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### About HealthConnect One

BACKGROUND

In its most recent report, the Center for Disease Control (CDC) indicated that Black women are still three to four times more likely than white, Latinx, and Asian/Pacific Islander women to die during pregnancy and childbirth. In states like Georgia however, these rates are six times the national average for Black women and twice the national average for white women. Across the nation, maternal mortality and morbidity remain a pervasive and systemic challenge for women, families, health care providers, and state agencies.

Maternal death, otherwise known as Maternal Mortality (MM), is responsible for the death of over 700 women in the US annually. However, tens of thousands of women suffer unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman’s health; this phenomenon is referred to as Severe Maternal Morbidity (SMM). In the US, more than 50,000 women are afflicted by SMM annually, and these incidences are often seen as ‘near misses’ as without intervention, these women may have died.

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Increasingly, for many women, pregnancy, and childbirth means risking death. The increased prevalence of SMM has been influenced by a broad spectrum of concerns ranging from increased cesarean delivery and obesity to high medical costs and longer hospitalization. In the US, the largest contributing factor for MM and SMM is ‘Race’. Racial disparities in maternal health are alarming, they go beyond education, income, or any other socio-economic factors, regardless of any other factor, and Black women are more likely to suffer maternal mortality or morbidity because of the color of their skin.

Racism is one of the most critical determinants of health.

### Maternal Mortality

The death of a woman while pregnant or within one year of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

### Severe Maternal Morbidity

The unexpected outcomes of labor and delivery that result in significant short-term or long-term consequences to a woman’s health. It also can be considered a near miss for maternal mortality because without identification and treatment, in some cases, these conditions would lead to maternal death.

### Pathways racism is thought to affect health

1. Limited access to social resources such as employment, housing and education and/or increased exposure to risk factors (such as unnecessary contact with the criminal justice system)
2. Negative affective/cognitive and other pathopsychological processes
3. Allostatic load (defined as the cost of chronic exposure to elevated or fluctuating endocrine or neural responses resulting from chronic or repeated challenges that the individual experiences as stressful) and other pathophysiological processes
4. Reduced engagement with healthy behaviors (for example, exercise) and/or increased adoption of unhealthy behaviors (for example, substance misuse) either directly as stress coping or indirectly via reduced self-regulation
5. Direct physical injury caused by race-based violence

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More importantly, racism in health eclipses economics and education, meaning that all people of color, not just the ones that are characterized by the social determinants of health, experience similar disparities.

The provider judgements and biases center on the superficial, they are based on appearance and assumptions, and have been shown to influence the quality or availability of healthcare for people of color universally.  

These disparities are experienced by all people of color, and not just Black people and these can as well be seen in the dismantling of health related cultural traditions in indigenous populations, as well as Latinx, Native Americans, Alaska Native, Pacific Islander, and immigrant populations.

In the United States, childbirth is an industry, but in most countries around the world, childbirth is a part of an overall healthcare system. Traditionally, laboring people received communal support, celebrating and supporting the birthing process. These traditions can be found in Native people of North America, Africa, Asian and Indian, and even throughout South America and the Caribbean, and even the majority of European countries deliver through midwife assisted births.

Among Native American people, there is a journey to bring back lost knowledge and empowerment to indigenous communities through birth work. A 2016 article ‘Indigenous Doulas Are Reclaiming Birthing Practices Colonization Tried to Erase For Centuries,’ states the following:

‘Indigenous communities considered the power inherent in birth as an extension of the power inherent in women. Although each nation varies in its specific beliefs around birth, and many traditionally revere women as bearers of life and “nourishers of all generations.” In particular, midwives are thought to be the authoritative embodiments of these values. Charged with passing down moral and ethical values through birth work, they’re meant to share their knowledge with the rest of the community and future generations, therefore ensuring that each birth is spiritually meaningful.’

Traditional birthing practices have for generations blended culture, tradition, and ancestral spirits in the birthing process, leveraging midwives and doulas as support throughout the perinatal period.

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For many in the US, these traditions have been stripped and replaced with medicalized hospital deliveries. Native American communities are not the only communities who are attempting to preserve their rich culture through birth work. Many community-based birthing initiatives stem from community members. This is seen in immigrant and refugee communities, and other communities that want to preserve culture, traditions, and language and then create supportive structures in perinatal health to marginalized communities.

The roots of maternal health inequalities span generations. Black women in the US, from the moment of their arrival, were treated as chattel, their bodies sold and traded as commodities, and their babies ripped from their arms. Their bodies were broken, whipped, raped, subjected to barbaric medical experimentation, and even their cells were used for scientific exploration without consent. Now, generations later, Black women still live with the intergenerational trauma of these distressing experiences. Post-Traumatic Slave Syndrome is the genetic imprint embedded in the DNA, changing one’s genetic makeup to become transferable to subsequent generations. According to the National Institutes of Health, chronic stress and exposure to stress hormones such as those experienced as a result of long term exposure to racism alter our DNA—not the gene sequence but rather gene expression from generation to generation.

The history and legacy of systematic, structural, and institutional racism on the health and wellness of people of color is very well researched and documented. In Michele Lamont’s writing on cultural processes and causal pathways, she and her collaborators examine the preconceived notions and attitudes of the dominant players and institutions’ unintended production and reproduction of inequality through routine action. Meaning that there can be unintended consequences in racialization and stigmatization by the creators of community-based initiatives, and the outcomes associated with these programs may in turn, perpetuate the very inequalities that they are intended to address. Therefore to address the issue of disparities in maternal mortality and morbidity, it is necessary to develop programs and initiatives that are based on community needs that are built and staffed by the people they intend to impact.

In our previous issue brief, ‘Securing Doula Access-Legislative Update’, we discussed the history of overregulation of Black birthing professionals and the traumatic history of weaponizing regulation, especially for Black birth professionals and Black women. The groundbreaking 1952 documentary ‘All My Babies’, which was sponsored by the Georgia Department of Health, chronicles the story of "Miss Mary" Coley, an African-American midwife more than half a century ago in rural Georgia.¹⁸ For generations, community elders have supported women throughout pregnancy and the perinatal period; these women were affectionately named ‘Granny Midwives’. From the 1600-1940's Granny, Midwives delivered nearly all African-American babies. At the turn of the century, this number was decreased to less than half as Midwifery services were considered by physicians to be second-class care; however, laws protecting a midwife’s right to practice remained after the Health Department realized the difficulties in providing maternity care to the poor, urban and rural populations, and as the practices of these midwives were not seen as an economic threat to physicians.¹⁹ Jessica Brown in her 2018 study ‘The Fight for Birth: The Economic Competition that Determines Birth Options in the United States’ states the following about medicalization of maternity care:

In hospitals, maternity care became more medicalized and standardized. As data from the past ten years indicates that, in the United States, doctors induce approximately twenty-three percent of labors, and almost one-third of all labors end in cesarean section, and seventy-one percent of women receive epidural blocks during childbirth. Ninety-two percent of women give birth in the supine position, or slightly elevated supine position, for the doctor’s convenience, though medical studies suggest the best way to give birth is by squatting. In fact, epidurals combined with pushing in a supine position are associated with an increased risk of episiotomies, vacuum and forceps-assisted deliveries, fetal heart rate abnormalities, second-degree tears, and blood loss.²⁰

The decline of midwife-attended births and the concomitant rise in births managed by physicians was due to a complex set of social, political and economic factors, which resulted in the transfer of childbirth from the domain of midwifery into the realm of obstetricians. ²¹

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While many pointed to granny midwives as the reason behind these alarming rates, endemic poverty, racism, and segregation, lack of education, and lack of emergency services are all factors which help account for the large discrepancy between black and white rates. Poverty generally leads to poor nutrition and poorer general health, and lack of access to medical services usually means little to no prenatal care and few methods to accomplish effective spacing. These factors, in turn, lead to high-risk pregnancies and births. In addition, doctors and hospital care were inaccessible to most southern blacks, forcing granny midwives to cope with labor and delivery complications alone. While granny midwives managed to deliver thousands of black children using ingenuity and simple techniques, the forces of poverty and racism, coupled with the unavailability of emergency services, kept maternal and infant mortality rates high.  

The journey to prevent community members from practicing and improving infant and maternal mortality culminated in 1921 when Congress passed the Sheppard-Towner Act.

The Sheppard-Towner Act, also known as the Promotion of the Welfare and Hygiene of Maternity and Infancy Act, provided federal funding for maternity and childcare to combat elevated mortality rates among mothers and newborns. Sheppard-Towner provided $1 million annually in federal aid (for five years), to state programs for mothers and babies, particularly prenatal and newborn care facilities in rural states. Sheppard-Towner set the framework for the inclusion of substantial provisions for maternal and infant care in the Social Security Act of 1935 and is seen as the precursor to the Title V Maternal and Child Health Services Block Grant Program.

From the birth of this nation to the turn of the century, community-based health workers, Granny Midwives, or other lay health workers have provided maternity care across the nation, and in rural areas and the south. While these practitioners were sharply criticized for maternal and infant mortality, the devastating effects of poverty and racism may have been insurmountable even for the most experienced Granny Midwife.

In her paper “Granny-midwives: Matriarchs of birth in the African-American community 1600-1940”, Elizabeth Graninger states the following regarding maternal and infant mortality rates:

‘While many pointed to granny midwives as the reason behind these alarming rates, endemic poverty, racism, and segregation, lack of education, and lack of emergency services are all factors which help account for the large discrepancy between black and white rates. Poverty generally leads to poor nutrition and poorer general health, and lack of access to medical services usually means little to no prenatal care and few methods to accomplish effective spacing. These factors, in turn, lead to high-risk pregnancies and births. In addition, doctors and hospital care were inaccessible to most southern blacks, forcing granny midwives to cope with labor and delivery complications alone. While granny midwives managed to deliver thousands of black children using ingenuity and simple techniques, the forces of poverty and racism, coupled with the unavailability of emergency services, kept maternal and infant mortality rates high.'
This history has served to discourage and limit participation in service delivery from community-based health workers. The history of the community-based birthing traditions starts with slavery, and is likely rooted in West African religious and medical practices. However, by the 1920s, state legislators intensified efforts to control practicing midwives with the long-term goal of elimination. Due to new regulations, midwives were required to obtain permission slips from licensed doctors to provide pre and post-natal care, and so hospital births became the standard as policies regulating the practice of medicine and who could provide child birthing services prohibited midwives from practicing. By 1975, less than 1 percent of all births occurred outside of a public hospital, and a midwife handled them all.

Weaponized regulations have served to create insurmountable and onerous certification and licensing standards, discouraging valuable diversity in labor support. As we examine approaches to address the recent elevation in maternal mortality and morbidity rates, it is important to consider the inclusion of community-based health workers, who for generations, have provided home-based support and care to women during the perinatal period, particularly for Black women and other communities of color.

COMMUNITY-BASED PREGNANCY SUPPORT

In the 1960’s, a new era in pregnancy support began to arise as the nation began to recognize the spike in cesarean births. This new era was the emergence of doula services. Gaining traction in the 1980’s, doulas became a viable option for providing support to pregnant people. There are many types of doulas, but the most popular are Birth, Postpartum, and Community-based; there are also doulas who specialize in contraception, miscarriage, and abortion.

While all doulas provide value to pregnant and birthing people, the modern-day equivalent of community-based perinatal support workers are Community-Based Doulas (CBDs). CBDs are community health workers who have training in prenatal health, childbirth education, labor support, lactation counseling, and infant care. Services are provided through home visits during pregnancy, continuous labor support at the birth site, and home visits during the postpartum period and ideally work with the birthing parent as early as possible in the pregnancy through one-year postpartum. However, much like the Granny Midwives of yore, CBDs face legislative challenges in the form of onerous certification and licensing standards, which unintentionally (or intentionally) inhibit these community members from providing services.

A CBD is a community health worker, whose work spans the perinatal period with training in prenatal health, childbirth education, labor support, lactation counseling, and infant care. They provide physical, emotional and informational support during pregnancy, continuous labor support at the birth site, and home visits during postpartum. Recruited from the communities being served, a CBD is significantly impactful because of their shared culture, language, and values with the mother. In this role, the doula is equity-focused and acts as an advocate to liaise between the mother and health providers.

COMMUNITY-BASED DOULA (CBD)

A CBD is a community health worker, whose work spans the perinatal period with training in prenatal health, childbirth education, labor support, lactation counseling, and infant care. They provide physical, emotional and informational support during pregnancy, continuous labor support at the birth site, and home visits during postpartum. Recruited from the communities being served, a CBD is significantly impactful because of their shared culture, language, and values with the mother. In this role, the doula is equity-focused and acts as an advocate to liaise between the mother and health providers.

COMMUNITY-BASED DOULA MODEL

The CBD model timeline begins during pregnancy, through the birth, and concludes at an agreed time after childbirth. Such programs are the most accessible to underserved populations, offering culturally relevant and equity-focused support to low-income communities. They tailor prenatal and postpartum services to the needs of the community at little to no cost.33

HealthConnect One, a CBD training and certifying organization (the National Community Based Doula Training Institute™), trains CBD organizations since 1996 and accredits programs since 2012. The organization also provides peer-to-peer mentorship to over 100 community leaders through their Birth Equity Leadership Academy (BELA). 34

Informed by 20 years of experience, the organization abides by five essential components of the CBD model:

1. “Employ trusted members of the community
2. Extend support from early pregnancy through the first months postpartum
3. Collaborate with community stakeholders and use a diverse team approach
4. Facilitate experiential learning through popular education, and
5. Value the community-based doula’s work with salary, supervision and support.”35

Cumulatively, these components serve as pillars that can be adapted to a successful implementation of CBD programs that are in alignment with HealthConnect One’s continued efforts to improve maternal health.

ADVANTAGES OF THE COMMUNITY-BASED DOULA PROGRAMS

CBD care provides many benefits from cost savings to lowered cesarean rates. The inclusion of CBD services can truly impact maternal health outcomes and support creating equity in maternal care.

COST SAVINGS

A correlation between doula care and cost savings has been demonstrated in numerous studies, citing reduction in cesarean rates, which cost 50% more than vaginal births and lowering the use of epidural analgesia and the costs associated with anesthesia services.36 This leads to reduced cost in instrument-assisted births, repeat cesarean births, postpartum maternal care and many associated mother and infant medical interventions.37 With regards to breastfeeding, its long-term economic impact can generate cost savings of $13 billion annually in the U.S., if guidelines are optimally followed for six months.38

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Given the health benefits of breastfeeding, these savings are in the form of avoided illnesses and chronic diseases for both the mother and infant. Thus, compliance with breastfeeding practices was recommended as a method to reduce the number of pediatric health complications and premature deaths.39

**INCREASED BREASTFEEDING PRACTICES**

A 2018 study that examined the impact of CBD programs on birth outcomes, postpartum maternal and infant health, and newborn care practices, found an increased likelihood for mothers to initiate breastfeeding.40 Breast milk has been proven to provide immunological and anti-inflammatory properties that protect infants and preterm babies from illnesses and infections. In fact, an observational study linked not breastfeeding with health risks that include: acute ear infections, gastrointestinal infections and lower respiratory tract infections among infants; plus an increased likelihood of breast and ovarian cancer among mothers.41 HealthConnect One’s long-running CBD programs affirm these findings, with data showing greater breastfeeding exclusivity and longer breastfeeding duration among African American and Hispanic women.42

**REDUCTION OF LOW BIRTH WEIGHT BIRTHS**

The risk of early infant mortality, developmental delays and health complications are increased by poor birth outcomes such as preterm (born before 37 weeks) and low birth weight (less than 5lbs. 8oz). The latter is the leading factor associated with neonatal mortality.43 CBD programs with home visits during and post-pregnancy were found to reduce this risk by approximately half, according to Healthy Families New York, a home visitation program.44 Evident in successful programs is coordination between healthcare providers and CBD programs, where women at risk for low birth weight deliveries are identified early and directed to the appropriate prenatal care, including home visitations. So such collaborations continue to address unmet needs in communities with health-determinant disparities.

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LOWERED CESAREAN BIRTHS

Benefits of community-based programs entail emotional, physical and informational support offered to pre and post-pregnancy, which are credited for the positive health outcomes for the mother and infant. In this instance, women who receive ongoing support through CBD programs are reported to have less stressful births, with fewer cesarean births, instrument-assisted births, requests for pain management medications and shorter labor durations. Also reported are higher newborn Apgar scores and overall maternal satisfaction. Cesarean births in U.S. hospitals are common, even though like any major surgery, there are still associated complications. The Mayo Clinic lists the following as cesarean birth risks: surgical injury and breathing problems for infants; and postpartum hemorrhage, blood clots, wound infections, adverse reactions to anesthesia and increased risks in future pregnancies for the mother.

REDUCED EPIDURAL ANALGESIA

Maternal anxiety, self-efficacy and pain perception are all positively affected by the presence and continuous support of a doula, reducing the need for epidural analgesia. This is best evident in studies comparing cohorts of women who were part of a CBD program versus those who were not.

EMOTIONAL AND PSYCHOLOGICAL SUPPORT

An additional advantage of doulas is the emotional and psychological support that doulas provide. A groundbreaking 2019 study ‘The Giving Voices to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States,’ Saraswathi Vedam and colleagues, states that:

‘One in six women experienced one or more types of mistreatment, including being shouted at or scolded by a health care provider, which is the most commonly reported type of mistreatment (8.5%), then followed by “health care providers ignoring women, refusing their request for help, or failing to respond to requests for help in a reasonable amount of time” (7.8%). Fewer women reported violation of physical privacy (5.5%), and health care providers threatening to withhold treatment or forcing them to accept treatment they did not want (4.5%). Very few women reported physical abuse, sharing of their personal information without consent, or healthcare providers threatening them in other ways. Additionally, ‘Indigenous women were the most likely to report experiencing at least one form of mistreatment by healthcare providers (32.8%), followed by Hispanic (25.0%) and Black women (22.5%). Women who identified as White were least likely to report that they experienced any of the mistreatment indicators (14.1%). Additionally, ‘Indigenous women were the most likely to report experiencing at least one form of mistreatment by healthcare providers (32.8%), followed by Hispanic (25.0%) and Black women (22.5%). Women who identified as White were least likely to report that they experienced any of the mistreatment indicators (14.1%).

Mistreatment of birthing parents during labor and delivery is ubiquitous and the presence of a doula during labor can provide emotional and psychological support. Birthing parents who received positive support and encouragement during labor felt more positively about themselves and their births as long as 20 years later.\textsuperscript{50} Research also indicates that mothers with the highest long term satisfaction ratings thought they had accomplished something important, that they were in control of what happened to them, and that the birth experience contributed to their self-confidence and self-esteem.\textsuperscript{51} Another study found out that a greater proportion of doula-supported women were breastfeeding, and they reported greater self-esteem, less depression, higher regard for their babies and their ability to care for them compared to the control mothers.\textsuperscript{52} This study also observed that when the doula was present with the couple during labor, the non-laboring parent offered more personal support.\textsuperscript{53} The non-laboring parent’s presence during labor and delivery is important to both parents, but it is the presence of the doula that results in significant benefits in outcome.\textsuperscript{54} The presence of a doula can bring about psychological safety and reduce stress and anxiety associated with the birthing process.

PATHWAY TO ECONOMIC SECURITY

Benefits of doula services go beyond clinical outcomes and include the economic security found in creating a career path to a livable wage. The CBD model is based on training and educating community members to provide support during the perinatal period. This model is practiced and best exemplified by community-based organizations that provide doula training and certifications to community members, creating a pipeline of prospective doulas in the healthcare workforce.

For instance, Open Arms Perinatal Services caters to marginalized populations affected by health disparities or racial inequities by providing access to CBDs. The organization also prides itself on its scholarship program, known for enhancing growth opportunities for CBDs in training. Added to this list are Black Mothers Breastfeeding Association and Birth Matters. Both organizations focus on marginalized communities by training CBDs. After training, participants go on to pursue careers as breastfeeding counselors, lactation consultants and midwives. This training model empowers communities through its investment and commitment to improving the trainees earning potential and ensuring economic security.

SERVICES TO MARGINALIZED POPULATIONS

For incarcerated women, wards of states and pregnant women at addiction treatment centers, doula services are rendered and tailored to meet their unique needs. According to the Association of State and Territorial Health Officials (ASTHO), the following states require correctional facilities to provide doula services to pregnant inmates: Minnesota, Oklahoma, Washington state, while Wisconsin has similarly introduced bills to support this. Given the extensive social and economic challenges that lead women to incarceration, many incarcerated women are at a higher risk for experiencing complications during pregnancy and birth, thus pose a greater need for doula care and support. Simply, empowering incarcerated women during pregnancy and childbirth, can improve health outcomes and decrease recidivism.

Although a gap in research regarding doula services for wards of the state and pregnant women in addiction treatment centers exists, it speaks to the need for this endeavor. Women in these cohorts need interventions that are void of judgment and focused on their wellbeing. For instance, unique partnerships between addiction treatment centers and CBD organizations have had success in providing maternal health services to women who are in treatment, citing the importance of making the mother to feel comfortable and not judged for their addiction. Similar collaborations can continue to build on this model and evolve to fit each mother’s specific needs.

Implicit bias is identified as one of the social determinants of health, and a significant factor in healthcare since providers are expected to deliver impartial care. In this setting, when a healthcare professional makes negative evaluations based on a client’s membership to a group or particular characteristic, it can be a matter of life and death. So implicit biases have an added layer of complication given that they are difficult to measure, on the one hand, and on another, their ramifications are harmful to a cohort that may already be vulnerable. Correlational evidence points to implicit bias’s influence on medical diagnoses, prognoses and treatment options offered to patients. It is a call for further exploration into its role in health disparities.

In some instances, the pregnant woman may be hesitant or resistant to receiving medical care, due to the lack of trust. The relationship between a pregnant woman and a doula is significantly impacted by whether they share the same race, culture or experience.

Often, when women of color who already face societal discrimination are additionally mistreated in the healthcare system, it affirms and continues this cycle of mistrust. Racial concordance between the mother-to-be and the doula serves to create a comfortable environment where the client is receptive to the services being rendered. Since CBDs are recruited from the community, they often look like, talk like and have a similar lived experience as the families that they provide support to. This strength allows them to be able to help families navigate the institutional racism that they face in the healthcare system and mediate the negative experiences during pregnancy, birth and in the postpartum period. Thus, racial concordance between the doula and the mother encourages trust in their relationship and can better the birthing experience.

HEALTH SYSTEM INTEGRATION OF COMMUNITY-BASED DOULA

Systemwide acceptance of doula services is burgeoning, proper integration of doula care into the health care infrastructure faces numerous challenges as attitudes toward doulas vary from complete support to lack of appreciation of the complementary nature of their individual roles. The benefits of doula services have been well researched as indicated earlier in this brief, however, integration of doula services in hospitals and acceptance by physicians and clinical care providers remains a challenge.

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The medicalization of pregnancy has transformed the birthing process as it becomes increasingly influenced by medical technology, making medical intervention the norm in most Western countries. Obstetricians have increasingly taken over responsibility for normal birth in addition to their involvement in complicated births. As labor intervention has become more widespread, so they have assisted delivery rates and major surgery; caesarean section rates in the United States have increased from 20% to 32%; obstetricians must be held accountable for these rising rates. While obstetrician-led birth remains the norm, evidence suggests that the highest rates of normal birth seem to be associated with successful community-focused approaches. For instance, in a randomized controlled trial, comparing community-based care with standard hospital care, a significant difference in caesarean section rates was found (13.3% vs 17.8%, respectively). It is thought that the use of community-based birthing professionals offers advantages such as continuous emotional and physical support throughout labor, use of immersion in water to ease labor pain, encouraging women to remain upright and mobile, minimizing the use of epidural analgesia, and as well as emotional support through home visits. Furthermore, doulas offer continuous one-on-one support to birthing parents, in busy birthing facilities that often have several birthing parents receiving services at the same time. Yet, birthing professionals face numerous challenges when attending a hospital-based birth.

Hospitals and birthing facilities have been slow to integrate the use of doulas. While some facilities have taken measures to have doulas available on staff, this does not offer the full advantage of the doula model, which is based on the notion of building rapport over time between the birthing parent and the assigned (or selected) doula.

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CHALLENGES WITH INTEGRATION

The goal of the nurse is to ensure the safe outcome of childbirth. While the goal of the doula is to ensure that the woman feels safe and confident; For nurses to value doulas, they must understand what a doula does and does not do and how she complements the nursing care and family support. In their report Nurses and Doulas: Complementary Roles to Provide Optimal Maternity Care, Lois Eve Ballen and Ann Fulcher list two main challenges that hinder the increase in nurse-doula collaboration:

1 Territorialism and Turf: Some nurses have described themselves as “territorial” about their patients, and doulas have reported feeling that there are “turf” issues in the labor rooms, especially when the nurse and doula have not met before.

2 Doulas Working Outside of Their Scope of Practice: Nurses have reported feeling that doulas sometimes try to “run the labor,” giving medical advice and asserting their own opinions and desires, and that patients sometimes turn more to the doula for recommendations than to the provider or nurse.

Relationships between doulas and nurses can be contentious, and research suggests that both the education and income level of both the doula and the nurse as well as cultural differences, can impact the quality of that relationship and whether or not true collaboration can occur.

APPROACHES TO EASE HOSPITAL INTEGRATION OF COMMUNITY-BASED DOULA

One of the biggest advantages of CBDs is the supportive nature of the established relationship between birthing parent and their doula over the expanded perinatal period. Labor wards are particularly busy places requiring clinical staff to perform many tasks, thereby limiting their ability to provide one-on-one support. Working together, nurses and doulas each play a role in maternal/fetal outcomes. Working together increases both patient satisfaction and the nurses and doula job satisfaction. In addition to her nonclinical care for the laboring woman, the doula can provide an extra pair of hands for busy nurses, and doulas can help the staff by supporting partners and family members during the long hours of labor and often can help with the initiation of breastfeeding.

Lois Eve Ballen and Ann Fulcher also recommend two strategies for increasing collaboration:

1. Good two-way communication and mutual understanding of the roles of everyone attending births are important. They also suggest that doulas introduce themselves to clinical staff prior to labor to aid in rapport development.⁸⁰

2. Guidelines for staff to address issues related to doulas.⁸¹ Facilities should create processes for nurses and clinical staff to use when issues or concerns arise. Likewise, doula servicing organizations should engage regularly with the hospital staff and create their own process to account for issues and concerns experienced by doulas.

On the whole, a team approach allows both nurse and doula to do their jobs well and to best serve the individual birthing parent.⁸²

POLICY AND REIMBURSEMENT

Even though doula care is associated with improved health outcomes and cost savings, commercial insurance and Medicaid have generally not paid for doula care. This approach implicitly considers these services to be a luxury, reserved for women who can afford to pay out of their pocket for them, and generally conceives of these services like those provided by an individual birth doula rather than a CBD model.

In recent years, however, as states have been paying more attention to unacceptably high - and rising - rates of maternal mortality, as well as poor maternal and infant health outcomes, there has also been more interest in looking at Medicaid as a source of reimbursement for doula services. Medicaid covers 43% of all births, largely serving low-income families.⁸³ It also has a reimbursement structure that has more flexibility to work with CBDS, especially in Medicaid managed care.⁸⁴

There has also been federal interest in demonstration projects related to doula access, as well as Medicaid and commercial insurance coverage.⁸⁵

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⁸⁴ More information about Medicaid and reimbursement is available in Issue Brief #1 and Issue Brief #3.
POLICIES THAT INFLUENCE COMMUNITY-BASED DOULA COVERAGE AND ACCESS

One of the most significant policies that would expand access to doula services - both independent and community-based - would be if the U.S. Preventive Services Task Force undertook a study and recommended doula services as a preventive service that should be covered under the Affordable Care Act’s (ACA) preventive services mandate. This would ensure that doula services would be provided at no cost-sharing, under private insurance and for many Medicaid enrollees. This change would likely open the door for broader coverage under Medicaid as well.

There are also two Medicaid-specific policies that work to limit access to CBD services:

Medicaid reimbursement is limited to licensed providers: under the Medicaid statute, Medicaid will only reimburse states for payments that are made to licensed practitioners whose credentials and qualifications are clearly identifiable and who have a specific scope of practice. There is, however, a limited exception for preventive services that were added into the Medicaid statute via the ACA in 2010, and for which the Centers for Medicare and Medicare Services (CMS) issued final regulations in July 2013. Previously, like other Medicaid services as described above, preventive services had to be provided by a licensed practitioner to be eligible for reimbursement - with the revised language, they have to be recommended by a licensed practitioner. States need to submit a State Plan Amendment (SPA) to CMS to add services by non-licensed providers to their state Medicaid program. While there are still challenges to this approach, this option at least provides a pathway for states to cover CBD services through Medicaid.

88 Social Security Act, 42 U.S.C § 1396d; Social Security Act, 42 U.S.C. § 1396a(a)(78)
89 Social Security Act, 42 U.S.C. § 1396d(a)(13); 42 C.F.R. § 440.130 (2013)
90 42 C.F.R. § 440.130 (2013)
Pregnancy-related Medicaid coverage ends 60 days postpartum: even with the Medicaid coverage expansions under the ACA, pregnancy remains a separate eligibility category for Medicaid, often with higher income eligibility levels and a more robust benefits package. However, when women qualify for Medicaid because they are pregnant, their coverage only extends to 60 days postpartum, and any care related to pregnancy generally must happen during that period so that it can be covered by Medicaid.

In states that have adopted the Medicaid expansion, many women will transition back to expansion Medicaid but may experience disruptions in care. There has recently been both federal and state interest in expanding the length of Medicaid coverage for postpartum women in order to improve maternal health outcomes, and New Jersey and Illinois became the first states to do so with an expansion of this coverage for six months and twelve months respectively in their Fiscal Year 2020 budgets. The limited length of postpartum coverage poses particular payment challenges for CBDs whose involvement with new mothers and families can last from six months to two years postpartum.

Both of these challenges also point to larger problems in the health care system about what is needed to support a pregnant woman before, during, and after pregnancy - particularly a woman of color who is facing a different set of risks and challenges than a white woman - and which a CBD may be particularly able to help address.

Reimbursement for CBDs is a critical issue - in a 2016-2017 survey of 98 doula service organizations conducted for HealthConnect One, 100% of them said that adequate funding is their greatest challenge, with 67% citing Medicaid reimbursement for doula services as their top policy priority.

### COVERAGE AND REIMBURSEMENT CHALLENGES

Reimbursement for CBDs is a critical issue - in a 2016-2017 survey of 98 doula service organizations conducted for HealthConnect One, 100% of them said that adequate funding is their greatest challenge, with 67% citing Medicaid reimbursement for doula services as their top policy priority.

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While two states - Oregon and Minnesota - include coverage of doula services in their Medicaid programs, the experiences in these states demonstrate the challenges that arise when setting up new systems of reimbursement for community-based providers.

These include:

**Low Reimbursement:** reimbursement rates have been set well below the cost of providing care with CBDs facing tough choices about their ability to participate, resulting in a less diverse doula workforce that doesn't reflect the Medicaid population.99

**Restrictive Requirements and Confusing Practices:** these include limits and restrictions on how a doula can provide care to a client as well as administrative barriers to doula practice, which can prevent doulas from contracting with Medicaid.

**Overregulation of Black Birthing Professionals:** the U.S. has a long and traumatic history of regulating, with the intention of trying to eliminate, community-based birthing practices and those who provide them in the Black community.100 What this history and the racial and class differences between independent doulas and CBDs implies is that certification, licensing, and other requirements for doulas will have more of a discouraging effect on CBDs.

It is likely that similar challenges will also be faced with commercial insurance. However, by sharing these challenges, as well as recommendations, hopefully, other states can learn from these experiences and reduce these challenges going forward.

**OPPORTUNITIES AND BEST PRACTICES**

Policy development related to CBD coverage and access is still in its formative stages, so it is too early to provide best practices in terms of specific legislation. However, there is an incredible opportunity to learn from CBDs about what they would want to see prioritized and included as policies are being developed to increase access to and coverage of their services. There are also some recommendations provided in the next section based on the experiences in the states that have implemented and passed policies related to coverage of CBD services, as well as recommendations related to sustainable funding, a key challenge articulated by CBDs.


Congress should include doula services as a mandatory service to be covered under Medicaid. As intermediate steps, CMS should provide additional federal guidance to states for Medicaid coverage of doula services, and Congress and/or CMS should expand options for coverage of non-licensed provider services. The easiest way to ensure that women covered by Medicaid would have access to doula services would be if Congress added it to Medicaid as a mandatory service - however, mandatory services do not get added frequently, so there would likely need to be a sustained advocacy campaign for this to happen. However, as an intermediate step, CMS could provide additional guidance and technical assistance to states to streamline the process to cover CBD services. Congress and/or CMS could also expand the options for how to include the services of non-licensed providers, which would help not only CBDs but also community health workers and other similarly situated providers.

The United States Preventive Services Task Force (USPSTF) could consider studying doula services and including coverage of these services as a preventive service under the ACA. The USPSTF is a national body that assesses the value of preventive services, and since the passage of the ACA, their recommendations determine whether or not certain preventive services are covered by private insurance and Medicaid without cost-sharing. The USPSTF could determine whether continuous labor support services provided by a doula meet their standards to be evaluated as a preventive service, and if so, they should evaluate them and provide a recommendation. If they are found to meet the standard of a recommended preventive service, this would require these services to be covered under a wide variety of private insurance and Medicaid plans, greatly expanding the number of people who have coverage for them.


Expand the duration of Medicaid postpartum coverage and the definition of doula services. As discussed above, Medicaid coverage for pregnant women ends in 60 days postpartum, which means that any services related to pregnancy must be completed and billed within this period. Expanding postpartum Medicaid coverage for a full year would not only have significant health benefits but would also allow CBDs to have more time to work with a postpartum woman, her baby, and her family. The family would gain more of the benefits of working with a doula, and the doula would be able to receive reimbursement for these services. The expansion of Medicaid postpartum coverage to a year after pregnancy also makes sense given that the definitions of pregnancy-related deaths and infant mortality include the year-long period after birth, so recognizing that this is a particularly vulnerable time for both the woman and her child. Medicaid coverage and access to health services should also be aligned with these definitions.

A change to the duration of postpartum coverage should also be accompanied by an expansion of the definition of doula services to ensure that these services can be provided for the full length of the newly expanded postpartum period. For example, if doula services are defined in a state in a way that only includes services provided during the prenatal period and labor and delivery, an expansion of Medicaid coverage during the postpartum period would not provide additional access to doula services. Ideally, both of these changes around the length of postpartum coverage and the definition of doula services would be made at the federal level for maximum impact, but states can also make these changes in their individual Medicaid programs.

Explore options for coverage of CBD services in Medicaid managed care and delivery reform efforts. Improving maternity care has been an increasing focus for Medicaid managed care and delivery reform efforts in recent years, and there is often more flexibility to try innovative models, which include relation to payment. This may provide opportunities for partnership with CBD organizations and/or groups. This topic will also be discussed in additional detail in Issue Brief #3.

Continue exploring opportunities for inclusion, coverage, and partnership with CBD services in other programs beyond commercial insurance and Medicaid, particularly for people not included in these programs. While including coverage for CBD services in Medicaid, private insurance will reach many people who need these services, and CBDs will also work with many people who are not covered by health insurance, because they cannot afford it, are ineligible, or face other barriers to coverage. There should continue to be efforts by the appropriate federal and state agencies that share a focus on ensuring healthy maternal and child health outcomes and reducing health disparities. These programs and agencies include, but are not limited to health and human services departments and programs, including maternal and child health, home visiting programs, community health centers, and Early Head Start; Healthy Start; early education departments and programs; and WIC, and CBDs to develop partnerships and funding streams to support CBD services for those women and families not covered by other sources.

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As covered in additional detail in the HealthConnect One Issue Brief: Creating a Policy for Equitable Doula Access, states can also set a policy to increase access to CBDs and ensure that their services are reimbursed, particularly through Medicaid.

Below is a summary of the recommendations:

Ensure meaningful engagement and collaboration with women of color and CBDs on designing policy solutions. The most crucial step that states can take is to collaborate with women of color and others who are experiencing and are at risk for negative maternal and infant health outcomes and the CBDs who are already providing care to them to make sure their voices are part of the conversation. CBDs can also provide valuable feedback on how to ensure that they can participate in any systems that are set up related to doula care.

Use Medicaid’s preventive services SPA option and embrace its flexibility. The SPA option to cover preventive services by non-licensed providers is likely to provide the most flexibility for states, helping them create requirements for doulas that aren’t overly restrictive and hopefully allowing for broad participation. States should consider if doula services can be covered when they are recommended by a licensed provider, rather than requiring the supervision of a licensed provider.

Consider the interplay with state definitions and regulations for Community Health Workers. States should consider if they already have policies or definitions in place that address the role of community health workers and how these may be able to facilitate access to doulas. The National Academy for State Health Policy provides an interactive resource map for states to find out about community health worker models in place in states across the country.106

Look for alternate funding opportunities. Exploring opportunities to reimburse for CBD services may include some nontraditional approaches. Other programs that may offer reimbursement for doula services are Early Head Start, SAMHSA (Substance Abuse and Mental Health Services Admiration), USDA (WIC), and the Department of Education.

Keep legislative language simple. Given that including doula services in Medicaid will require the state to submit a SPA, the legislation does not need to be detailed. However, ensure that the definition of doula services is broad enough to include education and emotional and physical support provided during the prenatal, labor, birth, and postpartum periods.

Ensure requirements for doulas (related to training, certification, etc.) are not overly restrictive. States should also work with the doula community, and ensure that CBDs from a variety of communities are part of these conversations, to make sure that any required qualifications, education, training, experience, credentialing, and registration are not overly restrictive and do not have the effect of significantly limiting the pool of available doulas, particularly in those communities most in need of doulas.

Ensure adequate reimbursement for CBDs and engage in ongoing consultation with CBDs to develop effective implementation policies and procedures. While low reimbursement rates are a common problem in Medicaid, states should work to ensure that reimbursement for doula services is at a level that these services are actually available for enrollees, especially considering the cost savings and improved outcomes doulas provide. In addition, states should create a feedback loop with CBDs to ensure that they can quickly address any challenges that arise with billing and reimbursement.

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Since 1986, HealthConnect One has worked with community clinics, Federally Qualified Health Centers, tribal organizations, and numerous other community groups. Rooted in the belief that communities know what they need but often require support to get it, we work with communities to co-create programs, initiatives, and services that support moms, babies and families. Always collaborative, our work continues to raise breastfeeding rates, lower c-section rates, and increase parent-child bonding.

HealthConnect One is a national leader in advancing community-based, peer-to-peer support for pregnancy, birth, breastfeeding, and early parenting. Our vision is to see every baby, mother, and family thrive in a healthy community. We work to achieve this vision through an equity-focused approach supporting the first 1000 days for birthing families.

For more information, please visit www.healthconnectone.org