although some of the women described that it was actually more challenging to enroll their child in Medicaid because in the hospital the paperwork somehow seems to automatically get filed, while the home birth mothers had to initiate the process themselves. For some women, the Medicaid access to home birth helped with other access issues, such as childcare during prenatal appointments and the birth itself as well as transportation issues, since some of the midwives provided prenatal care in the women’s homes, and certainly the births occurred there, where their older children were clearly welcome.
Form the midwives’ point of view, challenges with Medicaid included accessing assistance from state Medicaid officials when problems arose. In particular, midwives cited the lack of knowledge within the Council of Licensed Midwifery regarding the practice of Licensed Midwives in Florida and the particular challenges that arise when an agency designed to be one’s advocate is unclear of the function of the profession that it is charged to help advise, and turns to other professions such as nursing when it seeks clarification. The midwives also discussed challenges relating to the determination of a client’s Medicaid status, particularly when clients were unexpectedly switched to a Medicaid HMO, but these are further discussed under Research Objective Five below.

**Research Objective Three: Medicaid Recipients’ Motivations for Home Birth**
To examine the motivations for seeking home birth among Medicaid-funded women in Florida, and to document their barriers or facilitators to care

Chapter Seven provides details regarding the motivations that women on Medicaid had for seeking home birth. Primarily, women viewed pregnancy and birth as normal, natural events that did not require interventions or attention in the hospital. They wanted to avoid interventions such as IVs, epidurals, and Pitocin that they felt would inevitably be offered or forced on them in the hospital setting, thus stripping them of their autonomy to decide the way they would give birth. They desired the comforts of their own home where they would be the least stressed and be free to move about, eat and drink, and not face driving to a hospital while experiencing the pains of labor. For a few, their relative distance to the hospital made hospital birth unappealing as they felt they might not reach the hospital in time once labor started. By and large, the women felt that birth at home was safer than birth in the hospital, a concept that essentially contradicts the policy statements of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists, which tout their medical authority and proclaim that the hospital is the safest location for childbirth. However, the life-saving techniques and technologies that the hospital can indeed offer are rarely reserved only for those pregnancies
that have developed complications, so that iatrogenic risks such as infections and operative births actually increase in the hospital setting over the home setting.

Among the women who had previously given birth in the hospital, the main motivation for home birth was to avoid the hospital and the de-personalized care they experienced there that denied them the autonomy to make decisions about their own bodies and their babies once admitted under a professional’s care. Women wanted to avoid being “put on a schedule” and the “pressures” that come in the hospital environment where a clock is ticking and if a vaginal birth has not occurred, the risk of cesarean increases. Women who had given birth in the hospital also described the lack of autonomy they felt during those hospital births, where their choices and desires were often abandoned instead for routine hospital policy and procedure. Even among the women who had not personally given birth in a hospital, and who had only experienced out-of-hospital birth, the motivations for home birth stemmed from a desire to preserve their autonomy and decision-making, not only related to basic concepts such as being able to keep their babies with them after birth, but to have wishes respected, such as declining vitamin K for their newborns, or not being induced.

Medicaid-funded women described several barriers and facilitators to receiving home birth. By far, the Florida Licensed Midwives were the greatest facilitators. Some women described that their midwives were the ones who even suggested they apply for Medicaid, as they would have paid out-of-pocket if needed. Additionally, Licensed Midwives were the only providers willing to provide prenatal care to some of the recipients, either before their Medicaid was active or if activated beyond a gestational age that other providers were willing to accept. Several respondents had discussed that if they were already in the second trimester by the time that Medicaid was approved, many obstetrical practices would not enroll them into care. Another facilitator, although it was more frequently mentioned by the midwives than by the mothers, was the MomCare program. Midwives perceived this “MomCare list” as being one of their greatest referral sources, and they described how some women found out about their
option for a home birth after going down the list and finding that while listed providers were theoretically accepting new Medicaid clients, they did not always do so, and then the women would “stumble” on the home birth midwives and ultimately receive prenatal (and often delivery) care with them. Generally speaking, Florida laws and statutes can be considered a facilitator to Medicaid-funded women’s access to home birth care, and one mother described how she cited the statutes to her private insurance company in order to receive “coverage” of her planned home birth; in the end, however, she met eligibility criteria for Medicaid and did not need that “exception” coverage from the private insurer. Barriers to care included the Medicaid enrollment process, which resulted in significant stress as well as delays for the mothers. To an extent, another barrier could be considered the general societal view of hospital birth as normal and home birth as abnormal, and family reactions to home birth plans could have acted as barriers to completing home births, though obviously in this sample, the women ultimately overcame the stigma and negative reactions and gave birth at home.

**Research Objective Four: Medicaid Recipients’ Satisfaction with Care**

To examine and document the experience of and satisfaction with prenatal care and birth among Medicaid-funded women in Florida who chose home birth

Reported throughout this dissertation are the experiences of Medicaid-funded women in regards to their prenatal care and home births. Chapter Seven details the respondents’ views on the best parts of prenatal care and the advantages of having a home birth, while Chapter Nine reports on how respondents became empowered through their experiences partially through a true informed consent/informed choice process. Respondents expressed gratitude that their midwives had engaged them in a respectful decision-making process. In comparison to several respondents’ experiences in the hospital where they described feeling as though the hospital staff did not trust them to make sound decisions about their own and their babies’ health, and where they felt treated like children, the midwives treated them in a trusting, loving manner that made them feel more like “friends” than like “patients”. The close relationships that were built with their midwives contributed to their overall satisfying birth experiences. These relationships
were fostered by the personal nature of the care, by not being treated as a number, and by having direct access to their midwives via her cell phone that they felt they could call her on at any time. Importantly, the relationship was also fostered by the feeling of being treated as an equal, which was different from the power differential that they felt from doctors who saw themselves as the authority, or the expert. The midwives helped give these mothers the sense that they were the experts about their own bodies and babies, and this contributed to a sense that they could give birth naturally, by their own physical force, not augmented by some synthetic drug or process. In turn, women felt empowered because they had gained self-confidence and pride through their birth experience, which one woman described as “cliché”, that home birth had given her faith in her body and self-confidence. This all contributed to an almost “do-it-yourself” sense of accomplishment, because the women had been involved in the decision-making and actually had a say in which position they chose to deliver in, how they were able to move about in labor, and how they were able to allow the birth to unfold on its own time as opposed to being put on a “clock” at the hospital. Furthermore, the women described the importance of the “comforts of home” and being with known people in a known environment, as well as the importance of being able to involve the whole family, including other children, in the pregnancy and the birth. One woman also described how her experience had so changed her that she ultimately became somewhat of a cheerleader among her friends who also went on to choose home birth. Clearly, the importance of this trusting relationship with their midwives and also the life-changing experience of natural childbirth empowered the women and contributed to their positive experiences with and satisfaction from their home births.

The Birth Satisfaction Scale-Revised (BSS-R) was used in this study to objectively measure women’s satisfaction with their home births. The key components of the BSS-R relate to the perceived quality of care provided, women’s personal attributes, and stress experienced during labor. Given that within this sample the mean BSS-R score (44.44) fell nearly three standard deviations above the mean (29.19) of the validated sample among women who
experienced “normal childbirth” (Hollins-Martin and Martin 2014), it seems reasonable to conclude that the participants must have perceived their care quality to be superb, their own sense of control to be high, and their stress to be relatively low. It will be important to compare scores from this scale between women in Florida who had a home birth while on Medicaid with those who had a hospital birth while on Medicaid in order to better contextualize these high scores. Additionally, comparison could be made to women completing home birth with either private insurance or self-pay status to further contextualize the high scores found in this sample. For now, there seems to be no doubt that women are highly satisfied with their care, not only as evidenced by the score on this scale, but also by the report of all but one of the women interviewed who stated that she would only have a home birth again, unless there were extenuating medical circumstances. Whether satisfaction with prenatal and delivery care results in long-term benefits to the mothers or babies is certainly not fully understood, but no doubt the empowering experiences these women had with their home births contribute to both a sense of autonomy that is not likely often experienced by women receiving Medicaid as well as a sense of self-confidence that these women can draw from throughout their lives.

**Research Objective Five: Medicaid Providers’ Experiences with Medicaid**

To examine how home birth providers in Florida experience and navigate the Medicaid system.

Midwives described a number of positive and negative aspects associated with being a Medicaid provider of home birth. Most midwives felt that the application process to become a Medicaid provider was laborious and challenging, while a few actually found the process to be straightforward. By and large, the midwives appreciated that Medicaid paid them promptly and regularly, and they felt that this helped to keep their businesses afloat from month to month while they would be waiting for the lump sum payments that would come from commercial insurers or Medicaid HMOs, or the similarly “lumped” payments typically received from self-pay clients. Although the reimbursement rates were significantly lower from Medicaid than from commercial insurers or even self-pay clients, often in the 30 to 40% of total range, it was
relatively easy and straightforward to work with the system. However, system challenges did exist, such as for those midwives who were withheld future payments until they had “paid back” money to Medicaid that had erroneously come to them from “straight” Medicaid when it should have come from an HMO (and in fact when the HMO would never end up paying them for that service because the patient had likely not been pre-authorized by the HMO to receive the care from the midwife to begin with.)

Midwives described a sense of social justice as one of the reasons that they provide care to Medicaid clients. Their motivations were in providing care that supported their philosophy of informed consent and empowerment. However, several were also cognizant of the need to “make ends meet as small business owners” and therefore one had stopped taking Medicaid clients altogether while at least one admitted to capping or limiting the number of Medicaid clients she accepted into her practice. There was a sense among the midwives that taking Medicaid clients could help them build their practices, but that if they had to take on more clients just to pay the bills based on the low reimbursements of Medicaid, that they might actually be compromising the quality of their care. Thus, midwives described the benefit of Medicaid particularly when they were starting their practices, as Zoe put it, at a time when she really was not able to turn anyone away. Despite the low reimbursements, Medicaid recipients represent a somewhat reliable patient base, partly because so many women receive Medicaid coverage in pregnancy, but also because the Medicaid reimbursements are regular and provide a source of cash flow when a practice is getting off the ground. However, it appears that at least for the most seasoned midwives, over time Medicaid can become a disadvantage and once a practice is established, accepting Medicaid patients can limit slots that would be available to patients whose private insurance or self-pay payments would far exceed the Medicaid reimbursements. Yet, the midwives’ sense of “social justice” to provide their special type of care to anyone who seeks it contributes to their continued provision of care to these low-income, Medicaid recipients, as they felt they should not be denied care simply because of their
Medicaid status. Additionally, some midwives discussed that some of their current Medicaid clients were previous self-pay or privately insured clients who either due to their increased family size or change of life circumstances now qualified for and relied on Medicaid, and the midwives chose not to end the established relationships with these women just because their insurance status had changed.

One of the challenges that several midwives discussed in taking care of Medicaid clients included the clients’ overall “blasé” attitude towards their care, and their apparent lack of prioritizing the financial responsibilities related to their care with material goods or vacations. This led some midwives who were struggling financially themselves to be somewhat resentful of their Medicaid clients, particularly when they felt some of them were abusing the system. Several midwives also got the sense that some Medicaid clients might have enrolled in care with them in order to avoid detection of drug use or other types of involvement with law enforcement or child protective services, but that these clients inevitably did not complete home births anyway.

In reflecting on the data collected during this project, Medicaid appears almost as a “necessary evil” - that by not accepting Medicaid clients, the midwives would not be able to care for nearly half of the pregnant women in Florida. However, because home birth is such a “leap of faith” when it comes to the commitments required on the part of the pregnant woman and her family, it seemed that midwives were suggesting that those women who truly desired home birth would in fact, as the women in this study reported, “find a way to pay for it.” Most of the home birth midwives in Florida are willing to create flexible payment plans for their clients and work with them so that the woman gets the care she desires and the midwife gets appropriately remunerated for her time and expertise. The complete shift to Medicaid HMOs will likely cause the Florida midwifery community to pause and reflect whether this change and its ensuing lack of a centralized Medicaid portal, its shift away from weekly payments to lump sum/global payments, the need to contract with multiple HMOs, and the additional paperwork and
bureaucracy will be worth the effort or if Medicaid-funded home birth in Florida will become a thing of the past, existent only on paper but not in practice.

**Interpretation of Findings: Emergent Themes**

One of the first themes that emerged from the data was that the women who pursued home birth with midwives did so against the societal backdrop of the practice being considered “archaic” and “dangerous.” Several of the women discussed how, earlier in their lives, they themselves had believed home birth to be “crazy”. They described how they dealt with the mainly negative reactions they received from family and friends regarding their home birth choice, which they primarily made in order for them to access a “natural” experience. Many respondents “formed their own bubble” to keep negativity related to their home birth choice at bay, while others just “let it roll over my head.” Others “devoured” books on childbirth and on research about home birth that helped to inform them about their options and choices. This research helped them to make informed choices which they felt others would respect, more so than merely “going along with the cattle herd” and getting on the “McBirth” line.

Similarly, women faced both a personal and more generalized stigma by being on Medicaid. They described society’s views of Medicaid recipients as “moochers” and “welfare queens”, and yet they described their own experience with Medicaid as being a “lifeline” and “there in a time of need.” In fact, several participants described how they did not pursue or accept additional resources available to them, such as WIC, because of the stigma associated with it as well as the “humiliation” they would encounter if they went to the office to enroll. This has important implications for social service and public safety net program delivery because if the programs and services that are designed to benefit eligible members of society are not perceived by them as worthwhile, or are not accessible to potential recipients either from a practical, day-to-day perspective or from a more philosophical and lifestyle perspective, then the funding sources for these programs may choose to reallocate funds or at the least rate the programs as ineffective. The tools of social marketing seem as though they could be aptly
applied in these situations in order to not only promote the programs among eligible recipients but also to engage the eligible recipients to gain a better understanding of how the programs or their delivery could be more effective.

Another emergent finding was that while the women benefited financially from Medicaid assistance during their pregnancy, the vast majority would have pursued a home birth regardless of whether they had the financial support from Medicaid. The mother who reported that she would have given birth at home unattended because she otherwise would not have been able to afford a home birth appears to be the only woman in this sample that might have sought home birth for financial reasons. Except for the two participants in this sample that “stumbled” on to their home birth midwives because they were the only real option available on Medicaid, the women primarily knew they wanted a home birth and used Medicaid merely as a payment vehicle. However, while they say they would have “found a way to pay for it” may or may not have come true if Medicaid was not in place, particularly because Medicaid allayed their fears regarding the cost of a potential transfer to a hospital birth.

Some of the midwives felt that some clients sought home birth because of its relative low-cost, but several midwives also discussed that home birth is such a “leap of faith” that women will not pursue it solely for financial reasons. In fact, some midwives discussed that they were uncomfortable providing care to women who sought home birth primarily for financial reasons. Home birth, then, is a philosophical choice that women seem to arrive at based either on previous poor experiences with hospital birth or based on their desire to give birth naturally. Their perception that the hospital is neither a natural environment nor one where their desires for a natural birth will be respected plays significantly into their home birth choice. This is particularly true for women who seek to have a vaginal birth after a cesarean at home.

Despite the fact that women primarily spoke to the fact that they would have pursued home birth regardless of their Medicaid status, for a few women, it was their Medicaid status that took them on the path to home birth. Perhaps the most significant finding to emerge from
this study came from the stories of the women who experienced significant delays with their Medicaid enrollment. Particularly for the respondents who were in their late second or even third trimester of pregnancy when they finally had pregnancy Medicaid coverage, the only providers they could find that would either see them prior to their Medicaid being fully active or once it became active that late in gestation were the home birth midwives. This delay of care has significant implications for the Medicaid population related to identification and treatment of potential pregnancy complications as well as provision of counseling regarding healthy pregnancy lifestyle choices. The concept of “presumptive eligibility” does not seem to be happening in real time in Florida.

Furthermore, the fact that only one respondent had Medicaid prior to pregnancy, while the rest had to apply to Medicaid once they became pregnant, contributed to the delays in getting care from Medicaid providers and speaks to the large portion of adults in this country who are uninsured or underinsured. In addition, only the respondent already on Medicaid prior to pregnancy was able to remain on Medicaid afterwards, with half of the respondents having no insurance coverage once their Medicaid expired and two others having only Medicaid “share-of-cost” and one only the Medicaid “family planning waiver” (as described in Table 1.5, a form of Medicaid that only covers contraceptive services and products) and hence not comprehensive health insurance coverage. These stories give voice to the “cycling on and off” phenomenon and certainly remind us how much more reform is needed to ensure continuous health insurance coverage throughout the reproductive cycle. Of course, the fact that Florida chose not to expand its Medicaid program under the Affordable Care Act means this status quo of uninsured women of reproductive age will continue. As one participant said, “this is where life starts, do we want it to start out wrong?” This is the message that policy makers in the Florida Legislature need to hear when voting solely along ideological lines about issues that directly impact their citizens and the offspring.
Most respondents felt that the Medicaid coverage they received during their pregnancies was the “best insurance they had ever had.” Several wondered why “everyone can’t have insurance this good.” This will remain as a rhetorical question, and until an answer is given, the United States will likely continue to have some of the highest rates of infant and maternal mortality and morbidity among developed nations (MacDorman and Mathews 2008; World Health Organization 2010).

Of course, if everyone had access to “insurance this good” there would likely either not be enough providers to go around, or Medicaid would need to significantly increase its reimbursement rates to entice more providers to accept it. As of August 2014, HMOs are the new standard for the entire Florida Medicaid system, and this will likely lead to fewer providers accepting Medicaid, including home birth midwives. Among the most vulnerable populations who likely need the most time-intensive and compassionate care that is of the type provided by home birth midwives, the switch to HMOs will no doubt decrease access not only to home birth care but to quality care for pregnancy Medicaid recipients.

Is, then, Florida really a “model” state when it comes to the legislation regarding home birth midwifery and insurance reimbursement for out-of-hospital birth?

Critical Medical Anthropology and Medicaid-Funded Home Birth in Florida

Theories provide causal frameworks and can situate research within larger constructs that contextualize the phenomenon of interest. In this research, a Critical Medical Anthropology (CMA) approach has been used to demonstrate structural and politico-economic forces that contribute to understanding why, for instance, processes such as “cycling” on and off Medicaid exist, or how physician organizations seek to control the practice of non-physicians. CMA helped provide a framework for understanding the structural barriers that exist to care access, particularly by explaining power differentials that exist between physicians and patients, and between home birth midwives and the overall medical system.
One of the key concepts that emerged from the perspectives of both the midwives and the women was that home birth offered a way for women to protect themselves from the iatrogenic risks associated with hospital birth. Women described how they had felt treated as children and told what to do during their prior hospital births, and therefore home birth represented a way for them to exert autonomy over their own health choices during a very intimate and private family experience. Far from valuing medical authority over their own intuition, women chose to express their autonomy and complete home births. While in Florida, access to planned home birth with Licensed Midwives is allowed and to an extent promoted from within the Department of Health’s MomCare program, completing home birth still required a “leap of faith” among these women, particularly related to societal perceptions of home birth, that likely went far beyond any structural support granted to them under Florida Medicaid. The fact that Florida is one of only ten states that does reimburse for home birth with Certified Professional Midwives within its Medicaid program serves as an example of the power differentials that impact access to care among women in the 40 other states as well as the territories and the District of Columbia. In fact, this disparate and largely lacking coverage can be viewed as a form of structural violence.

Structural violence is said to occur when systems themselves contribute to harm or disadvantage (Farmer 2004; Mukherjee, et al. 2011). For instance, the fact that a woman in Alabama or Georgia might travel across state lines into Florida to have an out-of-hospital birth with a CPM places her at potential risk for negative financial, health, or even legal consequences. Alternatively, a woman from Florida might risk miscarriage if her enrollment on Medicaid is delayed beyond the therapeutic window for effective progesterone supplementation. The Medicaid application process which places a burden on pregnant women to transmit supporting documentation at their own expense and without the ability to track its receipt contributes to eligible women being denied coverage; the same is true to an extent for midwives applying to become Medicaid providers. The lack of adequate referral and/or transfer systems
places both the pregnant/laboring woman and her midwife at risk during a home to a hospital transfer (Cheyney, et al. 2014c). This “trouble with transport” (Davis-Floyd 2004) can lead to a lack of culpability for a “bad outcome”, and the powerful health authorities that placate home birth when it occurs within an “integrated system” essentially pay lip service knowing full well that such a system does not exist and therefore when they condone planned home birth it is couched in the reality that a “seamless, integrated system” of care does not exist. Despite these specific examples, structural violence can be thought of as being invisible in the sense that no tangible restriction can be documented. Perhaps in relation to home birth, particularly among Medicaid recipients, it is invisible, considering the fact that about 99% of U.S. births still occur in hospitals, and that in contrast to the one-half of hospital births that are Medicaid-funded, only one-third of home births in Florida are funded by Medicaid. Furthermore, with such low numbers, out of an average of 850 planned home births a year, only 285 are Medicaid-funded, and compared to over 200,000 hospital births per year, indeed, it is easy for the structural violence to become hidden. Some of the midwives interviewed described how their very low numbers, particularly in comparison to physicians or to hospital births, often pushed their issues with Medicaid to the back burner, despite the fact that Medicaid did help to pay the monthly bills. As one midwife described, she finally had enough of it and stopped accepting Medicaid.

Indeed, few State Medicaid Directors are fighting for a woman’s right to access home birth, particularly with CPMs, despite the likely cost savings Medicaid programs could reap. Only one federal House bill (H.R. 1076, formerly H.R. 1054) has proposed increasing access to CPM care among Medicaid recipients at the national level. Indeed, until 2008 when celebrity television host Rikki Lake highlighted the medicalization of birth and the economic incentives that treat birth in a routinized, industrial manner, with babies becoming the product of a system relegating women to a production line (and which one midwife labeled as a “McBirth”), widespread national attention did not focus on the power differentials that exist within our
“medical-industrial-complex” (Singer and Baer 1995) of hospital birth. After this documentary drew attention to this reality, however, the powerful organizations that set policies within medicine, particularly in obstetrics and pediatrics, reacted in a predictable fashion that from a CMA perspective would be described as “aimed at controlling production of health care specialists” when they produced statements that delegitimized the practice of non-nurse-midwives and non-physicians in pregnancy and labor care, knowing full well that the only viable providers of home births, Certified Professional Midwives, did not meet the requirements they set out.

As briefly described above, Critical Medical Anthropology can also be used to support the findings of this research in that one of the greatest problems women who had home births on Medicaid faced was the Medical enrollment process itself. This led many study participants to hold off on seeking prenatal care until their Medicaid was fully activated, although a few described the process by which their home birth midwives continued to provide care for them before the Medicaid had been activated, which few other providers would have done. This lack of access can be viewed as a “class struggle” in which low-income pregnant women who qualified for Medicaid were not able to access care that women without economic restrictions were able to pay for out-of-pocket or through their private insurance plans. Birth certificate analyses suggest that most women would have actually paid out-of-pocket for home birth, which might reflect the fact that some women were unable to complete the Medicaid application process. However, Medicaid was the second most likely payer, suggesting actually that while Florida has “strong” statutes that require all forms of insurance to provide coverage for home birth, as one of the respondents and one of the midwives described, the actual process of filing for “out-of-network” coverage, of getting “prior authorization” from the private insurers, or of meeting high-dollar deductibles and co-pays can be so cumbersome or costly that some women with private insurance choose instead to simply pay out-of-pocket. While this dissertation is focused on Medicaid-funded home birth, this private insurance blockage of coverage for what is
actually a state-mandate service gives another example of how the “powers that be” control access to care and in fact work to increase profits for the insurance companies as opposed to increase quality care for enrollees. With the shift to Medicaid HMOs that operate on a business model similar to private insurance, certainly this drive for profits will lead to increasing coverage denials and therefore decreased access to the state-mandated right to home birth among Medicaid recipients. This study therefore can act to provide “baseline” data regarding payer source for planned home birth, just prior to the implementation of the mandated Medicaid-HMO era.

In contrast, “traditional” Florida Medicaid has been a relatively straight-forward entity for home birth midwives to deal with, and while reimbursements are low, midwives have accepted Medicaid patients because of the ease of the system, the regular, steady payments, and also out of a sense of social justice. However, Medicaid HMOs will be operating in a way similar to private insurance companies with their main goal to maximize profits, not to foster improved health among their enrollees. Therefore, in this battle, it seems as though the powers that be may well be winning.

Therefore, as this research project comes to a close, Critical Medical Anthropology provides a framework to understand the systematic denial of access among both Florida Medicaid enrollees and even women with private insurance, and suggests that, even in a state long viewed as having “model” laws related to midwifery licensure and regulation as well as insurance mandates for midwifery coverage, structural violence related to the provision of home birth among Medicaid enrollees exists, and likely will only get worse with the arrival of mandated state-wide Medicaid HMOs.

**Study Limitations**

Most dissertations are limited by the availability of resources to conduct the research as well as the time frame that the completion of a dissertation allows, and this dissertation is no
exception to those factors. Specific to this study, however, a key limitation lies within the availability of secondary data sources from which to examine the research questions.

Birth certificates are one of the most commonly used data sources for birth-related research in the United States, but they have their own limitations. Key limitations to birth certificate data include their accuracy and the lag time between when the certificate is filed and when the data are available in aggregate form to researchers. Specific to this study, and to any home birth study, the fact that birth certificates do not present an “intent-to-treat” analysis related to birth site renders data recorded as home births to reflect only those “successful” home births; these data do not account for intended home births that ultimately transferred to the hospital. Therefore, birth certificates cannot be used to accurately estimate home birth incidence or to appropriately supply data related to outcomes from home births, especially considering that the home births that transferred to the hospital could likely have worse outcomes than successful home births, based on any number of clinical indications that may have warranted the transfer. Birth certificates also do not track the reasons for home birth transfers, or document how home birth transfers play out in real time, such as whether the transfers occurred for emergent indications, whether the length of time of transport impacted the ultimate birth outcomes, and other such parameters of interest.

With respect to using birth certificates to stratify a sample by payer source such as this dissertation did by Medicaid status, because birth certificates only indicate the primary payer source, they may miss some births where Medicaid was a secondary payer, or fail to capture births that had Medicaid pending status at time of delivery. Furthermore, birth certificate data may misclassify births as Medicaid when in fact the primary payer was a commercial insurer or self-pay. Additionally, the birth certificate only indicates the payer source at birth, so that if prenatal care was paid for out-of-pocket, or not accessed at all in the possible case of an undocumented woman, using Medicaid payer source only at birth could create a false representation of the overall population that relied on, or that may have benefited from,
Medicaid funding during the pregnancy. Birth certificates also do not discriminate between the types of Medicaid, so that a Medicaid HMO may have been inappropriately listed as a commercial insurer, a Medicaid share-of-cost recipient would still appear as a Medicaid recipient, and even a 'straight' Medicaid recipient is not necessarily delineated as having 'pregnancy only' Medicaid versus being enrolled in Medicaid prior to the pregnancy. This can impact when a pregnant woman can first access prenatal care, as the application process for pregnancy Medicaid can be laborious and take most of the pregnancy to secure, as documented by the experiences of this dissertation’s participants.

A possible workaround to some of these data issues would be to use Medicaid payment data instead, or to use a linked data set of Medicaid payments to birth certificates, in an attempt to track births that may have been intended home births but transferred to the hospital in labor. If the billing code for “labor support” was indicated as paid to a Licensed Midwife in the home setting, but the ultimate birth location was deemed as the hospital, these births could be coded as home birth transfers. Furthermore, linking both maternal and newborn Medicaid data, a more accurate picture of potential newborn outcome complications, such as seizures, could be more accurately captured, and a more reliable cost estimate of care in all settings can be made.

One of the original aims of this dissertation was to compare the data extracted from Florida birth certificates, which is a mandatory reporting system, to the data extracted from MANAStats, a voluntary data source compiled by out-of-hospital midwives across the United States and Canada. However, during preliminary, pre-dissertation data analysis, it became clear that the MANAStats data set represented less than ten percent of the home births recorded in Florida birth certificates. Therefore, it was felt that this additional data source lacked a true representation from which comparative statistics could be drawn. This was unfortunate, because MANAStats does represent an “intent-to-treat” analysis in that data collection begins for each pregnancy during prenatal care and women that transfer or are risked out of home birth prior to or during labor are appropriately tracked and coded. Additionally, MANAStats collects
several additional variables that are not present in the birth certificates, such as secondary payer source, specifics related to maternal and paternal employment, and items such as maternal herbal supplement use and dietary intake. While U.S. birth certificates do have fields to record the first and last date of prenatal visits that can then be used to calculate when prenatal care was initiated, calculated based on the date of birth, these fields are often missing or inaccurately reported. Therefore, unless the data collected become more robust, it is challenging to use birth certificates to evaluate the gestational age when care is begun, and impossible from birth certificates to determine when Medicaid enrollment occurs. It is theoretically possible to use Medicaid claims data to better understand women’s gestational age at Medicaid enrollment, but even this data will not likely capture the number of application attempts that were made. An examination from both such a quantitative perspective, as well as through a qualitative perspective, perhaps by interviewing women who have applied for Medicaid or shadowing several through the Medicaid application process, could likely provide valuable ethnographic data and information that policy makers and program directors could utilize to improve the application experience and most importantly attempt to decrease the application time and gestational age at enrollment. Of course, if a universal health system was in place in the United States, this would be irrelevant. Unfortunately, in this study, this issue regarding the timing of application, enrollment and gestational age were not fully appreciated until most data had been collected. In a future study, these would be key questions to ask in a demographic questionnaire as well as during qualitative interviews.

Additionally, the sample of midwives and mothers could have included a wider diversity of race/ethnicity, parity, age, and other demographics. They could have represented a wider geographic variation throughout Florida. HIPAA laws and other practical limitations such as obtaining a list of all Medicaid-funded births in Florida made it impossible to extract a random sample from within all women that had intended, Medicaid-funded home births. Therefore, results from this primarily exploratory research cannot be generalized. Additionally, while this
dissertation presented the perspectives of both women who had home births as well as midwives who provide home birth care, a comparison sample of women who choose to give birth in hospitals was not feasible within the time frame of this dissertation.

Furthermore, data and analysis streams could have contributed to a greater process of triangulation and to a “real-life contextual understanding, [from] multi-level perspectives, and cultural influences” (Tashakkori and Creswell 2007:4) of Medicaid-funded home birth. These could have included the voices of: obstetricians consulting to home birth midwives; pediatricians who provide follow up care for babies born at home; nurse-midwives who would like to provide home birth but face medico-legal obstacles; emergency room and labor and delivery staff who receive home birth transfers; health plan administrators and Medicaid staff; health department staff who administer MomCare programs; legislators at the state or federal levels who are responsible for amending laws to expand home birth coverage; Florida Council of Licensed Midwifery members; and certainly others. Therefore, proposed future research can include expanding the focus of data collection to the entities mentioned above, and undertaking cost-benefit analyses and/or cost-effectiveness analyses of the practice of home birth within the Medicaid funded population.

Recommendations for Future Research and Policy

Future research into this topic could be designed in such a way as to garner a more diverse sample in regards to race/ethnicity, age, parity, and insurance status. From this larger sample, comparison groups can more easily be obtained. Future research can focus on comparing the experiences of women who birth at home stratified by their payment source, or by women who have Medicaid insurance coverage stratified by their birth location, and can include not only planned home and hospital birth, but also birth center and if possible even intentional, unattended home births and unintentional, unplanned home births.

Due to the time lag between data reporting to Florida Vital Statistics and the availability of data to researchers, the quantitative techniques applied in this study could be reapplied to
more recent birth cohorts. Particularly because there has been increased interest in out-of-hospital birth since the 2008 release of *The Business of Being Born* examining data from 2011 and beyond can allow for tracking of trends after this important media highlight of home birth, as well as after the discouraging policy opinions of the American Medical Association, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics.

In addition, the impacts of the Affordable Care Act on health insurance coverage, particularly in the pre-conceptional period, warrant study. If the ACA helps women to secure coverage prior to pregnancy, issues related to accessing care when trying to enroll in coverage once already pregnant may disappear. However, it will be important to examine the impact that not expanding Medicaid coverage in Florida has on this population of low-income women who will therefore likely continue to “cycle on and off” Medicaid during pregnancy.

Tracking whether home birth midwives stop providing care to Medicaid clients, or if the percentage of planned home birth funded by Medicaid changes now that Florida has instituted a completely HMO-based system, will serve as potential ongoing research as well. This has implications not only for health care and health care access, but also carries an economic impact for the livelihoods of these small business owners. If women are willing to pay out-of-pocket for home birth, the midwives potentially can increase revenues since Medicaid reimburses them at about one-third of their normal rate anyway. But if women are not able to afford the care, then perhaps the midwives will either go out of practice or be forced to accept Medicaid HMOs after all. This bears watching.

The exploratory nature of this research has allowed several themes to emerge that could possibly be better explored through larger-scale quantitative surveying techniques. In addition to administering the Birth Satisfaction Scale-Revised among a larger sample of women who completed home birth and who received different insurance types, the scale can be administered to women across different birth settings to serve a comparative purpose.
Finally, a true cost-benefit analysis related to both home birth in general as well as Medicaid-funded home birth, either in Florida or from a more national perspective, would be an important undertaking. While Washington State has taken steps to understand if its Licensed Midwifery profession sustains itself in terms of the regulation required to maintain a robust licensure program (Health Management Associates 2007), and while cost-analyses of births by location and Medicaid status have occurred (Truven Analytics 2013), no study to date has truly estimated the costs and benefits associated with home birth in the United States, to include not only the savings of care provided out of the hospital, but the costs of transfers to the hospital and the costs of caring for any complications that could potentially arise specific to any birth setting. For instance, the increased costs of cesarean sections associated with hospital birth would be taken into account, or possible costs related to the ongoing care of a newborn that suffered a birth injury as a result of care out-of-hospital. Washington State, also considered a “model” state for legislation regarding home birth midwifery, does seem to be engaged in cost estimates related to birth location (Cawthon 2013), but much more could be done, particularly in Florida. In fact, for being considered such a “model” state, Florida seems to lag behind in terms of data collection or analysis and seems to have avoided any updates to its statutes since their 1995 and 1997 passage beyond simple “Rules Changes”, and has not made concerted efforts to collect or analyze data related to LM practice or Medicaid expenditures by birth site. Much could be done in this area.

Perhaps the most important recommendation for policy makers would be to undertake true health reforms that promote universal coverage and eliminate barriers to care, particularly as it relates to this study during pregnancy or the preconception period, for as one respondent put it, “This is where life starts. Do we want it to start out wrong?”

**Study Contributions**

Despite the study limitations described above, this study makes several important contributions to various audiences and within a variety of disciplines. First, as the participant’s
quote above laments, it is vital to start out life with the best chance for health. The implications of women’s positive experiences with care access and health delivery during pregnancy and birth can have significant impacts to the women’s own and their family’s future health seeking behaviors. Pregnancy is a known time for behavior change (Crozier, et al. 2009), and when women encounter stumbling blocks when trying to access care, they may hesitate to engage in the future. Whereas women who are highly satisfied with their care are more likely to continue to seek it out, and strive to maintain health.

A key contribution this study makes then, is to document how home birth midwives, specifically Certified Professional Midwives (CPM) who are regulated in Florida as Licensed Midwives, increase access to care among low-income women. By carrying through on their commitment to social justice, these midwives ensure that women otherwise rejected from the health system not only find access to care, but also become transformed and empowered through the care they receive. Although at least one midwife participant stated that midwives were more “in it for the care than for the reimbursements,” a key recommendation would be to ensure equitable reimbursements to CPMs for the care they provide, particularly among Medicaid clients who live on the social margins and at times require more in-depth care. These midwives also need to be recognized for the contributions they are making, rather than being ostracized by the medical authorities that fail to recognize or appreciate their contributions at all.

Another key finding lies in documenting the significant hassles that CPMs in Florida have with Medicaid HMOs, to the extent that several suggested they would stop taking Medicaid altogether if (and now when) the system converted to a solely HMO model. It would appear that this model of Medicaid managed care is here to stay, and therefore this study serves as an important historical record, documenting what might soon become a thing of the past and providing a baseline for comparison to the post-August 2014 era of Medicaid managed care in Florida.
To date, scant research has examined women’s experience in enrolling in pregnancy Medicaid or their experience as Medicaid enrollee’s during pregnancy, regardless of their ultimate choice of birth site. While Medicaid programs are State-administered and therefore these findings can truly only speak to the experience of women and the system in Florida. This study documents both the stigma that women feel related to being enrolled in Medicaid, but also the gratefulness they feel towards having insurance coverage that is relatively comprehensive and at no cost to them during a “time of need.” While midwives lamented that at times Medicaid clients can be “blasé” about their care, this might be a result of the concept of “moral hazard” (i.e., those that have health insurance will most utilize it) because women on pregnancy Medicaid have no co-pays or deductibles, and that may make them less invested in their care. However, while once enrolled the care is “free” this study documents the many costs (time, stress, and finances) that enrollment requires, costs that might ultimately prevent some women from enrolling, and therefore remaining without Medicaid coverage during pregnancy. While this study did not specifically examine rates of successful Medicaid enrollment, what became evident were the significant hassles associated with enrollment at a vulnerable time in women’s lives, pregnancy, a condition for which Medicaid mandates coverage, but does not support for the enrollment of women throughout their reproductive life cycle.

Combining the experiences of both midwives and pregnant women in this study also contributes a unique perspective on home birth, particularly at a time in U.S. history when an increasing number of women are choosing to give birth outside of the culturally accepted hospital. This study presents the voices of women who go against the authority of professional medical organizations (ACOG and AAP) that tout the superiority of care provided in hospitals and only by those providers they recognize (e.g., not CPMs). These women stood up to this authority and instead found a model of care where they would be considered the experts of their own bodies and where they felt safest to give birth, their own homes. This study therefore contributes to the few other primarily qualitative studies within the U.S. that document women’s
ultimate choice for home birth lies in their belief that birth is a normal and natural process that unfolds best when it is not monitored and timed by medical authorities.

However, this study also confirmed previous reports (Miller and Shriver 2012) that payment status most mediates a woman’s ultimate decision regarding her care and birth location. Because this study combines both qualitative and quantitative data analysis, it provides a window into the interaction between payment status and birthplace. Results from Florida birth certificate analysis demonstrate that even after controlling for multiple socio-demographic variables such as race/ethnicity, age, and parity, compared to women who gave birth in the hospital, women who birthed at home were ten-times more likely to be self-pay and four-times more likely to be on Medicaid than to be on private, commercial insurance. Therefore, this study contributes to an understanding, from a structural level, of how access to planned home birth can increase if this birth setting is more promoted through policies, particularly coverage through State Medicaid programs. The fact that self-pay is the most likely source after adjustment likely speaks to the fact that women are either unable to enroll in Medicaid (perhaps the application proves too challenging) or unwilling to pay a high deductible, especially with the advent of high-deductible health plans that have become even more popular after the implementation of the Affordable Care Act. Therefore, women who pay out-of-pocket for home birth are likely not choosing to be self-pay primarily as a cost-saving measure (despite its significantly lower costs), but rather are being structurally forced to pay out-of-pocket because it does actually cost less than their commercial insurance. Again, expanding coverage for home birth with CPMs among pregnancy Medicaid plans across the country would ease this financial burden and significantly increase access to home birth among low-income women. However, this also assumes that the Medicaid programs adequately reimburse home birth providers, a condition likely necessary in order to make it feasible for home birth providers to extend care to Medicaid recipients.
Finally, on the topic of home birth and midwifery care in general, this study contributed rich and contextualized findings that arise best from an anthropological perspective. While this study could have been examined from a purely epidemiological, public health, or even clinical perspective, and focused on factors associated with the outcome of planned home birth or the clinical factors that make it “safe” or “risky”, what would have been sorely missed would have been the emergent themes that arose from the qualitative data that most clearly said: women do face barriers to accessing care, particularly related to the Medicaid enrollment process, as well as significant stigma when choosing home birth and receiving health insurance coverage through Medicaid. However, they overcome these barriers because they believe that home is the safest place for them to give birth. Furthermore, midwives provide home birth care to Medicaid enrollee’s out of a sense of social justice, but they are not appropriately remunerated for their time and expertise and are misunderstood by the very agencies that are charged with supporting their practice in Florida. This anthropological perspective contributed to understanding home birth generally and Medicaid-funded home birth specifically from: the cultural lens of a somewhat deviant behavior and the ins and outs of how this behavior unfolds practically; the policy lens that views Florida as having supportive statutes for home birth but also politics that ultimately favor economic incentives (e.g., HMOs) above care provision; the power differentials between physicians and midwives that ultimately disempower CPMs and act as barriers to comprehensive care; and, to an extent, from the biological lens that demonstrates human’s unique “obligate midwifery” when it comes to the competing demands of the upright pelvis and the enlarged cranial capacity. Most notably, this study reveals real-time barriers (that incorporate cultural, political and economic factors) that interfere with midwifery clients’ access to comprehensive care, such as the need to rely on the emergency room to receive evaluation and management of conditions that CPMs are barred from providing directly, such as something as simple as prescribing an anti-biotic to treat a urinary tract infection. This documentation of the fragmentation of care and of the alienation of both home birth midwives and women
choosing home birth from the mainstream health system speaks to the need for a better integrated system wherein various health professionals are respectful of each other’s expertise.

In sum, taken from an anthropological lens, this study contributes to the cultural, political, economic, and to an extent biological understanding of how and why women seek to give birth at home, especially if their status is as members of the somewhat disenfranchised, low-income Medicaid population.

What therefore remains is to propose a framework for an improved maternal health system, where women are able to easily access the care they most desire, when and where that is appropriate for them, and where maternal health providers are able to practice to the full extent of their training. However, maternal care cannot exist in a vacuum. Similar to the call for an integrated system where out-of-hospital birth transfers are seamless if and when needed, the maternal health system should exist within a seamless, comprehensive care system where all people are able to attend to their health needs, both preventive and curative, throughout the lifespan. This would include the availability of primary and urgent care at all hours, or at least not only during the typical 8am to 5pm timeframe, and in convenient locations that also integrate childcare and transportation assistance. Inclusion of a cadre of health professionals who can make house calls would also be implemented for those who would require in-home care. A truly bio-psycho-social-spiritual approach would be taken wherein the basic care philosophy is one that recognizes the importance of integrating physical and emotional health, along with the understanding and recognition of humans as social creatures requiring caring relationships, even within health care encounters. In such a system, mutual trust and respect can be fostered so that health care becomes the shared responsibility of all participants, and the patients themselves are recognized as the experts of their own bodies. Rather than fragment into specialties, a robust primary care system would exist incorporating holistic family practice and truly promoting improved health.
Dissemination Plan

Applied anthropology aims to contribute to solutions for contemporary human problems in meaningful, practical ways. Therefore, the main goals of this dissertation’s dissemination plan are to inform policy makers, to provide Florida midwives with relevant data for their own lobbying and marketing efforts, and to inform the wider research and health practice communities regarding contemporary home birth practice and issues. Given that little research, quantitative or qualitative, of planned home birth in the United States, and in particular Florida, exists, this study and its potential routes of dissemination as described below, can help fill the void of information that is needed by clinicians, researchers and policy makers when acting on issues related to planned home birth and the practice of Certified Professional Midwives, as well as pregnancy Medicaid.

While it is not anticipated that members of the Florida Council of Licensed Midwifery would read this dissertation in its entirety, certainly the components that will be distributed and possibly published as listed below could serve as important tools to help educate the Council on the role of Licensed Midwives in Florida. Additionally, members of the U.S. Congress, particularly those from Florida, may find that the key findings from this dissertation, particularly that Certified Professional Midwives extend access to prenatal care when other providers do not, especially during the period of “presumptive eligibility”, could encourage them to support H.R. 1076 (formerly H.R. 1054), the Access to Certified Professional Midwives Act. Particularly because the articles cited on the website of the host organization promoting this bill, (the MAMA, Midwives and Mothers in Action, Campaign), are dated, this dissertation can help to provide this group with more current data, including the statistics derived from Florida birth certificates but more importantly the voices of the Medicaid recipients, and providers, themselves. Additionally, data from this dissertation can serve as a baseline from which to compare the inevitable changes in the Florida Medicaid program now that it is a solely HMO
model, and perhaps be used to compare how Medicaid-funded home birth in Florida existed under traditional Medicaid.

Finally, another important application of this study will be in the design of further data collection and analysis, particularly as it relates to planned home birth and Medicaid status. For instance, because the birth certificates do not include place of delivery planning status for all births, we cannot use birth certificates to examine out-of-hospital birth transfers, or for that matter, community hospital transfers to regional high-risk hospitals. Also, we cannot determine if payer status at time of birth is reflective of payer status for prenatal care, which could have important policy implications. Additionally, as much of this research has documented the struggles some women face in completing the Medicaid enrollment process, setting up future data sets to include questions related to timing of insurance enrollment can help to better understand whether “presumptive eligibility” is occurring in real time. Concerns regarding the truthful reporting of the actual delivery attendant were not specifically raised in this study, but in conducting the preliminary research into this topic, it is clear that getting a better understanding of “other” delivery attendants and “other midwives” can help ensure better data and clinical outcome tracking. Finally, this study represents an important contribution regarding analysis of out-of-hospital birth data analysis from birth certificates, and can be used as an initial foray into examining data quality among out-of-hospital birth certificates, or at the very least identifying the need for further evaluation of data quality among this population. Potential routes for disseminating these data are listed below.

Preliminary results from this study have been presented in poster and presentation formats at several conferences. In 2012, “Attending Births in Medicaid Homes” an oral presentation focused on the preliminary data from pilot interviews with home birth midwives, was delivered at the Society for Applied Anthropology annual meeting. Further analysis of the midwife interviews was presented in a research poster titled, “Midwife Perception and Experience of Attending Medicaid-Funded Home Births in Florida” at the American College of
Nurse-Midwives annual meeting in 2013. An oral presentation titled, “Florida Home Birth Trends: Your Data at Work” was delivered during the general session of the biennial meeting of the Midwives Association of Florida in 2013. This reported and compared data trends for planned home birth in Florida that were extracted from Florida birth certificates, the Florida open access data source Florida CHARTS (Florida Birth Query System 2011) and MANAStats. This presentation offered the researcher an opportunity to validate the findings among the group most responsible for the provision of planned home birth in Florida and to clarify certain aspects from the data, such as the consistently high quality data with few missing variables reported to Florida Vital Statistics from Licensed Midwives. These midwives described the process they go through in filing paper copies of birth certificates and how the birth registration clerks will contact them to clarify any missing data elements. In this way, the data reported on Florida Vital Statistics listing Licensed Midwives as the attendant likely carries a higher degree of accuracy, including for outcomes that may get underreported among the electronically filed birth certificates attributed to in-hospital physicians and midwives. This carries practical and research implications related to the use of vital statistics in comparing outcomes by birth site or birth attendant (Kirby and Demetrou 2013).

In 2014, results from the qualitative interviews with Medicaid recipients related to their beliefs about the societal perceptions of Medicaid and their realities as being Medicaid recipients were presented in a research poster titled, “Medicaid as a Lifeline: Perceptions and Realities of Florida Pregnancy Medicaid Recipients” at the Association for Maternal Child Health Programs annual meeting. Data extracted from interviews with both midwives and mothers related to their experience with this government assistance program (Medicaid) were presented in an oral session at the 2014 Society for Applied Anthropology annual meeting titled, “No Place Like Home: Government Intrusion and Home Birth Choice.” Finally a summary of the dissertation findings was presented in research poster format at the 2014 annual meeting of the

Further dissemination of study results is intended as well. Epidemiologic data from the birth certificate analysis will be drafted into a research article for submission to a clinical or public health journal. The poster regarding Medicaid recipients experience with pregnancy Medicaid and the stigma associated with being on Medicaid will be drafted into a research article to be submit to either a qualitative health, public policy, public health, or possibly maternal-child health journal. Other articles will be drafted as the opportunity arises.
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Appendix A: Interview Script - Midwife Respondents

A. Informed Consent/Procedures for Waiver of Documentation of Consent

B. Semi-structured interview questions:
1. Under what professional license are you providing home birth services?
2. How long have you been practicing in this profession?
3. How long have you been practicing in Florida?
4. Have you practiced in other states? If so, where?
5. Do you hold any additional health related licenses or degrees? If so, please describe.
6. Approximately how many home births do you attend each year?
7. How many of these are Medicaid-funded?
8. Do you attend births in any other locations? (freestanding birth centers, hospital, etc.)
9. How do Medicaid-funded women find out about their option to have a home birth?
10. How do you specifically advertise to or recruit Medicaid-funded clients?
11. Can you please describe the demographics of the Medicaid-funded women you have provided home birth care to in the past few years.
   - If not directly answered, ask about:
     age, ethnicity, relationship status, family structure, housing situation, employment status, etc.
12. What motivations for seeking home birth have these women discussed with you?
13. Have women mentioned any other reasons:
   - If not answered, ask: specific financial, health, philosophical or other reasons?
14. What characteristics distinguish Medicaid-funded home birthers?
15. Is there anything that is unique between them and other home birthers with different payment sources?
16. How about anything different between them and Medicaid-funded women who pursue hospital birth (if known)?
17. a. Do you have any criteria that exclude women from you providing them with home birth services?
    b. Are there any additional exclusion criteria specifically for Medicaid-funded women?
18. a. Describe the process you had to undertake to be a credentialed provider of home birth services in Florida, specifically to Medicaid-funded women.
   b. Alternatively, please detail the reasons you chose not to provide home birth services to Medicaid clients, or any difficulties you have had in providing this care to this population.
   c. Did you ever think about not applying for Medicaid credentials?
19. What difficulties have you encountered with the Medicaid system, as a provider of home birth services?
20. Compared to other payers (ie commercial insurance) or self-pay clients, what are the challenges of providing care to Medicaid-funded clients?
21. What are the rewards compared to other payers?
22. How have Florida health policies and statutes promoted or constrained the practice of home birth here?
23. How have they specifically promoted or constrained home birth among Medicaid-funded women?
24. Do you have any other observations or comments about Medicaid-funded home birth in Florida?
25. What do you think is the best way to reach out to women who have had a Medicaid-funded homebirth to see if they would be willing to participate in this study?

C. Thank you for your time and assistance in this study!
Appendix B: Interview Script - Maternal Respondents

Getting started: [Complete the Waiver of Documentation of Informed Consent process]
I’m interested in your experiences with giving birth at home. Home births are uncommon so I’d like to talk with you about your experiences and how you decided to have a home birth.

First of all, so I can know right away what types of experiences you have had with birth, can you tell me how many times you have given birth?

(If one: say, ok, and this is the birth we are going to talk about today)
(If more than one: can you tell me how many times you have given birth at home? If it is the total # of births, stop there;)
(If home births are < total # of births, ask: where else have you given birth?)

Great. Let’s get started. I am most interested in discussing your recent home birth that was covered by Medicaid, but please feel free to speak about whatever comes to mind when answering these questions.

First of all, what type of provider attended your home birth?

Pre-natal care (decisions and experiences) and Providers (how chosen, experience with)
When you first found out you were pregnant, what steps did you take to start prenatal care? Did you face any problems in being seen by any provider? If so, please describe. Did anything make it easy to see a health care provider? If so, please describe. How long did you have to wait to see the first provider? Did you go to more than one place to receive pre-natal care? How many home birth providers did you meet with / interview before choosing the one who cared for you in pregnancy and at your birth? Describe what you think are the most important characteristics of your provider. How could your provider have been better? What were the best parts about receiving prenatal care from a midwife who would be attending your birth at home?

Medicaid-specific questions
I’m really interested in how Medicaid influenced your decisions about prenatal care and where you would give birth.
Describe how you found out that you could receive your prenatal care from a midwife. Describe how you found out that home birth was an option for Medicaid clients. If not specifically mentioned: Did you receive any care, counseling or referrals from MomCare? Please describe this.

Were you already on Medicaid when you became pregnant?
   If no: Describe the process of applying for Medicaid.
   If yes: What steps did you have to take to continue coverage during pregnancy? Did you have to change the type of Medicaid coverage you had? If so, what was that process like?

What were the best parts of having Medicaid for your prenatal care and birth? What were the worst parts of having Medicaid for your prenatal care and birth? Were there any services that you were able to access because you had Medicaid that without it you wouldn’t have been able to access? If so, describe.
Were there any services that you desired but were unable to receive because of Medicaid? If so, which?
Did having Medicaid allow you to have a home birth that otherwise you wouldn’t have been able to have? Please describe.

**Home birth/hospital birth (decisions and experiences)**
At what point in your pregnancy did you decide you wanted to have a home birth?
What were the reasons you chose home birth?
Did you have any concerns about home birth? If so, please describe.
What made you decide against a hospital birth?
What concerns did you have about hospital birth?
What advantages do you think hospital birth offers?
What advantages does home birth offer?

**Reactions**
Besides you, who else was involved in your decision to have a home birth?
Did your family members or close friends have any reactions to your plans to give birth at home?
What have been the reactions of people you have told that you were planning a home birth?
How did you deal with people’s reactions to your decision to have a home birth?

**Birth experiences**
What were the best parts about giving birth at home?
What were the worst parts about giving birth at home?
Can you think about anything that was specific to you having Medicaid that made your home birth great? That made your home birth difficult?

To what extent did you feel you were supported while in labor?
To what extent did you feel in control at your birth?
Do you feel the birth went as planned?
Would you have a home birth again?
Would you plan to have a hospital birth in the future?

**Beliefs and Attitudes**
What do you think most people imagine when they hear the word, “midwife”?
What comes to mind for you?
What do you think most people imagine when they hear the word, “home birth”?
What comes to mind for you?
What do you think most people imagine when they hear the word, “Medicaid”?
What comes to mind for you?

**Summary**
Do you have any other comments or observations about your home birth?
What else do you think is important that I may not have asked already?

Thank you so much for your time, honesty and willingness to participate.

I will now ask you some demographic questions. Only answer what you feel comfortable sharing. [See Appendix C: Demographic Survey for Maternal Respondents]
Appendix C: Demographic Survey for Maternal Respondents

How old were you on the date of this delivery? __________

How many months old is your child now? __________

How many times have you been pregnant? __________

How many times have you given birth in the past at: (Please write the number at each type)
Home: _______ Birth Center: _______ Hospital: _______ Other: _______

Did you plan on becoming pregnant with this pregnancy? __________ (Yes/no/not sure)

What type of insurance did you have before you got pregnant? __________________________________________________________________________

If you had Medicaid before the pregnancy, did you have to change the type of Medicaid you had while you were pregnant? (Check one)
Yes _______ No _______ Don’t Know _______ Not Applicable _______
If yes: what other type(s) did you have? __________________________________________________________________________

What type of Medicaid coverage did you have for this pregnancy? (Check all that apply)
Pregnancy-only Medicaid _______ Medicaid HMO _______ Share of cost Medicaid _______
“Full Medicaid” (i.e., on Medicaid before pregnancy) _______ Other: _______

How far along were you in your pregnancy when your Medicaid was fully activated? _______

During your pregnancy, did you have to change the type of Medicaid you had? (Check one)
Yes _______ No _______ Don’t Know _______

Did you have any other insurance in this pregnancy or at delivery? If so, what kind: _______

Do you have insurance now? If so, what type? __________________________________________________________________________

What type of insurance did your child enroll in after the birth? __________________________________________________________________________

Did you receive any care, counseling or referrals from MomCare? _______ (Yes/no)
If yes, which? __________________________________________________________________________

Did you work during this pregnancy? _______ (Yes/no)
If yes, please describe the type of work you did and average # of hours per week _______

What do you consider to be your race and ethnicity? ____________________________

What is your highest level of education completed (circle choice):
8th grade or less Some high school High School Diploma GED
Bachelor’s Masters Degree Doctoral Degree

What was your marital status at the time of this birth? ____________________________
Appendix D: The Birth Satisfaction Scale - Revised Format

This brief survey will complete our interview. Thank you very much for taking part in this study. Your contribution is greatly appreciated.

Instructions:
Please read each statement carefully and once you understand what is being asked, respond fairly quickly. Do not ponder too long over each statement. For each statement, circle one of the following, adding any additional comments below each item if desired.

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Please note that this scale was not developed specifically for home birth, but is being used with its original language for validity purposes. When completing the survey, please consider “delivery room staff” and “staff” to be your “midwife” or “midwife and her assistant(s)”. Also the “delivery room” can be interpreted as your home in this case. Please complete all 10 items and be as honest as possible.

Please answer the following question and respond to the following statements:

Where did you have your baby (i.e., home, birth center, hospital, etc.)? ________________

(1) I came through childbirth virtually unscathed.

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Comments ____________________________________________________
___________________________________________________________

(2) I thought my labour was excessively long.

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Comments ____________________________________________________
___________________________________________________________

(3) The delivery room staff encouraged me to make decisions about how I wanted my birth to progress.

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Comments ____________________________________________________
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(4) I felt very anxious during my labour and birth.

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(5) I felt well supported by staff during my labour and birth.

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(6) The staff communicated well with me during labour.

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<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

(7) I found giving birth a distressing experience.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

(8) I felt out of control during my birth experience.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

(9) I was not distressed at all during labour.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

(10) The delivery room was clean and hygienic.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E: USF IRB Exemption Certification

January 3, 2012

Nicole Demetriou, MSN, ARNP, CNM, FNP
Anthropology Dept. SOC 107

RE: Exempt Certification for IRB#: Pro00006725 Title: Secondary Data Analysis to describe the Medicaid funded home birth population in Florida

Dear Ms. Demetriou:

On 1/3/2012, the Institutional Review Board (IRB) determined that your research meets USF requirements and Federal Exemption criteria as outlined in the federal regulations at 45CFR46.101(b):

(4) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

As the principal investigator for this study, it is your responsibility to ensure that this research is conducted as outlined in your application and consistent with the ethical principles outlined in the Belmont Report and with USF IRB policies and procedures. Please note that changes to this protocol may disqualify it from exempt status. Please note that you are responsible for notifying the IRB prior to implementing any changes to the currently approved protocol.

The Institutional Review Board will maintain your exemption application for a period of five years from the date of this letter or for three years after a Final Progress Report is received, whichever is longer. If you wish to continue this protocol beyond five years, you will need to submit a new application. Should you complete this study prior to the end of the five-year period, you must submit a request to close the study.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

E. Verena Jorgensen, M.D., Chairperson USF Institutional Review Board

\[V_{jorgensen}\; MD\]
# Appendix F: Florida Department of Health IRB Exemption Certification

## Florida Department of Health Human Subject Research Determination Worksheet

<table>
<thead>
<tr>
<th>Name of person requesting consultation:</th>
<th>Nicole Demetriou</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of project:</td>
<td>Medicaid-Funded Home Birth in Florida: Secondary Data Analysis of Birth Certificates</td>
</tr>
</tbody>
</table>

**KEY:**
- Solid box: All items in the box must be true
- Dotted box: One item in the box must be true

### Determination

- DOH is not engaged in this research (See part 6)
- DHHS-regulated research
- Research not involving human subjects (DHHS)
- Non-research: Public health practice
- Non-research Quality improvement
- FDA-regulated research

Completed by the Human Research Protection Administrator designated in the FWA within 5 business days of submission of a request for consultation; the person completing the form shall not have any involvement in the research

### Part I: DHHS research

- DHHS-regulated research involving human subjects as defined in DHHS regulations (both are true)

- Research as Defined by DHHS (45 CFR 46.102(d): A systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge

Project involves:
- an investigation (inquiry, examination, or search for facts, usually involving the formulation or testing of a hypothesis); and
- is systematic (conducted according to a plan, organized method, or procedure for testing or formulating a question or hypothesis and interpreting results); and
- is designed (planned, purposed, or conducted to apply to phenomena outside the observed data) to contribute to generalizable knowledge (observations, findings, information, or results that have been demonstrated with enough confidence and significance to confirm or alter the consensus within the professional norms of a community or discipline) or develop such knowledge

- Human subject as defined by DHHS (45 CFR 46.102(f): the project involves one or more living individuals about whom an investigator (whether professional or student) conducting research obtains

Both are true
- Investigator obtains data about living individuals through intervention or interaction or private and identifiable data
- data about living individuals through intervention (physical procedures or manipulations of individuals or their environment) or interaction (communication or interpersonal contact) with individuals
- OR
- data about living individuals that is private AND identifiable (the data are about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, or use of data provided for specific purposes in which the individuals can reasonably expect that it will NOT be made public (e.g., medical record)

AND
- The investigator is able to “readily ascertain” the identities of individual participants in research with the
DHHS research (45 CFR 46.102(d)) does not involve human subjects (45 CFR 46.102(f))
Insufficient information to determine; return for additional information

Part 2: FDA-regulated research

☐ Research as defined by FDA (21 CFR 102(c)) applies if any of the following are true:
- The activity will involve the use of a drug in one or more persons that is NOT the use of an approved drug in the course of medical practice (21 CFR 312.3(b))
- The activity will evaluate the safety or effectiveness of a device in one or more persons (21 CFR 812.2(a))
- Data regarding subjects or control subjects will be submitted to or held for inspection by FDA as part of an application for a research or marketing permit (21 CFR 50.3(c), 21 CFR 56.102(c))
- Data regarding the use of a device on human specimens will be submitted to or held for inspection by FDA as part of an application for a research or marketing permit.

Insufficient information to determine; return for additional information

Part 3: Non-research: public health practice

☐ Public health practice: the project
- Is designed to improve the health of a population; it is not designed in whole or in part, to contribute to generalizable knowledge;
- Involves specific legal authorization for conducting the activity under state public health law;
- The Department is required in the project to:
  - Identify, assess, and control the presence and spread of communicable diseases (381.001(2) F.S.)
  - Detect and investigate food-borne disease, waterborne disease, and other diseases of environmental causation where the Department under statutory authority conducts epidemiological investigations and ongoing surveillance (381.006(2) and (10))
  - Investigate the sanitary condition of any city, town, or place in the state (386.02)
  - Collect data and conduct analyses and studies related to health care needs of the community for purposes of advising county health departments and the state health department regarding local and state health planning (408.033 F.S.)
  - Conduct epidemiological investigations, surveillance, programmatic evaluations, and clinical care for the population (381.0032)
  - Includes a corresponding governmental duty to perform the activity to protect the public’s health;
  - Involves direct performance or oversight by a governmental public health authority (or its authorized partner) and accountability to the public for its performance;
  - May legitimately involve persons who did not specifically volunteer to participate (i.e., they did not provide informed consent); and
  - Supported by principles of public health ethics that focus on populations while respecting the dignity
and rights of individuals.
☐ Is not FDA-regulated
☐ Insufficient information to determine; return for additional information


Part 4: Non-research: quality improvement

☐ Quality improvement: data-guided activities designed to bring about immediate, positive changes in the delivery of health care or organizational effectiveness in particular settings. The project:

☐ is designed for the purpose of continuously improving ongoing care and management of the system for delivering clinical care, including but not limited to activities that (at least one is true):

☐ implement and monitor a practice to improve the quality of patient care
☐ collects patient or provider data regarding the implementation of the practice for clinical, practical, or administrative purposes
☐ measures and reports provider performance data for clinical, practical, or administrative uses

See OHRP Quality Improvement Activities Frequently Asked Questions

☐ is an integral ongoing part of standard program operations (organization may require participation and the use of a specific quality framework, such as Kaizen, Six Sigma, PDCA, TQM, etc)
☐ helps the organization track activities in terms of existing quality improvement frameworks or national best practices or benchmarks (e.g., Tobacco program activities are required in Florida statute to implement national best practices, including quality improvement monitoring)
☐ is funded as integral part of ongoing operations (e.g., through established ongoing programmatic commitment to continuous quality improvement)
☐ is the responsibility of institutional leadership who supervise quality initiatives; may involve a quality improvement committee or other ongoing organizational structure
☐ is consistent with principles of biomedical and organizational ethics that supports organization efforts to provide

high quality care aligned with ongoing systematic collection and measurement of quality data to improve individual patient care (e.g., transparency about the process, proportionality and use of the least intrusive monitoring, and fairness in the application of the results of monitoring)
☐ Is not FDA-regulated
☐ Insufficient information to determine; return for additional information

Part 5: Other Determinations

☐ The project meets the Florida Department of Health’s ethical standards (e.g., acceptable risk-benefit relationship, equitable selection, informed consent where appropriate, protections of privacy interests of participants and the confidentiality of their data (under state law) where appropriate, transparency about the process, proportionality, and where applicable community involvement in quality improvement efforts (e.g.,
through the PACE format, or other standard Department frameworks for incorporating community attitudes and information

### Part 6: Engagement in Research

- [ ] DOH is engaged in research (when any of the following are true):
  - [ ] The research is sponsored (funded) in whole or in part from federal research appropriations to DOH, even where all activities involving human subjects research are carried out by agents or employees of another institution ("pass-through funding");
  - [ ] The research is conducted by or under the direction of any employee or agent of DOH in connection with his or her official responsibilities;
  - [ ] The research is conducted using any property or facility of the DOH;
  - [ ] The research involves DOH clients;
  - [ ] The research involves the use of non-public information maintained by the DOH when released outside DOH, except as otherwise required by law.
  - [ ] The research is conducted in accordance with an Assurance filed with the Office of Human Research Protections (OHRP) in which the DOH IRB is designated as the IRB of record through an established Memorandum of Understanding.

- [ ] Insufficient information to determine; return for additional information

### Comments

The investigator is not able to readily ascertain the identity of the participants with the data that is being provided from the Office of Vital Statistics.

<table>
<thead>
<tr>
<th>Donna West</th>
<th>3/21/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed</td>
<td>Dated</td>
</tr>
</tbody>
</table>
Appendix G: Florida Vital Statistics Data Use Agreement

Vital Records Data Use Agreement

Date: 12/20/2011

I. Project Director Information

Name: Nicole Demetriou, MSN, ARNP, CNM, FNP

Title: Graduate Student

Organization/Agency: University of South Florida College of Public Health and College of Arts and Sciences

Mailing Address: 4722 E Poinsettia Ave, Tampa, FL 33617

Telephone Number: 615-210-8461

Fax Number: 813-905-9998

E-Mail Address: ndemetri@health.usf.edu

Does this application update a previous Data Use Agreement?

☐ Yes ☑ No

II. Project Summary

Project title: Demographics and outcomes of planned home births among Florida Medicaid-recipients, 2005-2010

Purpose of the project:
The aim of this study is to utilize existing data sources to better understand and describe the population of Medicaid-funded women in Florida who seek home birth services, and to examine differences between them and women of other payment sources and other delivery sites. Acting as a follow up to recent qualitative interviews with Licensed Midwives in Florida, this study will look for more statistical level observations, mainly associations noted between dependent variables (women who completed Medicaid-funded home births vs. non-Medicaid funded women and non-home birthers) and independent variables (i.e. demographics, maternal health status, outcome measures, and care seeking behaviors).

Intended uses of the data:
The data will be used to examine these associations in order to both inform future dissertation research of the investigator related to Medicaid-funded home birth in Florida as well as to make potential policy and practice recommendations for prenatal and delivery care within the State of Florida.

Are you the primary data custodian at this site? [The primary custodian is the person to whom data are given and who is responsible for ensuring adherence to the DOH data confidentiality and security policies.]

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☐ Yes  □ No

If no, please indicate the name of the primary custodian.

n/a

Is the requested data needed for work being performed under contract with the DOH?

☐ Yes  ☒ No

If yes, then please provide the DOH contract manager’s name.

N/A
III. Data Requested and Specifications

<table>
<thead>
<tr>
<th>Data Requested</th>
<th>Data Specifications</th>
<th>Data Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Birth</td>
<td>☑ Years (Specify) 2005-2010</td>
<td>☑ Photocopies</td>
</tr>
<tr>
<td>☑ Fetal Death</td>
<td>☑ Statewide Data</td>
<td>☑ Electronic Transfer (Secure FTP)</td>
</tr>
<tr>
<td>☑ Death with cause-of-death</td>
<td>☑ County Only (Specify)</td>
<td></td>
</tr>
<tr>
<td>☑ Death without cause-of-death</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☑ Marriage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☑ Dissolution of Marriage</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IV. Linkage

Describe any linkage of requested vital statistics data with any other data sources. Please specify which variables will be kept in the linked file.

none/not applicable

V. Security

Describe where data will be stored and how they will be accessed by authorized users.

Data authorization and access control mechanisms will begin with identification and authentication. A Windows authentication (user name and password) will be used to access the University of South Florida (USF) network domain (HSCNET) which resides behind the USF HEALTH firewall. Subsequently, data will reside on a USF HEALTH server, which will have its access restricted to members of the research team. No confidential vital statistics information will be transferred, in any way, once the data have been received and are placed on the targeted USF HEALTH server behind the USF HEALTH firewall.

VI. Data Destruction Schedule

Consistent with Florida law, applicants must make provisions for the destruction of records at the conclusion of their project, or when the data is no longer required. Maintaining the privacy of the individuals whose personal information is included in vital records is essential to preserving the integrity of the data sharing process.

Please detail the manner and timeline for destruction. If you are following a data destruction policy set by your organization or agency, please attach that policy to your application.

All confidential data will be destroyed upon completion of the project. All original data files received from the Bureau of Vital Statistics, as well as modified data sets, and any merged files used to create analytic data sets that possess any personal identifiers or otherwise confidential data will be destroyed within 2 years of the project end date, by May 31, 2014. All data stored on computers, including shared network servers and individual computers, will be erased using a 7-pass overwriting and deleting method based on "National Industrial Security Program Operating Manual", NISPOM (also known as US DoD 5220.22-M), of United States Department of Defense from January 1995 (chapter 8, section 3, 8-360. Maintenance). All media containing data will then be shredded and discarded.

VII. Data Use by Others

Will any sub-contractors affiliated with this project use the data during the course of the project? If yes, please identify the individuals and describe the work they will perform. Each sub-contractor or other individual will need to complete a separate Data Use Agreement.

n/a
VIII. Fees

Prior to generating the data, the Department will provide an estimate of the costs incurred in its preparation. Once the request is approved and payment received, the data will be provided. A waiver or reduction of the fees authorized by section 382.0255(1), F.S. will be considered only if the intended use of the data will have a direct health-related benefit to Florida citizens. If a waiver or reduction of the fees is requested, describe how use of the data is a direct benefit to Florida citizens.

A waiver of fees is requested because this study aims to describe the population of women in Florida who seek home birth services in order to inform research questions for future research related to Medicaid-funded home birth in Florida. Home birth services represent a significant savings over traditional obstetrical care services, and with Medicaid as payment source for nearly 50% of Florida births, this can represent significant cost savings to this state-administered program. Future dissertation work of the Investigator will specifically examine Medicaid funding of home birth services in order to make policy recommendations for more cost-effective strategies to the provision of prenatal and intrapartum care. Furthermore, the Investigator is a student at a publicly funded Florida university and does not have access to any funding to conduct this study.
IX. Contact with Human Subjects

No contacts of any kind can be made with any person named on a certificate or data file without the permission of the Bureau of Vital Statistics and review by the DOH Institutional Review Board (IRB). Data Use Agreement may be rejected if the research protocol involves intrusive follow-back of research subjects. If the project requires DOH IRB review, applicants must first submit signed and notarized Data Use Agreement along with the protocol for review to Bureau of Vital Statistics.

Will the project involve direct contact with individuals or establishments mentioned on the record? If so, describe the need for such activity and the types of individuals or establishments who will be contacted.

This is an analysis of an existing administrative dataset. No contact of eligible subjects will be performed and data will only be analyzed in aggregate form without the possibility for identification of any study subject.

X. All Staff Accessing the Information

List name, title, affiliation and role in project for each staff person

Nicole Demetriou, MSN, CNM, FNP, Investigator
University of South Florida Student in the College of Public Health (MPH) and College of Arts and Sciences (PhD)
For the proposed project, Ms. Demetriou completes study design and implementation and conducts data analysis and interpretation of study findings.

Russell Kirby, PhD, Professor, Advisor
For the proposed project, Dr. Kirby assists with study design, implementation, analysis and interpretation of study findings.

XI. Use and Consent of the Data

Vital records data may only be used for the specific purpose(s) described in this agreement. All persons with data access must maintain the confidentiality of the data and prevent release to unauthorized parties. All publications, tabular presentations, maps or depictions of cartographic information must aggregate results to protect the identity of individuals and comply with applicable state and federal laws. The Department shall be notified immediately by phone after discovery of any use or disclosure of the data not provided for by this agreement.

Any failure by the applicant to abide by the terms of this agreement constitutes a breach and may result in the department obtaining any contract remedy authorized by law including, but not limited to, specific performance and cancellation or rescission of the agreement. This will require that the applicant return all data obtained hereunder and the destruction under the supervision of the department of all copies of the data in the applicant’s possession, as well as in the possession of any of the applicant’s employees, agents, assigns or subcontractors. In any action brought by the department under this agreement in which the department prevails, the department shall be entitled to its attorney’s fees and court costs.

As the signatory on the Data Use Agreement, the primary data custodian bears full responsibility for adhering to all DOH data confidentiality and security policies. The primary data custodian serves as the point of contact for receiving, maintaining, protecting, and ultimately destroying the data provided by DOH. Data may be used by the primary custodian only for the purpose stated in the data use agreement and may not be used for any other purpose without direct approval from the Bureau of Vital Statistics.
No entity with data access may link vital records data with any other source of information without the written authorization of the Bureau of Vital Statistics.

*** All persons who come in direct contact with vital statistics data are required to sign this agreement. If additional signatures are required, please provide them on the last page of this agreement.
Project Director's or Primary Custodian's Name (Please Print):
Nicole K. Demetriou

Project Director's or Primary Custodian's Signature (Notarization Required):

Attest (If applicant is a corporation):
(As Corporate Secretary)

Subscribed and sworn before me Cnm Kimbal this 20th day of
December 2011.
Notary Public, State of Florida Cnm Kimbal (Affix Notary Stamp)

FOR OFFICE USE ONLY

Fees Waived: Yes [x] No [ ] Fees Reduced: Yes [ ] No [ ]

DOH IRB Recommendation: Yes [ ] No [ ]

Florida Department of Health Reviewer:

[Signature]

Florida Department of Health Authorization:

[Signature]

C. Made Grigg, State Registrar, Florida Vital Statistics and Director, Office of Health Statistics and Assessment

Date

This agreement shall expire one year from the date above. If the agreement is not renewed, all vital records data must be handled in accordance with the data disposal plan.
Vital Records Data Use Agreement

Signatures below, by individuals who will access vital records data, acknowledge agreement to the terms of this Data Use Agreement.

Name: Nicole Demetriou
(Please Print)
Signature:

Name: Russell Kirby
(Please Print)
Signature:

Name: 
(Please Print)
Signature:

Name: 
(Please Print)
Signature:

Name: 
(Please Print)
Signature:

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<table>
<thead>
<tr>
<th>Variable Name Per Vital Statistics</th>
<th>Basic Description</th>
<th>Used in Present Study?</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVENT_YEAR</td>
<td>Year birth occurred</td>
<td>Yes(^{45})</td>
</tr>
<tr>
<td>MOTHER_RES_COUNTY_CODE</td>
<td>Mom’s county of residence</td>
<td>No</td>
</tr>
<tr>
<td>MOTHER_RES_STATE_CODE</td>
<td>Mom’s state of residence</td>
<td>Yes(^{46})</td>
</tr>
<tr>
<td>MOTHER_RES_COUNTRY_CODE</td>
<td>Mom’s country of residence</td>
<td>No</td>
</tr>
<tr>
<td>MOTHER_BIRTH_COUNTRY_CODE</td>
<td>Mom’s birth country</td>
<td>Yes-Recoded</td>
</tr>
<tr>
<td>MOTHER_AGE</td>
<td>Mom’s age at birth</td>
<td>Yes-Recoded</td>
</tr>
<tr>
<td>MOTHER_BIRTH_STATE_CODE</td>
<td>State where mother was born</td>
<td>No</td>
</tr>
<tr>
<td>MOTHER_EDCODE</td>
<td>Mother’s education level</td>
<td>Yes-Recoded</td>
</tr>
<tr>
<td>MOTHER_MARRIED</td>
<td>Mother’s marital status at birth</td>
<td>Yes</td>
</tr>
<tr>
<td>FATHER_AGE</td>
<td>Father’s age at birth</td>
<td>No</td>
</tr>
<tr>
<td>FATHER_BIRTH_STATE_CODE</td>
<td>State where father was born</td>
<td>No</td>
</tr>
<tr>
<td>FATHER_EDCODE</td>
<td>Father’s education level</td>
<td>No</td>
</tr>
<tr>
<td>HOME_BIRTH_PLANNED</td>
<td>If a home birth, was it planned</td>
<td>Yes</td>
</tr>
<tr>
<td>FACILITY_TYPE_CODE</td>
<td>Birth location (hospital, etc.)</td>
<td>Yes</td>
</tr>
<tr>
<td>CHDCountyofBirth</td>
<td>County birth occurred in by code</td>
<td>No</td>
</tr>
<tr>
<td>BSTATE</td>
<td>State birth occurred in</td>
<td>Yes(^{47})</td>
</tr>
<tr>
<td>BCOUNTY_CODE</td>
<td>County birth occurred in by code</td>
<td>No</td>
</tr>
<tr>
<td>SEX</td>
<td>Baby: male or female</td>
<td>No</td>
</tr>
<tr>
<td>DATE_OF_BIRTH_MONTH</td>
<td>Birth month</td>
<td>No</td>
</tr>
<tr>
<td>DATE_OF_BIRTH_YEAR</td>
<td>Birth year</td>
<td>No</td>
</tr>
<tr>
<td>TIME_OF_BIRTH</td>
<td>Birth time</td>
<td>No</td>
</tr>
<tr>
<td>TIME_OF_BIRTH_UNIT</td>
<td>12 or 24 hour clock</td>
<td>No</td>
</tr>
<tr>
<td>BIRTH_WEIGHT_UNITS</td>
<td>Whether birth recorded in lb or gm</td>
<td>Yes</td>
</tr>
<tr>
<td>BIRTH_WEIGHT_GRAMS</td>
<td>Birth weight in grams</td>
<td>Yes-Recoded</td>
</tr>
<tr>
<td>BIRTH_WEIGHT_LBS</td>
<td>Birth weight in pounds</td>
<td>No</td>
</tr>
<tr>
<td>BIRTH_WEIGHT_OZ</td>
<td>BW in ounces (used with lbs)</td>
<td>No</td>
</tr>
<tr>
<td>GESTATION_WEEKS(^{48})</td>
<td>Estimated clinical gestational age</td>
<td>Yes-Recoded</td>
</tr>
<tr>
<td>PLURALITY_CODE</td>
<td>Singleton or higher order birth</td>
<td>Yes(^{49})</td>
</tr>
<tr>
<td>TRANS_INFANT</td>
<td>Did infant transfer after birth</td>
<td>Yes</td>
</tr>
<tr>
<td>MOTHER_WIC_YESNO</td>
<td>Was mother on WIC</td>
<td>Yes</td>
</tr>
<tr>
<td>WeightGain</td>
<td>Calculated variable of maternal weight gain</td>
<td>No</td>
</tr>
</tbody>
</table>

\(^{45}\) Some variables were used to elicit basic demographic data but not ultimately included in the model, either due to lack of clinical significance or if they proved not to hold statistical significance.

\(^{46}\) This variable was utilized to exclude from the analysis any birth to a mother who was not a Florida resident, as she would not likely have been eligible for Florida Medicaid, other than perhaps the emergency Medicaid for the birth only.

\(^{47}\) This variable was utilized to exclude from the analysis any birth to a mother who was not a Florida resident, as she would not likely have been eligible for Florida Medicaid, other than perhaps the emergency Medicaid for the birth only.

\(^{48}\) This variable represents the clinical estimate of gestation as reported by the delivery attendant, not the calculated gestational age which utilizes two variables, the Last Menstrual Period and the Date of Birth to calculate a gestational age.

\(^{49}\) This variable was utilized to exclude non-singleton pregnancies from the final analysis.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>FATHER_RES_SAME_MOTHER</td>
<td>Did mother/father live together</td>
<td>No</td>
</tr>
<tr>
<td>PRINCIPAL_SRCPAY_CODE</td>
<td>Payer source by code</td>
<td>Yes-Recoded</td>
</tr>
<tr>
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<td>Infant alive at time of certificate</td>
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<td>Is infant breastfeeding</td>
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<td>MR_DIAB</td>
<td>Mother: diabetic</td>
<td>Yes 51</td>
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<td>MR_DIAB_GEST</td>
<td>Mother: gestational diabetic</td>
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<td>MR_HYPERT_CHRONIC</td>
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<td>MR_HYPERT_PREG</td>
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<td>CLD_PREMATURE_ROM</td>
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<td>Successful cephalic version</td>
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<td>OB_TOCOLYSIS</td>
<td>Labor tocolysis</td>
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</table>

50 This variable provides free-text descriptions, mostly used in the “Other” pay code category, which was not analyzed within this study, as “Other” comprised 2.7% of the total.

51 The MR_ variables describe maternal medical conditions, and were used mostly to check that the women who had planned home births met risk criteria outlined within Florida Statutes.
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<th>CHARSET</th>
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<td>Labor induced</td>
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<td>CHAR_AUGMENT</td>
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<td>CHAR_NON_VERTEX</td>
<td>Non-vertex fetal presentation</td>
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<td>CHAR_STEROID</td>
<td>Antenatal steroids used</td>
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<td>Antibiotics given</td>
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<td>CHAR_MECONIUM</td>
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<td>CHAR_FETAL_INTOLEANCE</td>
<td>Fetal intolerance of labor</td>
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<td>MD_VAGINAL_FORCEPS</td>
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<td>Did mom get blood transfusion</td>
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<td>MM_PERINEAL_LACERAT</td>
<td>Did mom have perineal laceration</td>
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<td>MM_RUPTURED_UTERUS</td>
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<td>MM_HYSTERECTOMY</td>
<td>Did mom require a hysterectomy</td>
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<td>MM_ICU</td>
<td>Did mom go to ICU</td>
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<td>MM_OR_PROC</td>
<td>Maternal operative procedure</td>
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<td>Fetus received surfactant</td>
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<td>TOBACCO_USE_YESNO</td>
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<td>BIRPRESENT_CODE</td>
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<td># of previous live births living</td>
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<td>APGAR_5</td>
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<td>APGAR_10</td>
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</table>

52 Incorporating the Live_Birhts_Dead variable into the recoded “Parity” variable proved challenging, and given that 98.6% of the original sample had no previous Live_Births_Dead the decision was made to recode the party variable based only on previous Live_Births_Living.

53 The Kotelchuck Index variable was missing data for 12% of the records and therefore a decision was made not to utilize this variable in the analysis given its poor quality.
10/14/2011

Nicole Demetriou
Anthropology
SOC 107

RE: Expedited Approval for Initial Review IRB#: Pro00005677

Title: Medicaid-Funded Home Birth in Florida: An Exploratory Study Among Home Birth Providers

Dear Ms. Demetriou:

On 10/14/2011 the Institutional Review Board (IRB) reviewed and APPROVED the above referenced protocol. Please note that your approval for this study will expire on 10/14/2012.

Approved Items:

Protocol Document(s):

Research Proposal 0.02 Consent/Assent Documents:

Waiver of informed consent documentation granted.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.116 (d) which states that an IRB may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent, or waive the requirements to obtain informed consent provided the IRB finds
and documents that (1) the research involves no more than minimal risk to the subjects; (2) the waiver or alteration will not adversely affect the rights and welfare of the subjects; (3) the research could not practicably be carried out without the waiver or alteration; and (4) whenever appropriate, the subjects will be provided with additional pertinent information after participation.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

John A. Schinka, Ph.D., Chairperson USF Institutional Review Board

Cc: Christina Calandro USF IRB Professional Staff
Appendix J: Waiver of Documentation of Informed Consent - Midwife Respondents

Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. This form tells you about this research study. We are asking you to take part in a research study that is called: **A Mixed-Methods Analysis of Medicaid-Funded Home Birth in Florida.**

The person who is in charge of this research study is **Nicole Demetriou.** This person is called the Principal Investigator (PI). However, other research staff may be involved and can act on behalf of the person in charge.

The research will be done at a location that is agreeable to you. This could be at your clinical office, at the home or office of the researcher, over the telephone, or at some other location that is convenient for you.

**Purpose of the study**

- The purpose of this study is to better understand and describe the population of Medicaid-funded women in Florida who seek home birth services.
- This study is being conducted as part of a course assignment in ANG 6766: Research Methods in Applied Anthropology, in the Fall 2011 semester. Results from this study might also be used to further inform the research questions for the Principal Investigator’s PhD dissertation.

**Study Procedures**

If you take part in this study, you will be asked to:

1. Be interviewed by the PI on one occasion, after an informed consent document is shared either on paper or read aloud and verbal agreement to participate is completed.
2. The interview will last approximately 30-60 minutes, after the informed consent process.
3. The research will be conducted at a time that is convenient to you, and can take place over the telephone or in person either at your clinical office or the PI’s home office. The PI may contact you by telephone or email after the interview for clarification if needed during interview analysis.
4. Audio-taping is planned of this interview, pending your agreement. Audio recordings will be downloaded onto a password protected laptop owned by the PI and the original recording destroyed once the transfer has occurred. Audio recordings will then be transcribed by the PI without any identifying information linking the interviewee. Once the transcription is completed, the computer back-up audio file will also be destroyed via
deleting the item from computer memory. If you do not wish to have the interview audio-taped, the PI will be typing notes into a laptop Microsoft Word file during the interview.

**Alternatives**
You have the alternative to choose not to participate in this research study.

**Benefits**
We are unsure if you will receive any benefits by taking part in this research study.

**Risks or Discomfort**
This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.

**Compensation**
We will not pay you for the time you volunteer while being in this study.

**Conflict of Interest Statement**
No conflicts of interest exist.

**Confidentiality**
We must keep your study records as confidential as possible. Your recorded and transcribed interview will be identified only as “Interview 1”, “Interview 2”, etc. Audio recordings will not include your name and will be deleted from the digital audio recorder once they have been transferred to a password-protected computer owned by the PI. Once the interview is transcribed, again only using “Interview 1” etc. as identification, the compute audio file will be deleted from the computer’s memory. Only these de-identified transcripts would be shared with faculty members of the PI; otherwise, the transcripts will be used solely by the PI.

However, certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator and faculty involved in her training.
- Certain university personnel who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety. These include the University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Other individuals who work for USF that provide other kinds of oversight may also need to look at your records.
- Any agency of the federal, state or local government that regulates this research. This includes the Department of Health and Human Services (DHHS) and the Office for Human Research Protection (OHRP).

**Publications**
We may publish what we learn from this study. If we do, we will not let anyone know your
name. We will not publish anything else that would let people know who you are.

Voluntary Participation / Withdrawal
You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study to please the investigator or the research staff. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

Questions, concerns, or complaints
If you have any questions, concerns or complaints about this study, call Nicole Demetriou at 615-210-8461 or contact her by email at ndemetri@health.usf.edu

If you have questions about your rights as a participant in this study, general questions, or have complaints, concerns or issues you want to discuss with someone outside the research, call the Division of Research Integrity and Compliance of the University of South Florida at (813) 974-5638.

If you experience an unanticipated problem related to the research call Nicole Demetriou at 615-210-8461 or contact her by email at ndemetri@health.usf.edu

Consent to Take Part in this Research Study
It is up to you to decide whether you want to take part in this study. Please understand that by proceeding with this interview you are agreeing to take part in this research.

Statement of Person Obtaining Informed Consent
I have carefully explained to the person taking part in the study what he or she can expect.

I hereby certify that when this person begins this interview, to the best of my knowledge, he or she understands:

• What the study is about.
• What procedures/interventions/investigational drugs or devices will be used.
• What the potential benefits might be.
• What the known risks might be.

Signature of Person Obtaining Verbal Informed Consent Date

Printed Name of Person Obtaining Verbal Informed Consent
Appendix K: USF IRB Approval of Dissertation Research

2/18/2013

Nicole Demetriou
Anthropology SOC 107

RE: Expedited Approval for Amendment IRB#: Ame1_Pro00005677 Title: A Mixed-Methods Analysis of Medicaid-Funded Home Birth in Florida

Dear Ms. Demetriou:

On 2/16/2013 the Institutional Review Board (IRB) reviewed and APPROVED your Amendment. The submitted request has been approved for the following:

1. Change in title from "Florida: An Exploratory Study Among Home Birth Providers" to "A Mixed-Methods Analysis of Medicaid-Funded Home Birth in Florida"

2. Change in short title from "Florida Medicaid Homebirth Providers" to "Medicaid-Funded Home Birth in Florida"

3. Change in procedures/instruments: (A) The study is now being conducted for purposes of the PI's dissertation (B) The study is being expanded to include qualitative interviews with both midwives and women who have given birth at home, as well as secondary data analysis of Florida vital records. (C) Addition of Expedited category 5 for the new record review component (D) New midwives and moms interview scripts

4. Change in inclusion/exclusion criteria to include the new cohort of subjects (women who have had a Medicaid-funded home birth in the past year).

5. New anticipated end date of 12/31/14

6. Change in consent forms: New Moms-HomeBirth and FLMedicaid-Providers consent forms, v1 dated 2/13/13

7. Revised protocol (PI's dissertation proposal replaced previous protocol)

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.
Sincerely,

[Signature]

John Schinka, Ph.D., Chair USF Institutional Review Board
Appendix L: Recruitment Flyer

Have you had a home birth in Florida while on Medicaid? A USF student researcher is interested in understanding how Medicaid helped or hindered your access to and experience with home birth. Please contact me if:

- You are between 18-45
- You had a home birth in Florida in the past year
- You were on Medicaid at the time of delivery

Participants will receive a $25 Publix gift card!

Contact:
Nikki Demetriou
ndemetri@health.usf.edu

(615) 210-8461
Appendix M: Waiver of Documentation of Informed Consent - Maternal Respondents

Informed Consent to Participate in Research
Information to Consider Before Taking Part in this Research Study
IRB Study # Pro 5677

Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. This form tells you about this research study.

We are asking you to take part in a research study that is called:
A Mixed-Methods Analysis of Medicaid-funded Home Birth in Florida.

The person who is in charge of this research study is Nicole Demetriou. This person is called the Principal Investigator (PI). However, other research staff may be involved and can act on behalf of the person in charge.

The research will be done at a location that is agreeable to you. This could be at your home, the office of your midwife, over the telephone, or at some other location that is convenient for you.

Purpose of the study

• The purpose of this study is to better understand and describe the population of Medicaid-funded women in Florida who seek home birth services. In addition, the study will examine and document the experience of and satisfaction with prenatal and birth care among Medicaid-funded women in Florida who chose home birth, and investigate how Medicaid fosters or hinders access to home birth.

• This study is being conducted towards the fulfillment of the PI’s Master of Public Health and Doctor of Philosophy in Applied Anthropology at USF.

Study Procedures

If you take part in this study, you will be asked to:

5. Be interviewed by the PI on one occasion, after an informed consent process is completed. If this interview will occur via telephone, the written informed consent document will be mailed to the participant, but the content shared with them via telephone prior to the interview.

6. The interview will last approximately 30-60 minutes, after the informed consent process.

7. The research will be conducted at a time that is convenient to you, and can take place in a convenient location for you, including your home, your midwife’s office, via the telephone or some other location. It is unlikely, but the PI may contact you by telephone or email after the interview for clarification if needed during interview analysis.

8. Audio-taping is planned of this interview, pending your agreement. Audio recordings will be downloaded onto a password protected laptop owned by the PI and the original recording destroyed once the transfer has occurred. Audio recordings will then be transcribed by the PI without any identifying information linking the interviewee. Once
the transcription is completed, the computer back-up audio file will also be destroyed via deleting the item from computer memory. If you do not wish to have the interview audio-taped, the PI will be typing notes into a laptop Microsoft Word file during the interview.

Alternatives
You have the alternative to choose not to participate in this research study, with no known risk of non-participation.

Benefits
We are unsure if you will receive any benefits by taking part in this research study. This research might contribute to policy recommendations that could increase access to home birth for more Floridian and U.S. women.

Risks or Discomfort
This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.

Compensation
At the conclusion of the interview, you will receive one $25 gift card to the grocery chain Publix in recognition of the time you are taking to voluntarily participate in this study. If this interview is done over the phone, you will receive the card via U.S. mail.

Conflict of Interest Statement
No conflicts of interest exist.

Confidentiality
We must keep your study records as confidential as possible. Your recorded and transcribed interview will be identified only as “Interview 1”, “Interview 2”, etc. Audio recordings will not include your name and will be deleted from the digital audio recorder once they have been transferred to a password-protected computer owned by the PI. Once the interview is transcribed, again only using “Interview 1” etc. as identification, the computer audio file will be deleted from the computer’s memory. Only these de-identified transcripts would be shared with faculty members of the PI; otherwise, the transcripts will be used solely by the PI.

However, certain people may need to see the study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator and faculty involved in her training.

- Certain university personnel who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety. These include the University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Other individuals who work for USF that provide other kinds of oversight (including in the financial management of the compensation gift cards) may also need to look at your records.
• Any agency of the federal, state or local government that regulates this research. This includes the Department of Health and Human Services (DHHS) and the Office for Human Research Protection (OHRP).

Publications
We may publish what we learn from this study. If we do, we will not let anyone know your name. We will not publish anything else that would let people know who you are.

Voluntary Participation / Withdrawal
You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study to please the investigator, the research staff, or anyone else such as any health care providers that cared for you during your pregnancy. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

Questions, concerns, or complaints
If you have any questions, concerns or complaints about this study, call Nicole Demetriou at 615-210-8461 or contact her by email at ndemetri@health.usf.edu

If you have questions about your rights as a participant in this study, general questions, or have complaints, concerns or issues you want to discuss with someone outside the research, call the Division of Research Integrity and Compliance of the University of South Florida at (813) 974-5638.

If you experience an unanticipated problem related to the research call Nicole Demetriou at 615-210-8461 or contact her by email at ndemetri@health.usf.edu

Consent to Take Part in this Research Study
It is up to you to decide whether you want to take part in this study. Please understand that by proceeding with this interview you are agreeing to take part in this research.

Statement of Person Obtaining Informed Consent
I have carefully explained to the person taking part in the study what he or she can expect.

I hereby certify that when this person begins this interview, to the best of my knowledge, he or she understands:
• What the study is about.
• What procedures/interventions/investigational drugs or devices will be used.
• What the potential benefits might be.
• What the known risks might be.

Signature of Person Obtaining Verbal Informed Consent     Date

Printed Name of Person Obtaining Verbal Informed Consent
Appendix N: Approval to Utilize Birth Satisfaction Scale

Dear Nicole,

I would be delighted for you to use the birth satisfaction scale. I have attached both versions. The BSS-LF (long form) and the BSS-R (revised post validation).

The scores are on both of them and should be removed from the copy the participant keeps. The information sheet at the front will require adaptation for your purpose. The validation paper justifying the shortened version is at a journal just now and hopefully should be published soon.

One validity paper for the long form is published and attached. Also the development paper.

Once you have entered all the data into the spreadsheets, perhaps we could write a validity paper for the Florida women. This would help to add to the body of knowledge on the scale. I am happy to organise the stats.

Thank you for your interest.

Best CJ

Prof Caroline J Hollins Martin
PhD MPhil BSc ADM PGCE RMT RM RGN MBPsS
Professor in Midwifery
Mary Seacole (Room 2.78)
School of Nursing, Midwifery and Social Work
College of Health and Social Care
University of Salford
Frederick Road
Salford
Greater Manchester
M6 6PU
Email: C.J.Hollins-Martin@salford.ac.uk
-----Original Message-----
From: Demetriou, Nicole [mailto:ndemetri@health.usf.edu]
Sent: 01 April 2013 02:41
To: caroline.hollinsmartin@gcal.ac.uk; Hollins-Martin Caroline Joy
Subject: Birth Satisfaction Scale

Hello, Dr. Hollins Martin,

Greetings from the other side of the pond.
I am a midwife in the U.S. working on a doctorate examining publicly-funded home birth in the state of Florida.
I am hoping to begin interviewing women shortly and wanted to include some measure to help compare across women's experiences.

I have been searching for an appropriate scale to administer, and I wanted to find out how to obtain permission to utilize the "Birth Satisfaction Scale."

I do believe the scale is still undergoing validity testing, and that your concurrent analysis identified three key factors (being in control, being supported and the birth going as planned), but I find the scale to be the most accurate measure of satisfaction I have seen thus far, particularly if considering different delivery sites (ie home, birth center, hospital). I applaud your work in helping to develop a measure - indeed, this is long in the making and tough work!

Please let me know if it might be possible for me to use the Birth Satisfaction Scale in my interviews, and if so, if there is a "scoring" system that has been developed.

Thanks so much in advance for any help you can provide.

Sincerely,

Nikki Demetriou, MSN, CNM, FNP
PhD/MPH Candidate, Applied Anthropology and Global Health
University of South Florida
ndemetri@health.usf.edu
Mobile: 615-210-8461

"Speak tenderly to them. Let there be kindness in your face, in your eyes, in your smile, in the warmth of your greeting. Always have a cheerful smile. Don't only give
Appendix O: Approval to Report BSS-R Results

RE: Results from Birth Satisfaction Scale-Revised among Home Birthers in Florida
Hollins-Martin Caroline Joy [C.J.Hollins-Martin@salford.ac.uk]

You replied on 7/21/2014 3:04 PM.

Sent: Monday, July 21, 2014 10:44 AM
To: Demetriou, Nicole

Hello, Nicole,

I would be delighted for you to present this data in your dissertation. One your dissertation is finished, I would love to read it. We could then maybe look at adapting it into a publication with your name first. I could take a look and see what we could do to get it into shape. A nice publication under your belt.

Looking forward

Best CJ

Prof Caroline J Hollins Martin
PhD MPhil BSc ADM PGCE PGCC RMT RM RGN MBPsS
Professor in Midwifery
Mary Seacole (Room 2.78)
School of Nursing, Midwifery, Social Work & Social Sciences
College of Health and Social Care
University of Salford
Frederick Road
Salford
Greater Manchester
M6 6PU
Email: C.J.Hollins-Martin@salford.ac.uk
Telephone: 0161 2952 522
SEEK PROFILE: http://www.seek.salford.ac.uk/profiles/CHollinsMartin.jsp
BLOG: http://carolinejoyhollinsmartin.blogspot.co.uk/

-----Original Message-----
From: Demetriou, Nicole [mailto:ndemetri@health.usf.edu]
Sent: 17 July 2014 21:46
To: Hollins-Martin Caroline Joy
Subject: Results from Birth Satisfaction Scale-Revised among Home Birthers in Florida

Good day, Dr. Hollins-Martin,

I apologize for my lengthy delay in reporting results from my dissertation research which included the use of the 10-item Birth Satisfaction Scale-Revised.

I conducted qualitative interviews over the telephone with thirteen women in Florida who had a planned home birth within the past year attended by a midwife and while receiving Medicaid as insurance source. Medicaid is a federal-state program in the U.S. that insures nearly 50% of births, and is provided to women who meet certain low-income criteria. Each state determines its own eligibility. In any case, home births in the State of Florida represent about 0.5% of all births, and while Medicaid pays for ~49% of all Florida births, it pays for ~33% of (planned) home births. Florida is one of only 9/50 states that allow Medicaid to reimburse home birth midwives for home births. The overall aims of this exploratory study (which also included interviews with home birth midwives and analysis of birth certificates) were to assess how Medicaid increased or decreased access to home birth, and to better understand the experiences of these women who had experienced home birth.

I have attached the file that compiles the results from the BSS-Rs. Since I conducted telephone interviews, I mailed the survey to 12 participants (1st participant was interviewed before I had IRB approval for the BSS-R) along with stamped return envelopes addressed to the PI. I received 9 surveys back (75% response rate). I've also attached the blank survey that I sent to the women - you will see that I added a brief instruction set at the start because these births were all home births.

I would like your permission to include both of the attached files (the BSS-R adapted for this study and the compiled results) as appendices in my dissertation. Once approved, dissertations are generally viewable online in PDF format to those with access to ProQuest or ScholarCommons type services.

I look forward to hearing from you.

Thank you in advance for considering, and thank you sincerely for your work in developing this scale.

Sincerely,

Nikki Demetriou, MSN, CNM, FNP
Appendix P: Recoding Steps for Final Race/Ethnicity Variable

1. **Recoded** mothers_calculated_race and fathers_calculated_race variables into fewer categories:
   - White Non-Hispanic – 01 kept as 1 - WNH
   - Black Non-Hispanic – 02 kept as 2 - BNH
   - Asian/Pacific Islander – recoded Chinese (04), Japanese (05), Hawaiian (06), Filipino (07), Korean (08), Vietnamese (10), Asian Indian (11), Asian Other (12), Guam (13), Samoan (14), Other Pacific Islander (15), all into new race category 5 - Asian/Pacific Islander
   - Hispanic (09) became race category 3 - Hispanic (see below where Hispanic ethnicity was used to pull out the Haitians from Hispanics)
   - Created race category 4 - Haitian from within the Hispanic variable
   - Created 99 – Other/Unknown/Mixed from Race not (01-15) or already listed as (20) and (99)

2. Created dichotomized Hispanic / Haitian Variable to separate the Haitians from Hispanics (Hisp_Haitian and Father_Hisp_Haitian)
   Recoded Mother_CalculatedHisp and Father_CalculatedHisp so that if they were non-Hispanic (00), they remained non-Hispanic (0), if they were Mexican (01), Puerto Rican (02), Cuban (03), or Other Hispanic (05) they were categorized into Hispanic (1), and if they were Haitian (06) they remained as (06).

3. Created the MotherFinalRace variable by combining the Mother_CalculatedRace and Mother_Hisp_Haitian (the same was done for fathers, FatherFinalRace). That is, for any Mother_Hisp_Haitian that was 1 (Hispanic) they became Race Category 3 - Hispanic (regardless of Black or White). If they were 6 for Mother_Hispanic_Haitian, they became Race Category 4 - Haitian. All other categories for race remained the same. So, if they were White-Hispanic, they simply became Hispanic, same for Black-Hispanic.

**FinalRace Categories:**
1 – White Non-Hispanic
2 – Black Non-Hispanic
3 – Hispanic
4 – Haitian
5 – Asian/Pacific Islander
99 – Other/Unknown/Mixed Race

**SPSS Syntax:**
compute FathersFinalRace = Father_CalculatedRace.
if (Father_Hisp_Haitian = 1) FathersFinalRace = 16.
if (Father_Hisp_Haitian = 6) FathersFinalRace = 17.
if (Father_Hisp_Haitian = 99) FathersFinalRace = 99.
execute.

compute MothersFinalRace = Mother_CalculatedRace.
if (Hisp_Haitian = 1) MothersFinalRace = 16.
if (Hisp_Haitian = 6) MothersFinalRace = 17.
if (Hisp_Haitian = 99) MothersFinalRace = 99.
execute.
Then, frequencies were ran on these variables to verify no record was being 'double counted'.

4. **Created ChildCalculatedRace** variable to match the categories above, with any mismatch between parents creating “Mixed” which is under 99:Mixed/Other/Unknown

Below is the syntax for all the iterations when combining MothersFinalRace and FathersFinalRace in order to create ChildCalculatedRace.

**SPSS Syntax:**
```spss
compute ChildCalculatedRace=$sysmis.
if (MothersFinalRace=1 & FathersFinalRace=1) ChildCalculatedRace=1.
if (MothersFinalRace=1 & FathersFinalRace=2) ChildCalculatedRace=99.
if (MothersFinalRace=1 & FathersFinalRace=3) ChildCalculatedRace=99.
if (MothersFinalRace=1 & FathersFinalRace=4) ChildCalculatedRace=99.
if (MothersFinalRace=1 & FathersFinalRace=5) ChildCalculatedRace=99.
if (MothersFinalRace=2 & FathersFinalRace=1) ChildCalculatedRace=99.
if (MothersFinalRace=2 & FathersFinalRace=2) ChildCalculatedRace=2.
if (MothersFinalRace=2 & FathersFinalRace=3) ChildCalculatedRace=99.
if (MothersFinalRace=2 & FathersFinalRace=4) ChildCalculatedRace=99.
if (MothersFinalRace=2 & FathersFinalRace=5) ChildCalculatedRace=99.
if (MothersFinalRace=3 & FathersFinalRace=1) ChildCalculatedRace=99.
if (MothersFinalRace=3 & FathersFinalRace=2) ChildCalculatedRace=99.
if (MothersFinalRace=3 & FathersFinalRace=3) ChildCalculatedRace=3.
if (MothersFinalRace=3 & FathersFinalRace=4) ChildCalculatedRace=99.
if (MothersFinalRace=3 & FathersFinalRace=5) ChildCalculatedRace=99.
if (MothersFinalRace=4 & FathersFinalRace=1) ChildCalculatedRace=99.
if (MothersFinalRace=4 & FathersFinalRace=2) ChildCalculatedRace=99.
if (MothersFinalRace=4 & FathersFinalRace=3) ChildCalculatedRace=99.
if (MothersFinalRace=4 & FathersFinalRace=4) ChildCalculatedRace=4.
if (MothersFinalRace=4 & FathersFinalRace=5) ChildCalculatedRace=99.
if (MothersFinalRace=5 & FathersFinalRace=1) ChildCalculatedRace=99.
if (MothersFinalRace=5 & FathersFinalRace=2) ChildCalculatedRace=99.
if (MothersFinalRace=5 & FathersFinalRace=3) ChildCalculatedRace=99.
if (MothersFinalRace=5 & FathersFinalRace=4) ChildCalculatedRace=99.
if (MothersFinalRace=5 & FathersFinalRace=5) ChildCalculatedRace=5.
If (MothersFinalRace=99 & FathersFinalRace =1) ChildCalculatedRace=99.
If (MothersFinalRace=99 & FathersFinalRace =2) ChildCalculatedRace=99.
If (MothersFinalRace=99 & FathersFinalRace =3) ChildCalculatedRace=99.
If (MothersFinalRace=99 & FathersFinalRace =4) ChildCalculatedRace=99.
If (MothersFinalRace=99 & FathersFinalRace =5) ChildCalculatedRace=99.
```

if (MothersFinalRace=2 & FathersFinalRace=1) ChildCalculatedRace=99.
if (MothersFinalRace=3 & FathersFinalRace=1) ChildCalculatedRace=99.
if (MothersFinalRace=4 & FathersFinalRace=1) ChildCalculatedRace=99.
if (MothersFinalRace=5 & FathersFinalRace=1) ChildCalculatedRace=99.
if (MothersFinalRace=2 & FathersFinalRace=1) ChildCalculatedRace=99.
if (MothersFinalRace=3 & FathersFinalRace=1) ChildCalculatedRace=99.
if (MothersFinalRace=4 & FathersFinalRace=1) ChildCalculatedRace=99.
if (MothersFinalRace=5 & FathersFinalRace=1) ChildCalculatedRace=99.
if (MothersFinalRace=1 & FathersFinalRace=2) ChildCalculatedRace=99.
if (MothersFinalRace=3 & FathersFinalRace=2) ChildCalculatedRace=99.
if (MothersFinalRace=4 & FathersFinalRace=2) ChildCalculatedRace=99.
if (MothersFinalRace=5 & FathersFinalRace=2) ChildCalculatedRace=99.
if (MothersFinalRace=1 & FathersFinalRace=3) ChildCalculatedRace=99.
if (MothersFinalRace=2 & FathersFinalRace=3) ChildCalculatedRace=99.
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if (MothersFinalRace=3 & FathersFinalRace=4) ChildCalculatedRace=99.
if (MothersFinalRace=5 & FathersFinalRace=4) ChildCalculatedRace=99.
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if (MothersFinalRace=3 & FathersFinalRace=5) ChildCalculatedRace=99.
if (MothersFinalRace=4 & FathersFinalRace=5) ChildCalculatedRace=99.
if (MothersFinalRace=5 & FathersFinalRace=5) ChildCalculatedRace=99.

If (MothersFinalRace=99 & FathersFinalRace =1) ChildCalculatedRace=99.
If (MothersFinalRace=99 & FathersFinalRace =2) ChildCalculatedRace=99.
If (MothersFinalRace=99 & FathersFinalRace =3) ChildCalculatedRace=99.
If (MothersFinalRace=99 & FathersFinalRace =4) ChildCalculatedRace=99.
If (MothersFinalRace=99 & FathersFinalRace =5) ChildCalculatedRace=99.

If (MothersFinalRace=1 & FathersFinalRace =99) ChildCalculatedRace=99.
If (MothersFinalRace=2 & FathersFinalRace =99) ChildCalculatedRace=99.
If (MothersFinalRace=3 & FathersFinalRace =99) ChildCalculatedRace=99.
If (MothersFinalRace=4 & FathersFinalRace =99) ChildCalculatedRace=99.
If (MothersFinalRace=5 & FathersFinalRace =99) ChildCalculatedRace=99.
Execute.
Appendix Q: Compiled Results from Administration of Birth Satisfaction Scale-Revised
(Hollins-Martin & Martin, 2014)

Among a convenience sample of women that gave birth at home while receiving Medicaid funding in Florida; Response rate was 9/12 or 75%
Four separate moms gave written comments to at least one statement, included below.

Composite scores range from 10 - 50 with 10 representing the least satisfaction and 50 the most; This sample range: 39-50 (Mean 44.44).

<table>
<thead>
<tr>
<th>Mom</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>46</td>
</tr>
<tr>
<td>2</td>
<td>44</td>
</tr>
<tr>
<td>3</td>
<td>39</td>
</tr>
<tr>
<td>4</td>
<td>42</td>
</tr>
<tr>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>6</td>
<td>47</td>
</tr>
<tr>
<td>7</td>
<td>41</td>
</tr>
<tr>
<td>8</td>
<td>50</td>
</tr>
<tr>
<td>9</td>
<td>41</td>
</tr>
</tbody>
</table>

(1) I came through childbirth virtually unscathed.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strongly agree: No tears, stretches or anything!
Strongly agree: It was a breeze! No birth trauma or tearing despite a 9lb 6oz baby!

(2) I thought my labour was excessively long.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strongly disagree: 12 hours of contractions, not too bad, 6 minutes of pushing
Strongly disagree: My hospital labor was 73 hours, my home birth labor was 12 hours.
Strongly disagree: My labor was very short, I only did 3 pushes.

(3) The delivery room staff encouraged me to make decisions about how I wanted my birth to progress.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strongly agree: Everything was exactly how we wanted!
Neither: They were not present during my birthing (midwife arrived after baby was born).
Strongly agree: Everything was 100% up to me.

(4) I felt very anxious during my labour and birth.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Agree: Eager to meet our daughter.
Strongly disagree: I felt supported, safe and encouraged.

(5) I felt well supported by staff during my labour and birth.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strongly agree: My midwife, her assistant and my fiancé were super helpful.
(6) The staff communicated well with me during labour.

<table>
<thead>
<tr>
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<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither</th>
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Strongly agree: We had great, easy to understand conversations about pregnancy, childbirth

(7) I found giving birth a distressing experience.

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Neither: Only distressing in the sense that it was painful and physically demanding. But ultimately a positive experience

Strongly disagree: It was a breeze.

Strongly disagree: Birthing at home was amazing and empowering.

(8) I felt out of control during my birth experience.

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Strongly disagree: I have never felt more in control of anything before.

Strongly disagree: I felt completely in control, everything I did was up to me.

Strongly disagree: I feel in control when I was in birth.

(9) I was not distressed at all during labour.

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Disagree: I disagree because I was “distressed” in the sense that I was experiencing birth pains with contractions and so of course it’s distressing.

Strongly Agree: I felt pampered with helpful massages and was very well taken care of.

(10) The delivery room was clean and hygienic.

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Strongly agree: I was nesting the day before ☺ and fiancé helped a lot too.

Strongly agree: My husband cleaned like a mad man during the final weeks ☺

Scale Source:
Hollins-Martin, C.J., and C.R. Martin