ADVANCING BIRTH JUSTICE:

Community-Based Doula Models as a Standard of Care for Ending Racial Disparities

ANCIENT SONG DOULA SERVICES
VILLAGE BIRTH INTERNATIONAL
EVERY MOTHER COUNTS

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Ancient Song Doula Services is a social profit organization working towards addressing racial disparities and inequities within the healthcare system. We do this by providing full spectrum doula services, training & certification, conferences and educational forums to address the maternal mortality and severe maternal morbidity, implicit bias, and racism within healthcare systems.

Village Birth International (VBI) is a community-based organization dedicated to improving outcomes in maternal-child health while seeking birth and reproductive justice for families facing inequities in the childbearing year. We are committed to universal health equity for all families by eliminating the impact of racism and systemic oppression on perinatal outcomes. Our work is currently based in Syracuse, NY, New Jersey, and Northern Uganda.

Every Mother Counts is a non-profit organization working to make pregnancy and childbirth safe for every mother, everywhere. We work to achieve quality, respectful, and equitable maternity care for all by giving grants and working with partners and thought leaders to increase awareness and mobilize communities to take action.

Executive Summary

In 2018, New York State Governor Andrew Cuomo announced a comprehensive initiative to address poor maternal and infant health outcomes and disparities, which included the development of a Medicaid pilot program to cover doula services. This initiative includes the development of a Medicaid pilot program to cover labor support and home visits by doulas in order to address the discrimination and inequities in health care experienced by low-income communities and communities of color. Doula care includes non-clinical emotional, physical, and informational support before, during, and after labor and birth, and is covered by state Medicaid fee-for-service plans, managed care organizations, or both, in a few other states.

Extensive, reliable research shows that doula care is a high-value model that improves childbirth outcomes, increases care quality, and holds the potential to achieve cost savings.[1-3] Doula support during pregnancy, birth, and the postpartum period reduces rates of cesarean deliveries, prematurity and illness in newborns, and the likelihood of postpartum depression. Doula care also improves the overall satisfaction with the experience of childbirth care and increases breastfeeding initiation and duration.

Cost analyses have found that doula care can reduce overall spending by avoiding unnecessary medical procedures and the potential complications and chronic conditions that may result, reducing NICU admissions, and fostering healthy practices such as breastfeeding.[4-6] Despite the numerous, well-documented benefits of doula care, the services remain widely underutilized. A number of barriers contribute to poor access, but cost has previously been identified as the most significant obstacle to obtaining doula services. [10] Medicaid coverage would eliminate this barrier making doula support accessible to those who need it most.

"One of the most effective tools to improve labor and delivery is the continuous presence of support personnel, such as a doula."

– Safe Prevention of the Primary Cesarean Delivery. Consensus Statement of the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine, March 2014.

New York State's commitment to the Medicaid Doula Pilot is a welcome step towards addressing long-standing health disparities, but to be effective, policies must incorporate and advance community-based doula approaches, including the responsibilities, core competencies, and principles of practice, which extend beyond those of the traditional doula model. Traditional "private-pay" doula care has been used primarily by people with private insurance, financial and social resources because it must be paid for out of pocket. The traditional doula model, and the trainings associated with it, do not address many of the issues that are essential to serving Medicaid enrolled clients with complex social needs.

Community-based doula programs have been developed to make doula care and other perinatal support services available in and appropriate for underserved communities. These programs and organizations are situated in the communities they serve, and their services encompass and go beyond those offered by private doulas. Community-based programs typically provide more home visits and a wider array of services and referrals for individuals who need more comprehensive support than would be provided by a traditional doula. The support provided is low or no cost and focuses on ensuring safe, dignified and respectful care. Most community-based doulas are members of the community they serve, sharing the same background, culture, and/or language with their clients and have additional training that supplements the traditional doula education curriculum.

Medicaid coverage makes doula support more accessible to communities with the greatest needs, and it has already been established in Oregon and Minnesota. An analysis of the utilization of Medicaid coverage in those two states shows that structural barriers have hampered widespread participation and suggests that Medicaid reimbursement is more likely to be successful when services are provided by doulas working in community-based organizations or programs. Such programs provide essential training, mentorship, supervision, and referral networks that enhance the impact and reach of their services.

This document will outline the ways in which community-based doula programs in New York State have been strategically implemented to serve families most at risk for poor maternal and infant health outcomes. By elevating human rights and reproductive justice principles, community-led doula support serves as a model for envisioning new approaches to the current maternal health crisis in the US. It will also outline successful elements of community-based doula trainings and practices that would enhance the New York State Pilot and help it meet its ultimate goal of reducing disparities.

Key recommendations:

New York and other states planning or providing Medicaid coverage of doula care should:

- **Adjust reimbursement rates** to ensure that doulas have the opportunity to earn a living wage
- **Collaborate with and invest in community-based doula programs** to ensure that doulas enrolled in Medicaid reimbursement programs are equipped to serve communities of color and low-income communities
- **Support best practices through the pilot design**, including ensuring adequate training, certification, supervision, mentorship and peer support to appropriately serve communities of color and low-income communities
- **Develop a comprehensive approach to wellness and support by ensuring organizations or agencies** are equipped with the structure, relationships, and processes in place to provide a coordinated network of referrals
- **Provide funds to train and certify a diverse doula workforce,** specifically from underserved rural and urban low-income communities, communities of color, and communities facing linguistic or cultural barriers.
- **Incorporate community engagement as an essential component to improve health equity.**
- **Take active steps to raise awareness about the benefits and availability of community-based doulas**.

Understanding the limitations of efforts underway opens the door to identifying strategies to make the NY State Pilot, and future programs in other states, as successful as possible.

WHAT IS DOULA CARE?

Doulas are trained to provide non-clinical emotional, physical and informational support for people before, during, and after labor and birth. Birth doulas provide hands-on comfort measures and share resources and information about labor and birth. Doulas can facilitate positive communication between the birthing person and their care providers by helping people articulate their questions, preferences and values.

In addition to providing continuous support during labor and childbirth, birth doulas typically meet with clients one or more times at the end of pregnancy, as well as early in the postpartum period, although some hospital-based doula programs provide care only during labor and birth. In the postpartum period, doulas may offer help with newborn feeding and other care, emotional and physical recovery from birth, coping skills, and appropriate referrals as necessary.

Doulas work with pregnant people to help them experience care that is individualized, safe, healthy, and equitable. **Doulas can be particularly beneficial for women of color and women from low-income and underserved communities and can help reduce health disparities by ensuring that pregnant people who face the greatest risks have the added support they need.**

Doula care can vary significantly depending on their training and approach. Community-based doulas offer an expanded model of traditional doula care that provides culturally appropriate support to people in communities at risk of poor outcomes. They are usually trusted members of the community they serve who are particularly well-suited to address issues related to discrimination and disparities by bridging language and cultural gaps and serving as a health navigator or liaison between the client and service providers.

Community-based doula programs include services tailored to the specific needs of the community they serve at no or very low cost. In addition to birthing support, community-based doulas usually offer prenatal and postpartum home visits, childbirth and breastfeeding education, and referrals for needed health or social services. Many also support attachment and responsive parenting.

Because the benefits are particularly important for those most at risk of poor outcomes, **doula support has the potential to reduce health disparities and improve health equity.** But for women in low-income communities living in maternal toxic zones, doula care is often out of reach due to financial constraints and the limited availability of doulas in their communities.

"Most of the time, mothers from my community are alone in the hospital. For my refugee community, to be a new mother in this country means being afraid and not knowing how to navigate this system. The language barrier makes it very difficult for them and they need someone they can trust to encourage them and reassure them. Having a doula from their own country makes them feel safe, comfortable, and helps the mother understand the process."

Juliet Ilunga, Certified Village Birth International Doula, Syracuse, NY March 13, 2019.

Introduction

MATERNAL HEALTH LANDSCAPE

In April 2018, New York State Governor Andrew Cuomo announced a comprehensive initiative to reduce maternal mortality and racial and economic disparities in maternal and infant health outcomes. By highlighting the high rates of maternal death and illness, specifically those of black women, this announcement opened new opportunities for partnership between state policy makers and the community members most affected by pregnancy- and childbirth-related disparities.

Despite decades of medical advancements, maternal and infant death, illness and injury persist at alarming rates, particularly in communities of color and low-income communities. In New York State, maternal deaths and severe complications of pregnancy remain higher than the national average and have been increasing. NY State maternal deaths increased by 60% over the last decade, reaching 20.9 deaths per 100,000 live births in 2015.[12] In New York City, where half of all births in the state take place, the maternal mortality rate is even higher (22.6 deaths per 100,000 live births).[13] Life-threatening complications of pregnancy and birth (severe maternal morbidity) are 1.6 times higher than the US average and increased 28.2% from 2008 to 2012 (197.2 to 252.9 per 10,000 live births). [14]

As is true for the US overall, New York State maternal mortality rates for black women are between three and four times higher than those of white women.[13, 15]. According to the 2017 New York Maternal Mortality Review report, 68% of women that experienced a pregnancy-related death were enrolled in Medicaid.[16] Similarly, rates of maternal mortality and morbidity in New York City are highest among women of color and women living in high poverty communities. From 2006 to 2010, black women were twelve times as likely to die from pregnancy-related causes compared to white women (56.3 per 100,000 live births compared to 4.7).[13] The rates were also high among Hispanic and Latina women and Asian/Pacific Islander women (15.9 and 19.9 per 100,000 live births, respectively).

Maternal health outcomes are equally dire in other regions of New York State. In Onondoga county, where Village Birth International is based, maternal and infant mortality rates are higher than state averages. In this region, the maternal mortality rate is 31.6 deaths per 100,000 live births.[17] Infant mortality is 6.2 deaths per 1,000 live births with significant racial disparities (14.8 for black infants and 4.4 for white infants).

STRATEGIES FOR CHANGE

Programmatic strategies specifically targeting maternal and infant health outcomes are an essential addition to efforts to improve clinical care and include providing community-based doula support for at-risk women and families. Strategies to improve infant and maternal outcomes, particularly for families of color and low-income families, have historically focused disproportionately on addressing pre-existing conditions, structural barriers to care access, and individual behavior. A successful approach to improving outcomes for families requires incorporating human rights and reproductive justice frameworks that not only value lived experiences, but that also center community-led approaches to resolving the maternal health crisis in the US.

In order to tackle racial disparities in maternal and infant health, state agencies must examine health care systems with a race equity lens. Solutions to racial disparities in birth outcomes must be designed with a full understanding of the racial barriers, socially constructed yet systematically upheld, which exclude families from accessing equitable options for healthy living including reproductive choice.

Resources articulating the needs of communities facing the highest risk for poor maternal outcomes, as well as proposed solutions, have already been developed. In 2016, the Center for Reproductive Rights and SisterSong Women of Color Reproductive Collective published "Black Mamas Matter: Advancing the Human Right to Safe and Respectful Maternal Health Care." Using a human rights framework to develop maternal health solutions grounded in reproductive justice, the toolkit highlights poor outcomes as preventable yet resulting from "laws, policies, and institutional practices that can be changed."[18]

Honoring the commitment to a human rights approach in respectful maternity care also ensures government accountability in the core obligations of respect, protection and fulfillment of optimal health care for all people. Additionally, policies must reflect the essential elements of the right to health: availability, accessibility including non-discrimination and economic accessibility, acceptability including culturally respectful care, and quality.[19]

New York State's commitment to the Medicaid Doula Pilot is an important step towards addressing long-standing health disparities. However, to be effective, policies must incorporate input and feedback from community-based leadership and advance their recommendations for family-centered models of care. **Program activities and training must extend beyond traditional doula models of care and incorporate aspects of community-based programs if they are to achieve the Pilot's stated goals of reducing disparities and improving health outcomes.**

Reimbursement rates must be sufficient for doulas to earn a livable wage. Community-based programs must have the capacity to support workforce development and subsidize doula training for a diverse group of doulas to work in a variety of communities. Collaborative relationships need to be established to connect Medicaid and other payers with health professional associations and health care delivery systems to increase uptake of doula services.

Medicaid coverage of doula support is increasingly recognized as a promising model to improve maternal and infant health outcomes, improve the experience of and satisfaction with care, and improve health equity, while reducing or maintaining current levels of health

BENEFITS OF DOULA CARE

Doulas are well-positioned to improve outcomes in communities of color and low-income communities. Doula support has been well-documented to improve health outcomes, enhance care engagement and satisfaction, and reduce spending on unnecessary procedures and avoidable complications.

The benefits of doula care are supported by consistent, high-quality research.[1] Cochrane systematic reviews have reported the positive effects of continuous labor support since 1995.[7] In 2017, the most recent review analyzed data from 26 individual studies involving more than 15,000 women.

The review found numerous benefits to continuous labor support and no known harms of such care, including:

- **39% reduction in the likelihood of cesarean births**
- **15% greater likelihood of a spontaneous vaginal birth**
- **10% reduction in the use of pain medications**
- **Shorter labor by an average of 41 minutes**
- **31% reduction in reporting a negative birth experience**

Other studies have found that community-based doula support that begins during pregnancy and continues through childbirth and the postpartum period is associated with lower rates of preterm and low birthweight births and postpartum depression, while increasing breastfeeding initiation and duration. [2, 3, 8, 9]

In the Safe Prevention of the Primary Cesarean Delivery, the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM), the pre-eminent professional associations for obstetric care, report that **continuous labor support by a doula is "one of the most effective tools to improve labor and delivery outcomes."**[11]

spending. As New York and other states prepare to design and implement Medicaid doula reimbursement programs, approaches must move towards successful implementation by collaborating with and engaging community-based partners. Communities and state agencies must work to build sustainable programs that are equitable for doulas and that have the potential for long-lasting health improvements for women and infants.

Community-Based Doula Models Are Uniquely Suited to Address Disparities

Community-supported birth has always been a fundamental characteristic of healthy pregnancy, childbirth, and parenting outcomes for all people across circumstance, time, or geographic location. Much of the literature on maternal health and reproductive disparities highlights social determinants of health as the drivers of inequity. While poverty and inadequate resources certainly affect quality of life, levels of chronic stress, and health, a singular focus excludes the burden of racism, gender oppression, obstetric violence, and institutional policies that negatively affect pregnant people of color.

Birth workers of color are responding to the maternal health crisis with doula care that is reflective of the needs of families in their local communities. Communal responses to disparities reveal the activation of pregnant people raising their families in environments where resources, dignity, quality care, support and humane treatment are scarce. Solutions for mortality and morbidity in birth actually reside in the resilience of people facing inequity every day.

Racism and implicit bias continue to drive health inequity in the United States. Community-based doula care reflects an organized, collective framework where African American, African immigrant/refugee, Latinx, Indigenous or historically underserved individuals formalize and implement programs with the specific aim of serving their own communities. Fundamental values of support are rooted in individual wisdom and self-determination. These programs are culturally infused, generationally informed, and responsive to years of ongoing oppression resulting in trauma informed actions that pull families together in crisis.

The collective action of community-based doula care supports a pregnant person and their family in the childbearing year. The intimacy and cultural humility provided through that care serve to mitigate effects of inequity and disparities in health care. Health care systems that serve communities of color through a one-dimensional approach in birth continue to contribute to preventable death, complications, and illness. Community-led doula models reframe the current health care model by advancing policy and engagement that reflects improving the quality of medical care, cultural humility, and implicit bias awareness for providers and caregivers.

Situated in the communities they serve, community-based doula programs generally encompass all of the services that private doulas offer, and add additional home visits and a wider array of services and referrals for individuals who need more comprehensive support. Most community-based doulas are members of the community they serve, sharing the same background, culture, and/or language with their clients. Community-based doulas have additional training that supplements the traditional doula education curriculum. Care provided is low or no cost and is grounded in safe, dignified and respectful access to health care.

"We're talking about systemic oppression and if we can't recognize it for our own people then we're not going to know how to annihilate it. Everything is relevant."

- Dawn Wright-El, VBI Community Doula

Organizations like Ancient Song Doula Services, Village Birth International, Black Mamas Matter Alliance, Black Women Birthing Justice, Mamatoto Village, Commonsense Childbirth, Mama Sana Vibrant Woman, Uzazi Village, Tewa Women United, ROOTT (Restoring Our Own Through Transformation), and others work to bridge disparities in maternal/infant health by offering and engaging community members in education, advocacy, policy work and full-spectrum community-based doula care services, as well as by training members of the communities within their immediate areas and across the US.

Research related to community-based doula programs has demonstrated the benefits of this approach.[2, 20] In 2012, an expert panel on the "Promotion and Support of Community-based Doula Programs" convened to evaluate, discuss, and identify key lessons from four years of Health Resources and Services Administration (HRSA) funding of community-based doula programs. This panel found significantly higher breastfeeding rates and lower cesarean rates among participants in community-based doula programs. Specifically, 87% of community-based doula clients were breastfeeding at six weeks compared with 61% of the comparison group; at 3 months, 72% were still breastfeeding compared with 48% of the comparison group.[2] This panel emphasized that "HRSA should continue to promote and expand Community-based Doula Programs with federal funding, based on the uniqueness of the model, the workforce development implications, and the data analysis which identifies significant and important outcomes."

COMMUNITY-BASED MODELS OF PRACTICE AND TRAINING ARE ESSENTIAL

In order to achieve long-standing positive outcomes in maternal health care, it is essential that community-based models of doula care are highlighted and replicated. Community members have the expertise to articulate programmatic models of care and reimbursement rates that will lead to improvements in quality of life and better individual birth outcomes, and as such are essential participants in efforts to shape state policy and institutional practice.

To meet the needs of clients facing complex social, economic and environmental issues, such as homelessness, mental illness, and intimate partner violence, community-based doulas are prepared to and skilled at providing culturally competent, trauma informed, social, emotional, and informational support to their clients. Community-based programs, trainings, mentorship, supervision, and peer support include core competencies nationally recognized for doula certification, as well as additional components that address the need to incorporate a human rights, birth justice, anti-racist, and culturally relevant framework that clearly defines and addresses disparities and strategies to engage with families experiencing institutional racism and discrimination in health care. Training, mentorship, supervision, and peer support includes navigating the social determinants of health affecting birth disparities, a full understanding of local resources and referral options, and applying a reproductive justice framework.

Traditional doula organizations historically have not centered the leadership, voices, or experiences of people of color or low-income communities. These are key tenets of community-based doula organizations. Traditional doula trainings provide a doula with the skills to provide unconditional, non-judgmental support, but lack a historical, educational cultural context on how race, institutional and interpersonal bias, and other social determinants play an integral role in birth disparities affecting communities of color. Under traditional models, doulas are trained in an entrepreneurial private practice framework that differs in purpose and mission from community-based doula work.

Community-based doula programs add multiple prenatal and postpartum home visits, referrals to comprehensive support, and additional resources, to the services typically provided by a traditional doula.

Standard or traditional doula trainings typically prepare doulas to work as independent entrepreneurs immediately following their training. They do not include ongoing supervision or mentorship, as is common in community-based programs. A typical doula training consists of 16 hours of group classroom time, after which new doulas have one to two years to independently complete any program requirements for certification. Trainers can be from locations other than where they are conducting the training, which usually do not include information specific to any particular area or community.

COMMUNITY-BASED DOULA PROGRAMS IN NEW YORK

Ancient Song Doula Services and Village Birth International have been providing community-based doula support in New York State for ten and eight years, respectively. These organizations were formed by women of African descent who directly experienced the hardships of the maternity care system in the US. The founders' lived experiences were the catalysts that prompted them to organize and frame practices that would improve the lives of others in their communities. The human rights and reproductive justice frameworks, as defined below, are fundamental to all services provided. As kindred partners and collaborators in the Black Mamas Matter Alliance, Ancient Song and Village Birth International not only work to ensure respectful maternity care and center solutions for the black maternal health crisis, but also develop policies that have a positive impact on the families they see every day. The following sections describe the principles, strategies, and priorities of their work.

Principles of Practice for Community-Based Doula Care

The principles of practice embedded in community-based doula programs differ from the model of care practiced by traditional doulas. Community-based doula programs best meet

the needs of communities of color, low-income communities, and other communities facing barriers and disproportionately poor health outcomes, when they:

Community-based doulas lead with the understanding that choice, access and informed, shared decision-making in pregnancy, childbirth, and reproductive care are central to improving outcomes. Listening to and valuing the autonomy of pregnant people guide supportive responses.

- **Incorporate a human rights framework** to address physical, emotional, psychological, and social elements of health in order to create the best outcomes for pregnant people and babies. The fundamental right to health is centered and focuses on making sure services are available, accessible, acceptable and of excellent quality.
- **Are rooted in an understanding of racism and** discrimination, including the historical trauma of racism and implicit bias and their impact on maternal health disparities and the reproductive health of pregnant and parenting individuals.
- **Center a culture of care recognizing the intersections of health and racial equity**, the interrelation of health and equity, and the relationship of health equity to a pregnant person's access to care and their choices of care providers.
- **Address intergenerational trauma of people of color** and centered communities to incorporate their lived experiences and recognize the direct impact of trauma and stress on infant and maternal health.
- **Are community-based,** meaning that participants either are trusted members of the communities they serve, come to birth work with a broad range of complex experiences that mirror the communities they serve, or have a deep understanding of these communities.
- **Expand the traditional doula framework** beyond the perinatal, birth, and postpartum periods to a model that connects maternal health advocacy and direct engagement with the communities in which we live in the US.
- **Provide a platform for solution driven responses** to long-standing infant and maternal mortality and morbidity.
- **Adopt a life-course perspective**, recognizing that respectful maternity care includes reframing the experience of childbirth not as a single medical event, but as a series of experiences over a person's lifespan that transition the individual into parenthood.
- **Support the development of a Reproductive Life Plan** that provides non-directive, non-coercive, and fully informed options that are family driven and culturally relevant.
- **Prioritize the self-determination, compassion, and trust in the individual wisdom of families served.** Community-based doulas lead with the understanding that choice, access and informed, shared decision-making in pregnancy, childbirth, and reproductive care are central to improving outcomes. Listening to and valuing the autonomy of pregnant people guide supportive responses.
- **Value collective models of care** that enable doulas to support groups of pregnant people together as they build lasting relationships during the transition to parenthood. Prenatal and postpartum care offered in communal spaces to support mental health, education, and promote healing between pregnant families facing disparities or adversities in reproductive care. These communal healing spaces are used to mitigate the effects of toxic environments and increase community-based problem solving.

Professional Standards of Community-Based Doula Care

Professional standards establish that community-based doulas are expected to:

- **Inform clients about their human right to respectful care and shared decision-making,** including informed consent, refusal without reprisal, and choosing treatment alternatives free from fear-based coercion.
- **Evaluate evidence-based research findings and current best practices**, understand the strengths and limitations of such studies, and trust the pregnant person to make the best decision as the expert regarding their own care.
- **Understand the complex identity of the pregnant person** they are supporting.
- **Learn to use advocacy tools and methods of communication to ensure that the pregnant person is centered in a position of agency** in relation to the hospital staff and other care providers attending the birth. These strategies encourage the provider to listen more than speak, to be aware of their power, and to provide care that allows for clients to exercise agency and empower themselves.
- **Provide non-clinical care including physical comfort measures, emotional support, informational assistance, and client advocacy** during childbirth, the postpartum period, and abortion (in full-spectrum programs).
- **Abide by Standards of Practice and Code of Ethics as set by the certifying agency.**

Core Competencies

The following core competencies reflect the skills, knowledge, and attributes needed by a community-based doula to carry out their responsibilities, grouped to indicate which are shared by doulas in community-based and traditional roles and which are unique to the community-based model.

All doulas should develop and maintain their skills in the following areas:

Shared by Both Traditional and Community-Based Doulas

- Understanding of anatomy and physiology as related to the childbearing process;
- Capacity to employ different strategies for providing emotional support and resources;
- Skills providing a wide variety of labor coping strategies;
- Strategies to foster effective communication between clients and clinicians by employing a range of positive communication techniques;
- Awareness of allopathic and holistic health care systems and various modalities of care that doulas can refer clients to in order to address client needs beyond the scope of the doula (e.g. acupuncture)
- Knowledge of strategies for supporting breastfeeding/chestfeeding, breast-milk feeding, and lactation.

Community-based doulas are prepared to and skilled at providing culturally competent, trauma informed, social, emotional, and informational support to their clients.

Unique to Community-Based Doulas

- Understanding of ways that social determinants affect pregnancy, childbirth, and the postpartum period and the local resources available to support families, including transportation assistance, financial support, mental health resources, substance abuse counseling, incarceration advocacy, access to health services and insurance, housing assistance, environmental justice-toxic lead conditions, immigration assistance, and others
- Understanding process and importance of making referrals to appropriate social support services and follow-up (including WIC, housing, case management) and

community-based health care systems that promote the advancement of the pregnant person and community

- Skills providing lactation support including sharing knowledge of the significance and impact of breastfeeding for families facing health disparities, including a thorough understanding of structural, physical and emotional barriers to breastfeeding in communities of color, low-income communities, and the communities doulas plan to serve
- Understanding of reproductive justice and birth justice frameworks and how they intersect
- Cultural sensitivity to the lived experiences of people of color, Indigenous people, people in low-income communities, and an understanding of the impact of structural racism and implicit bias role in accessing care, experiences of care, and birth outcomes
- Modalities of practice that are culturally sensitive and relevant to the pregnant person's needs based on an understanding of experiences that may reflect societal, institutional, or interpersonal bias
- Cultural humility and recognition of the intersectional needs of the childbearing person across the reproductive health spectrum
- Various strategies to address structural and institutionalized racism and intergenerational trauma (i.e. trauma informed care)
- Understanding of the value of community representation in the doula workforce, recognizing the benefit of families being served by individuals who share ethnic, racial, and cultural backgrounds as well as lived experiences in transitioning to parenthood
- Incorporate doula skills to support individuals throughout their reproductive life course.

"Community doulas being there is a way to help a sister make these disparities better. Reminding people that they're not a burden is very important."

Tanaya Thomas Edwards, VBI Community Doula

Elements of Community-Based Doula Practice

Doulas should be prepared to offer the following to their clients as appropriate:

Shared by Both Traditional and Community-Based Doulas

- Information and support on general health practices that enhance normal functioning pertaining to pregnancy, childbirth, postpartum, and the newborn
- Evidence-based information on the uses, benefits, and risks of medical interventions, pain medications, and Cesarean birth
- Unconditional, continuous support, and care for the laboring pregnant person and their support people/person with attunement to their physical, emotional, and psychological needs
- Emotional support, physical comfort measures, and physiological pain management techniques to assist coping with labor and birth and guidance to help navigate decisions and avoid unnecessary medical interventions
- Guidance to help navigate decisions and avoid unwanted and unnecessary medical interventions
    - Explanation of medical procedures, interventions, inductions, or Cesarean
    - Initial breastfeeding and newborn care support
    - Ongoing support for partner or anyone else present at the birth
- Evidence-based information on infant feeding, general breastfeeding guidance and referral to lactation resources as needed

- Make appropriate referrals in allopathic and holistic health care systems to address client needs beyond the scope of the doula
- A collaborative approach to working with pregnant people and their chosen care providers and support community
- Encouragement of bodily autonomy, advocacy, and informed consent for the pregnant person and newborn
- Education on infant soothing techniques and coping skills for new parents.

Unique to Community-Based Doulas

- Evidence-based pre-conception, inter-conception and post-partum education and resources that can improve childbirth-related outcomes
- Collaboration with other health care and social service providers when necessary (including transportation, housing, alcohol, tobacco, and other drug (ATOD) cessation, WIC, SNAP, and intimate partner violence resources)
- Referrals and assistance obtaining appropriate social support services and follow up (including WIC, housing, case management) and community-based health care systems that promote the advancement of the pregnant person and community.
- Assistance in preparing for and carrying out a pregnant person's plans for their childbirth that affirms their race, gender, sexuality, and cultural and religious beliefs, practices, and traditions
- Support achieving Respectful Maternity Care for the family and aligning values of care as articulated in the Black Mamas Matter Alliance toolkit, including that all women have the right to respectful maternity care that supports healthy pregnancies and birth
- Trauma informed care practices
- Community education and engagement. Community-based doulas as reproductive and maternal health educators to mobilize and inform families on choices for improving health outcomes in the childbearing year
- Continuity of Care: Providing support and resources to the family from birth through the baby's first year

Medicaid Pilot Models

NEW YORK PILOT MODEL

The NY State Department of Health has made the details of the New York State Medicaid Doula Pilot Program available on their website and has shared it with community organizations. Implementation was set to begin on March 1, 2019 in Erie County (Buffalo), with implementation in Onondaga (Syracuse) and Kings (Brooklyn) Counties on hold until sufficient numbers of doulas have registered to participate. The pilot will be available for anyone enrolled in Medicaid in fee-for-service or managed care plans who reside in those counties, which were selected for their high maternal and infant mortality rates and high number of births covered by Medicaid.

All participating doulas must apply for enrollment with the state and are required to provide a doula training certificate or proof of doula training and must also meet the following requirements for training:

- At least 24 contact hours of in-person education that includes any combination of childbirth education, birth doula training, antepartum doula trainings, and postpartum doula training
- Attendance at a minimum of one (1) breastfeeding class
- Attendance at a minimum of two (2) childbirth classes
- Attendance at a minimum of two (2) births
- Submission of one (1) position paper/essay surrounding the role of doulas in the birthing process
- Completion of cultural competency training
- Completion of a doula proficiency exam
- Completion of HIPAA/client confidentiality training

The scope of services for the project allows up to 4 prenatal visits ($30/visit), intrapartum care ($360), and up to 4 postpartum visits ($30/visit) for a total of $600 for all services. Fees were calculated at approximately 43% of NY OB/GYN professional fees and 50% of midwifery services fees. Doulas must bill for each visit and at this time must do so as individual providers, rather than through an organization billing on behalf of the doulas who work with them.

MEDICAID COVERAGE IN OTHER STATES

Statewide, Oregon Medicaid reimbursed a total of:

- **41 claims in 2016**
- **27 claims in 2017**
- **24 claims between January and June 2018.**

The New York Pilot has been based in large part on similar efforts in Oregon and Minnesota. While these two states, the only ones with statewide coverage, deserve recognition for being early adopters of Medicaid doula coverage, implementation has proven difficult. A careful look at the history of these programs indicates that the states' laudable efforts to innovate should serve as a starting point for further refinement.

In these states, doulas can bill independently or have a physician or midwife bill on their behalf and then collect the fee from that health care provider. In Minnesota, doula agencies or organizations can also bill on their behalf for doula services. An examination of the design of these programs provides valuable insight into the challenges of implementation and offers lessons learned to move forward in developing a new model, such as the New York Pilot.

Oregon

In 2013, Oregon became the first state to include birth doula services in Medicaid coverage, based largely on their potential to reduce health disparities. Under Oregon's program, trained birth doulas can register to become "Traditional Health Workers (THW)," a parallel profession to Community Health Workers.[i] THW doulas are eligible to bill for two prenatal visits and two postpartum visits ($50/visit) and intrapartum care ($150) for a total fee of $350 under fee-for-service Medicaid. Some doulas have been able to negotiate higher rates with individual Medicaid coordinated care organizations.[21]

[i] The other four categories of THWs are community health workers, personal health navigators, peer wellness specialists, and peer support specialists.

Structural barriers in the state's THW doula certification and reimbursement systems have resulted in low participation rates by doulas, and the program has been unable to achieve its goals. **As of 2018, utilization was still extremely low, with just 121 claims for doula services having been submitted and 92 reimbursed between January 2016 and June 2018:**

- 41 claims reimbursed in calendar year 2016
- 27 claims reimbursed in calendar year 2017
- 24 claims reimbursed between January 2018 and June 2018
- 24% of claims submitted were denied (29 of 121 claims). [22]

THW birth doulas have reported that low reimbursement rates and significant barriers in the billing process have deterred widespread utilization. Additional barriers include a lack of support for doulas by the medical community, a lack of funds for doula trainings, limited doula services in rural areas, challenges accessing state certification requirements, and difficulties navigating the state doula/THW certification process. [22]

In order to address these barriers and the low utilization of Medicaid reimbursement for birth doula services, the non-profit organization Heart of the Valley Birth and Beyond obtained grant funding to create the Community Doula Program (CDP) in Corvallis, Oregon. The CDP has trained three cohorts of doulas (a total of 88 doulas trained) - the majority of whom represent and have the capacity to serve Oregon Health Authority's priority populations. Program staff also are responsible for coordinating referrals, socially and culturally-matching doulas with clients, as well as managing billing and reimbursement. The CDP also provides peer-to-peer mentorship, support, professional development and continuing education opportunities for CDP doulas. In addition to increasing the accessibility and availability of doula trainings and births, the CDP is collecting health outcomes data and conducting a qualitative assessment on the experience of CDP doula care from the perspective of clients, doulas, collaborating providers and referrers.[21]

In 2018, the Minnesota legislature voted to increase Medicaid reimbursement rates for doula care to $47 for each home visit and $488 for each birth, 57% and 36% higher than in New York State.

Minnesota

In 2014, Minnesota also launched a Medicaid doula reimbursement program in fee-for-service and managed care plans. Like Oregon, Minnesota's program was intended to respond to racial and geographic disparities in maternal and infant health outcomes, and like Oregon, it has experienced substantial barriers to implementation. In **Minnesota**, certified doulas who become registered with the state are eligible to bill up to a total of $411, for attending the birth plus 6 visits either prenatally or postpartum.[23] Challenges in Minnesota have included low reimbursement rates, doulas experiencing difficulties enrolling as providers with managed care organizations, and the need to bill under the NPI of an independent (not MCO-employed) licensed midwife or physician. Representation of communities of color among trainers and doulas is limited by the low fees and also by the costs of certification and registration.

In 2018, the Minnesota legislature introduced a new bill to increase Medicaid reimbursement rates for doula services, to increase utilization of doula services. Prenatal and postpartum visits would be raised to $47 and labor and birth support to $488, for a total reimbursement of $770. The bill passed both the Minnesota House and Senate, but ultimately was not signed by the governor, because it had been inserted into a large omnibus budget bill that included unrelated and highly contentious provisions.[24] The same bill (HF 259 / SF 1044) has been reintroduced in the 91st Legislature (2019-2020) and is expected to pass and go into effect later in 2019.

LESSONS LEARNED FROM EARLY IMPLEMENTATION EFFORTS

Including community-based organizations as partners in the work of program development and implementation would help avoid the problems encountered in Oregon and Minnesota. In particular, community organizations have the knowledge, expertise, and relationships needed to identify feasible reimbursement rates, to appropriately lead and mentor a diverse community of doulas through training, certification and service provision, and to support the process of applying to become a state-recognized service provider.

In both states, the extremely limited implementation has deterred additional doulas from registering with Medicaid until they see evidence of the program's effective operation. Community-doula organizations, academics, and advocacy groups have made a number of financing and policy recommendations to improve the implementation of these programs and to ensure that future programs take lessons learned into account. These recommendations emphasize the need to:

- Increase doula reimbursement rates
- Utilize grant programs or other outside funding sources to support workforce development and subsidize doula training
- Increase diversity of doulas and their availability in underserved urban and rural communities
- Develop collaborative relationships connecting various stakeholder groups including Medicaid, other payers, health professional associations, and health care delivery systems, to increase uptake of doula services.

Reimbursement Rates

For a Medicaid doula pilot to operate and become sustainable, reimbursement rates must allow community-based doulas to support themselves and their families at a living wage. Currently, New York State rates are set at $30 for each prenatal and postpartum visit (up to 4 of each), and $360 for attendance at the birth, for a maximum total of $600.

Doulas already serving low-income communities and communities of color in Kings County have reported to their programs' supervisors that the low rates are a deterrent to their participation in the Medicaid pilot. Shortly before the March 1, 2019 pilot launch, few doulas from Kings County had registered with the state, leading the state to delay implementation in Kings County. Because low reimbursement rates have also been a leading reason cited for low participation in Medicaid coverage in other states, this section will detail why compensation rates must be increased and will identify alternatives that are better aligned with the types of services community-based doulas provide and the time spent with clients.

The method that NY Medicaid has employed to determine rates - setting doula reimbursement levels at a percentage of physician and midwife rates - is inherently problematic. Physicians and midwives are compensated for their time at substantially higher rates than doulas, which is appropriate given the differences in training, roles, and

level of responsibility.[ii] However, the amount of time doulas spend with clients and performing unbillable responsibilities, as well as their expenses and unpredictable work hours must be taken into consideration when setting reimbursement amounts, if Medicaid doula coverage is to succeed.

Several additional rationales support significantly increasing current rates:

- At planned rates, doula compensation would fall below the equivalent of the minimum wage for New York City.
- Planned Medicaid rates are significantly lower than those of all three doula programs currently serving communities of color in Kings County (Ancient Song Doula Services, By My Side Birth Support Program, and Healthy Women Healthy Futures).
- Recent pilots and proposed legislation are setting rates higher than those planned by New York State.
- Proposed rates are significantly lower than the rate at which doula support would "break even," according to recent studies that each considers just a subset of the expected health care cost savings.[3-5]

Provider Medicaid reimbursement levels vary significantly by state and Medicaid is currently compensating midwives and physicians at rates so low making childbirth related care a "loss-leader," particularly for uncomplicated vaginal births.[25] Rather than extending that philosophy to create a new group of undercompensated health professionals, payment rates must be re-calibrated to achieve the best health outcomes possible for the resources expended and fair compensation for the workforce.

PHYSICIAN AND MIDWIFE PAYMENTS ARE NOT APPROPRIATE BENCHMARKS FOR DOULA RATES

Fair and reasonable reimbursement rates cannot be calculated using physician and midwife fees as a benchmark or comparator, because this approach overlooks fundamental differences between the workflow, costs incurred, and employee status of the two groups.

- Community-based doulas spend considerably more time with a person than health care providers in clinic and hospital settings.
- Doulas are independent contractors who do not receive employee benefits and incur out of pocket expenses.
- Doula work includes considerable uncompensated time that should be reflected in rates.

Doulas spend 6 to 11 times as much time with clients as do health care providers working in a hospital or clinic setting.

[ii] The rates paid by NY Medicaid to health care providers for uncomplicated vaginal births are currently under-reimbursed and are too low to be sustainable unless they are balanced out by other types of fees (e.g. private insurance or out of pocket payments for vaginal birth, or other revenue sources such as cesarean births and other surgical procedures). This is relevant because community-based doulas are unlikely to have other sources of income, making low Medicaid rates particularly onerous.

Typically, routine prenatal and postpartum visits with a health care provider last about 15 minutes [26] or less, whereas a community doula spends on average two hours with a client at prenatal and postpartum visits, usually meeting at the client's home, with the attendant round trip travel time.

If a pregnant person is already enrolled in Medicaid, can access prenatal care without delay, and receives the recommended 14 visits[27] plus one postpartum visit at 15 minutes each, that would total approximately 225 minutes, or 3.75 hours, of time spent in prenatal and postpartum office visits.[iii] By contrast, a community-based doula attends 8 prenatal and postpartum visits that each last approximately 2-hours for a total of 16 hours. Additionally, doulas are available for responding to texts, emails, and calls throughout the weeks or months they are supporting their client and spend significant time traveling to and from each visit at the client's home.

Community-based doulas spend an average of 6 to 11 times as much time per client than health care providers.

The discrepancy in time holds true for labor and childbirth. During labor, the health care provider checks in periodically and attends the last stages of birth, usually only until the end of their shift. Health care providers in hospitals are generally responsible for several patients at once and usually spend less than two hours with a patient in labor and childbirth including both periodic checks and attendance at the actual birth.

By contrast, birth doula care is defined explicitly as "continuous" labor support throughout labor and childbirth, ranging from a few hours to a few days and averaging about 18 hours.[22, 28] Doula support begins in a client's home and continues until an hour or so following childbirth, reflecting a considerably longer time commitment than that of the health care provider. (See Table 1. for a detailed comparison of time spent with a patient or client by healthcare providers and community-based doulas).

TABLE 1: ESTIMATED TOTAL TIME SPENT PER PATIENT, BY SERVICE TYPE

	Health Care Services				Community-Based Doula Services		
Activity	Number of visits	Hours per visit	Total Hours		Number of visits	Hours per visit	Total Hours
Prenatal Visits	14	.25	3.5		4	2	8
Postpartum Visits	1	.25	.25		4	2	8
Labor/Birth	1	2	2		1	18	18
Remote client support - phone, text, email							2
TIME (excluding transportation)			5.75 hrs				36 hrs
Time transportation - home visits + birth	-	-			9	1	9
TOTAL TIME			5.75 hrs				45 hrs

[iii] This is a conservative estimate. Numerous barriers to entering care and attending office visits, particularly for people with low-wage jobs and/or complex social needs result in pregnant people often attending fewer than 14 prenatal visits. Frequently, those visits are shorter than 15 minutes.

Doulas generally work as independent contractors, whereas health care providers for the majority of Medicaid enrollees in New York City are likely to be employees of the medical centers where they work.

Doula coverage rates that appear modest but feasible in comparison to those of hospital staff, may be untenable considering doulas' added expenses. Doulas have to pay out of pocket for expenditures that salaried employees do not, either because they receive them as part of their employment arrangement such as benefits (e.g. health insurance, vacation time, etc.) and supplies, or because they do not incur them (e.g. transportation expenses of home visits and costs related to highly unpredictable work hours).

In 2018, the U.S. Department of Labor's Bureau of Labor Statistics calculated that, on average, employee benefits were valued at 46.3% of employee salaries.[29] In other words, a doula would have to pay approximately 46.3% of their income to get benefits that an employee with an equal income would obtain from their employer. This includes paid vacation time, sick leave, unemployment insurance, health and dental insurance, and retirement contributions. Health insurance alone, even when purchased on the NY State insurance exchange with subsidies, can cost hundreds to thousands of dollars a year for an individual, and nearly three times as much for a family.

On average, in 2018, the US Department of Labor reported that:

Employer-paid benefits increase employee salaries by an average of 46%.

Department of Labor Reported Averages for Civilian Employees [29]

Transportation costs in New York City add to doula's out-of-pocket expenditures. In Kings County, many doulas depend on public transportation to reach clients for home visits, adding approximately $5.50 to the cost of providing a single prenatal visit (currently billable at $30 per visit). When a client goes into labor, often in the middle of the night, safety concerns and lengthy nighttime subway waits often make a taxi the most appropriate option for reaching a client promptly. Taxi rides can surpass $20 each way, and parking fees in New York City are comparable, with street parking often unavailable. Doulas are also responsible for purchasing their own supplies, which may include a computer, printer and other equipment as well as items that cannot be reused and must be replaced or replenished after each birth.

Doulas also face added childcare costs associated with their inconsistent schedules. Doulas with children need flexible and last-minute childcare options in order to be on call at all times, because of the unpredictable timing of birth. Reasonable child care options, like group daycare, is not generally available during evenings and nights and is not usually available on a last-minute, drop-in basis.

Doula support includes significant uncompensated time outside the hours spent providing home visits or attending a birth.

Doula fees must also cover their time providing remote support by text, phone, and email, as well as un-reimbursable time spent traveling to each home visit, and the several weeks spent "on-call" around the time of the client's birth. Being on call and providing home visits at the convenience of the family can make it difficult or impossible to schedule other work into the available gaps, inevitably creating pockets of time when the doula cannot schedule paid work.

RATES DO NOT CONSTITUTE A LIVING WAGE AND ARE NOT EQUITABLE

Fee-for-service reimbursement rates would not meet the benchmark set by New York City's minimum wage.

Community-based doulas would receive the equivalent of $5.58 per hour for each 2-hour home visit in New York, when including travel time, subway costs, and benefits.

New York State plans to reimburse each prenatal and postpartum visit at $30 per visit. Paying on a fee-for-service basis is the norm under Medicaid. Both private and community-based doulas are also generally paid either in a fee-for-service model or at a set rate for a package of services. While an hourly minimum wage is not directly applicable in a fee-for-service context, an hourly minimum wage can serve as a benchmark when determining appropriate rates.

Community-based doulas spend about two hours with a client when conducting each home visit.[iv] Time may be spent providing information, education, and emotional support; performing needs assessments; preparing the client and planning for labor, childbirth, breastfeeding, and parenting; building trust with the client; making and following up on referrals; screening for depression, intimate partner violence, and food insecurity; providing lactation support and information; supporting reproductive life planning; assisting with and educating about newborn care; and fostering bonding and attachment between baby and family members. These responsibilities require a significant investment of time.

New York City's minimum wage is $15.00 for employers with more than 11 employees and $13.50 for employers with 10 or fewer employees in 2019, increasing to $15.00 in 2020. Given that a prenatal visit with a doula lasts 2 hours, the fee would just meet the minimum wage if the visit were performed in an office. However, because travel to a home visit costs a minimum of $5.50 for a round trip on the subway or bus, once a doula pays out of pocket for public transportation, the compensation falls to $24.50 for two hours, or just $12.75 an hour. That calculation excludes the hour of round-trip travel time that is common for subway trips between 2 locations in Kings County. If a doula receives $30 for a home visit that lasts 2 hours, requires 30 minutes of travel each way, with a subway cost of $5.50 (round trip), the doula will have $24.50 after expenses for three hours of time, **the equivalent of $8.17 per hour required to complete the visit.** As addressed above, that amount would not be supplemented by employer-provided benefits. Accounting for employee benefits valued at 46.3% of employee salaries,[29] $8.17 per hour without benefits is the equivalent of a full time job that pays **$5.58 per hour plus benefits.**

Medicaid fees fall well below rates in existing Kings county community doula programs.

Three local programs currently compensate community-based doulas providing support for members of low-income communities and communities of color in New York City: Ancient Song Doula Services (ASDS), funded through private grants and donations; Healthy Women Healthy Futures (HWHF), funded by New York City Council; and the By My Side Birth Support Program (BMS), which receives federal funding and operates as part of Healthy Start Brooklyn. In those programs, doulas are paid for prenatal and postpartum

[iv] While the state has not set a required length of time for home visits, that is how long ASDS, VBI, and HWHF programs allot based on their experience operating community-based doula programs, and this length of time is consistent with the operation of other similar programs.

visits, and attendance at the birth at rates between nearly 2 to 3 times those proposed by the state. (See Table 3).

Currently, other Kings County based programs cover between 3 and 5 prenatal visits and 3 to 10 postpartum visits as well as attendance at the birth. Hourly compensation for doulas ranges from $25 per hour for HWHF to $37.50 per hour for BMS doulas with over a year of experience. Compensation for the birth alone ranges from $400 for a new doula with less than a year of experience at BMS to $500 for an experienced doula at BMS and all HWHF doulas, to $575 at ASDS.

The total rates of compensation for the three programs range from $900 to $1,555 for a full complement of services. The total number of hours doulas in these programs spend with clients ranges between 34 hours (assuming an average length of labor of 18 hours) and 57 hours, which amounts to 6 to 11 times the total amount of time a health care provider in a clinic and hospital setting would spend with a patient. (See Table 2). ASDS has the highest total payment, but BMS and HWHF cover additional services or costs for the doulas that either reduce out of pocket expenditures or provide additional income. HWHF covers travel costs to home visits, monthly program meetings, and births (including taxis for late-night travel), and BMS pays doulas $35/hr for attendance at monthly administrative meetings, taxis to and from births late at nights, and occasional required trainings in addition to a $75 per-client fee for completing all required documentation forms and data entry.

Three Kings County community doula programs pay 1.5 to 3 times as much as NY Medicaid in the same communities.

NY State has indicated that its set reimbursement fees are based on those in Oregon and Minnesota, but those rates have been demonstrated to be too low to permit doulas to participate in areas where the cost of living is significantly lower than New York City. In Minnesota, state legislation passed the legislature in 2018 which would increase rates to $47 per prenatal and postpartum visit and to $488 for doula services during labor and birth.[30] The package of 6 home visits ($282) with the birth would total $770. However, the cost of living in New York, particularly in Kings County and other parts of New York City, is higher than Minnesota's. Moreover, the market rate for doulas in New York City, the cost of doula services ranges as high as $4,000 or more (see NYC Doula Collective and Birth Day Presence) compared with $800-$1200 in Minnesota. Coverage rates in New York should be higher to reflect those differences.

New York State programs operating with fees comparable to proposed Medicaid rates have been unsustainable.

Village Birth International and Healthy Women Healthy Futures have each previously had contracts setting service reimbursement rates between $500 and $600, and have determined from experience that those rates are too low. VBI was previously contracted by Healthy Start Syracuse to provide doula services for a total of $500 for prenatal, intrapartum, and postpartum care. After two years, that amount was increased to $600. However, doulas found even the higher amount to be insufficient, because they had to maintain other sources of income and because of the challenges of completing required billing paperwork. Similarly, Healthy Women Healthy Futures has increased rates for childbirth and home visits from $550 in 2015 to the current total of $900.

Medicaid rates fall below rates in place or proposed in other states. (See Table 3).

Higher Medicaid reimbursement rates are already being implemented and included in new legislation. Legislation introduced in Massachusetts sets the reimbursement for the episode of care at a maximum of $1,500, with rates per service not yet determined.[31]

In Los Angeles, a new pilot program recently been established to improve birth outcomes for African American women and infants. It was developed by Health Net, one of the largest Medi-Cal HMO providers in California, which is partnering with the Association for Wholistic Maternal and Newborn Health, a local community-based organization. Health-Net is covering the cost of doula services, as well as training, mentoring, and supervision for doulas from the communities to be served, as well as covering the associated administrative and overhead costs. The program aims to reduce cesarean rates, low birth weight and prematurity, and maternal stress and anxiety. The program also seeks to increase breastfeeding initiation and maternal satisfaction with the childbirth experience. Contracted reimbursement rates are $100 for each of 6 home visits and $1250 per birth.[32]

New York State notes that the New York pilot rates are above those currently in place in Oregon and Minnesota. The lower cost of living in those states make them poor comparators for New York City, but more importantly, the existing rates in Oregon and Minnesota have not led to successful implementation. The limited implementation has been primarily from community-based organizations where temporary grant funding can supplement Medicaid reimbursement.

Both Oregon and Minnesota are continuing to review and consider increases in reimbursement rates. In Oregon, a law enacted in 2017 (HB 2015) requires the Oregon Health Authority (OHA) to review and revise reimbursement rates every two years and provide an annual report to the legislature on the status of doulas in the state.[33]

EQUITABLE REIMBURSEMENT RATES ARE COST-EFFECTIVE BASED ON SHORT-TERM AND LONG-TERM BENEFITS OF DOULA CARE

Like Oregon and Minnesota, New York has recognized that the primary benefit of doula support is its potential to improve health outcomes, health equity, and respectful and satisfying care experiences. However, rising health care costs require Medicaid programs to consider the financial impact of their decisions. For community doula support to succeed, doulas must be paid an appropriate living wage, and their fees should not be limited in any way by the capacity to demonstrate cost savings. Fortunately, research demonstrates that community-based doula support results in substantial cost savings in both the short and long term, which permits doula care to be appropriately reimbursed without increasing Medicaid spending.

Support by a trained doula during labor and birth results in:

- **fewer cesareans**
- **shorter labor**
- **fewer negative birth experiences**

Cochrane Review [1]

In the US, four of every five dollars spent on childbirth related care is concentrated on the care provided during the childbirth hospital stay,[34] signaling the undervaluing of and underinvestment in the prenatal and postpartum periods. Currently, there are multiple opportunities to reduce spending during the childbirth hospital stay and avoid future medical costs, and it is the opportunity to achieve these savings that make community-based doula programs a high value model.

Studies from three states (Minnesota, Oregon and Wisconsin) have concluded that Medicaid reimbursement of doula care holds the potential to achieve cost savings even when considering just a portion of the costs expected to be averted.[4, 5, 20]

Medicaid coverage of doula support has been found to reduce spending by as much as $1450 per birth.[5] Existing studies have focused on the cost savings that are easiest to track and are realized in the short term: lower rates of preterm birth and a reduction in cesarean rates.

High rates of cesareans and neonatal intensive care unit admissions are key drivers of high maternity care costs. Both of these rates can be reduced with community-based doula support. Cesarean rates have risen by 50% over the last two decades and now account for one of every three births,[35] despite the fact that they have been associated with rising complications and no improvements in health outcomes for either the mother or the infant.[11] There is widespread recognition that this rate is too high and national quality improvement efforts are focused on bringing those rates down. Because cesareans cost approximately 50 percent more than vaginal births, a reduction in their rates will have a significant impact on reducing costs.[6]

High rates of preterm birth resulting in NICU admissions similarly lead to health care costs of at least $26 billion annually.[36] In the US, one in ten babies is born prematurely and the risk is higher for low-income communities and communities of color.[37] The additional prenatal support provided by community-based doulas has been associated with a lower risk of preterm birth and low-birthweight infants, [8] and continuous labor and birth support by a doula is linked to reductions in cesareans.[1, 2]

Eliminating spending on non-beneficial procedures, avoidable complications, and preventable chronic conditions would each contribute to significant savings that would cover the cost of doula care.

In Minnesota, in one study, women who received services from community-based doulas, including 4 prenatal visits had a 4.7% lower preterm rate compared to 6.3% of regional Medicaid beneficiaries and a 20.4% cesarean birth rate compared to 34.2%.[3] In this study, savings were associated with doula support, when doulas were reimbursed up to an average rate of $986, with numbers ranging from $929 - $1,047 across states depending on several variables.

In a second study evaluating the cost-effectiveness of doula care, researchers in Oregon designed a model to compare outcomes of women with a trained doula versus women without a doula using a theoretical cohort of 1.8 million women. In this study, having doula care saved $91 million and increased QALYs (quality-adjusted life years) for the first and second delivery by 7,227.[5] These outcomes were attributed to 219,530 fewer cesarean deliveries, 51 fewer maternal deaths, 382 fewer uterine ruptures, and 100 fewer hysterectomies. This study demonstrated a cost-effectiveness of up to $1,452 per doula-attended birth and concluded that having a trained doula during a woman's first delivery leads to improved outcomes, decreased costs, and increased QALYs. The study additionally recommends an increase in the reimbursement rate for doula care, as a way to promote better outcomes for women.

These short-term, easily-estimated cost savings -- based primarily on calculations of the reduction in spending on cesarean sections at the time of a single pregnancy and birth -- reflect just a small portion of the spending that would be avoided in the subsequent months and years. Additional savings would be expected to result from reducing unnecessary downstream spending by preventing or reducing the severity of complications and avoiding costly rehospitalizations and chronic conditions requiring long-term treatment, care, and

cost. Particular savings would be achieved by avoiding repeat cesareans, because currently 87% of births following a cesarean result in a repeat cesarean.[38]

Among the complications and costs that could be avoided with doula support are the following:

- Cesareans have been associated with an increased risk of long-term as well as short-term complications.[39, 40] The risk of severe maternal complications is three times greater following a cesarean which also results in greater chance of hospital readmission.[39] Risks are magnified in subsequent pregnancies, with the risk of several serious types of placental complication rising exponentially with each repeat cesarean.
- Systematic reviews have found that babies born via cesarean face an increased risk of breathing problems and chronic diseases such as asthma,[41] Crohn's disease,[42] Type 1 diabetes,[43] allergies,[44] autism spectrum disorder,[45] and obesity.[46]
- Care provided by trained, experienced doulas has been found to increase the establishment and duration of breastfeeding. Increasing breastfeeding has been a top public health priority because it is linked to reduction in the risk of asthma, obesity, diabetes and ear infections in babies, and the risk of heart disease, obesity, diabetes and breast and ovarian cancers in women.[47, 48]
- Studies have found that peer postpartum support (such as that provided by a community-based doula) may help identify and reduce postpartum depression and improve parent- infant interaction.[9, 49]
- Other factors that would contribute to cost savings include reduced use of epidural pain relief and instrument assisted births.

"The rapid increase in the rate of cesarean births without evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused."

– Safe Prevention of the Primary Cesarean Delivery. Consensus Statement of the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine, March 2014.

In sum, eliminating spending on non-beneficial procedures, avoidable complications, and preventable chronic conditions would each contribute to significant savings that would cover the cost of doula care and contribute to health benefits that will continue well into the future.

Conclusion

Medicaid coverage of community-based doula support is increasingly recognized as a promising model to improve maternal and infant health outcomes, improve the experience of and satisfaction with care, and improve health equity, while reducing or maintaining current levels of health spending.

New York State is poised to lead growing efforts to expand coverage of community-based doula support with the Medicaid pilot, but to do so effectively and successfully, will require innovative approaches that build on and move beyond the early efforts in Oregon and Minnesota. In order to fully realize the promise of this model of support and care, attention must be paid to the details of the service model, the composition of the service provider workforce, and the circumstances under which the work is being performed.

Doulas trained through and working with community-based initiatives are the best prepared, suited, and supported to provide the specialized support required to meet the needs of clients facing complex social, economic and environmental issues. Organizations rooted in their communities and connected with other service providers are best placed to

make referrals and link clients to appropriate, nearby, specialized support services and programs.

Recognizing, engaging, and learning from leadership within communities of color is essential and community leaders should participate in program design. Accountability is an essential function of government, and processes should be established to ensure input and participation from relevant stakeholder groups, including those representing the most affected communities as well as doulas already serving those communities.

A Medicaid pilot will not succeed without community participation and engagement. A lack of partnership with community organizations may result in doulas enrolling in the pilot who are trained in a private doula model, are not connected with robust social service referral networks, and are not trusted members of the communities in which they are working. Should a future evaluation of the pilot show little impact on outcomes or disparities from entrepreneurial, non-community-based doula care, the lack of positive outcomes could be interpreted as the failure of doula care to achieve positive results, without accounting for the fact that best practices associated with a successful program design were not adopted. This in turn could jeopardize not only the future of the NY State pilot program, but efforts in other states or at the national level.

To realize the vision behind the pilot, implementation must reflect community wisdom and proven strategies for success. Implementation can be strengthened by working to identify opportunities with the State Department of Health, NY Medicaid, Medicaid MCOs, and community groups. Individuals in communities with the knowledge, skills, and influence to support community-based doula programs can make it possible for doulas to become registered and be paid at an equitable rate for seeing clients.

Concerted effort will be required to avoid repeating the barriers to participation and consequent underutilization of Medicaid reimbursement in Oregon and Minnesota, and with increased communication and building trust, strategies to move forward effectively can be developed.

Recommendations

The following recommendations reflect concrete steps that New York and other states, should adopt to best meet the needs of the intended populations, to ensure that community-based doula support is sustainable, and to successfully improve health equity. New York and other states should:

1. **Adjust reimbursement rates** to ensure that doulas have the opportunity to earn a living wage, accounting for
    - the average amount of time spent with clients at home visits and births
    - care-associated costs incurred and time required, including
        - transportation fees
        - transportation time
        - uncompensated support and communication time
        - data collection and reporting
    - program operation costs, including

        - administrative responsibilities and program management, such as time spent matching doulas with clients, managing client database, etc.
        - supervision for doulas
        - peer mentorship for doulas
        - billing assistance
        - developing the resources, information, and relationships needed to maintain a comprehensive array of referrals
        - providing continuing education and professional development for doulas
        - overhead
    - the doula's benefits, whether paid for directly by the doula or by or a community-based organization

Adequate reimbursement rates for doulas in large urban areas like New York City would be a minimum of between $1100 and $1550, depending on the number of visits provided and other work-related requirements. Additional funds should be allocated to programs in order to support program costs.

2. Collaborate with and invest in community-based doula programs to ensure that doulas enrolled in Medicaid reimbursement programs are equipped to serve communities of color and low-income communities.

3. Support best practices through the pilot design, including but not limited to establishing mechanisms to ensure:

- **Adequate training and certification** for appropriately serving Medicaid population, which must go beyond traditional doula training to include reproductive and birth justice frameworks, race equity, cultural humility, home visiting skills, and knowledge of social services
- **Doula supervision and mentorship**, specifically by those with experience with community-based doula support, home visiting, and other forms of community-based support and services
- **Peer support** for newly trained community-based doulas

4. Develop a comprehensive approach to wellness and support by ensuring organizations or agencies are equipped with the structure, relationships, and process in place to provide the network of referral resources needed to appropriately serve clients with complex social needs. Facilitate a unified approach to the services provided.

5. Provide funds to train and certify a diverse doula workforce, specifically from underserved urban and rural low-income communities, communities of color, and communities facing linguistic or cultural barriers.

6. Incorporate community engagement as an essential component to improve health equity. Implementation of the doula pilot program should include centering leadership from within communities of color with the aim of working towards equitable models of care.

7. Take active steps to raise awareness about the benefits and availability of community-based doulas among health professional groups and associations and health care, and service delivery systems to increase uptake of doula services.

Glossary

Anti-Racist Framework - An anti-racist framework seeks to examine the ways in which people are greatly affected by lived experiences of implicit bias and racial inequity. Addressing the ways institutional and systemic racism has historically and currently impacted the reproductive health for people of color is imperative to contextualizing barriers, social determinants of health and quality of life for birthing people.

Birth Justice - Birth justice is achieved when individuals are able to make informed decisions during pregnancy, childbirth, and postpartum, that is free from racism, discrimination of gender identity, and implicit bias. Birth justice requires that individuals fully enjoy their human rights regarding reproductive and childbirth-related health decisions, without fear of coercion, including coercion to submit to medical interventions, reprisal for refusal of care, and/or face the threat of inadequate medical care. Birth justice centers the intersectional and structural needs of individuals and communities.[50]

Centered Communities - Communities that have been identified as having some of the highest disparities including but not limited to socially, economically, health, and environmental inequities encompassed within large communities of people of color. Typically, referred to as marginalized communities.

Community-Based Doula - Community- based doulas are birth workers serving families within varying communities that center African descended people, Indigenous families, and people of color. Community-Based Doulas understand the importance of seeing a birthing individual, baby, and partner as a connected unit. This support is responsive to the whole birth experience and considers how physical, emotional, mental, and spiritual experiences impact pregnancy, labor, birth, and postpartum period. Community-Based Doulas serve in a human rights framework to ensure that all people and families have access to safe, dignified, and culturally relevant care geared toward elevating the platforms of health equity, reproductive justice, and all stages of maternal health.

Cultural Humility - A framework that values and affirms the potential differences between a provider and a client within language, religious beliefs or values, age, gender, race, understandings of health and illness, or sexual orientation, and it is a model focused on understanding a client's health concerns, experiences, and preferences for care. Cultural humility encourages developing an attitude of not knowing and learning from the patient.

Full-Spectrum Doula: A full spectrum doula is a trained professional who provides comprehensive emotional, educational, advocacy, and physical support throughout an individual's reproductive lifespan, prenatally, during childbirth, and postpartum, including all pregnancy outcomes, including abortion, miscarriage, and adoption. All through an intersectional lens that incorporates a reproductive justice and birth justice framework.

Health Equity - The opportunity for all people to reach their highest attainable level of health. Health equity requires ensuring that all people have full and equal opportunities that enable them to lead healthy lives, including removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[51]

Intergenerational Trauma - The transmission of trauma from survivors to subsequent generations.

Intersectionality - The interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.

Implicit Bias - Unconscious attitudes, reactions, stereotypes, and categories that affect behavior and understanding.[52]

Maternal Toxic Zones - an area where it is unsafe to be pregnant or parenting including because birth outcomes for women and infants are worse than in neighboring areas; any area where a woman herself would not feel comfortable being pregnant, breastfeeding, or parenting.[53]

Perinatal Community Health Workers - Trusted members of the community they serve providing information and support related to pregnancy, childbirth, and infant care. PCHWs bridge language and cultural gaps and may serve as health navigators or liaisons between clients and service providers, connecting families with social, economic and health care resources that support pregnant people during the childbearing year. The goal of the PCHW is to reduce barriers to care by promoting a dialogue of cultural humility and reciprocity.

Reproductive Justice - The term "reproductive justice" was coined in 1994 by U.S. women of color who attended the International Conference on Population and Development in Cairo. It has since become a critical framework for understanding the intersections of reproductive oppression that women experience, both individually and as members of distinct communities. Reproductive justice aims to transform inequalities so that "all people have the social, political, and economic power and resources to make healthy decisions" about their "gender, bodies, sexuality, and families." This includes the right to have children, to not have children, to parent one's children, and to control one's birthing options. [54]

Race Equity - The condition where one's race identity has no influence on how one fares in society. "A Race Equity lens centers place environment and social determinants. It also addresses intergenerational and cumulative effects of racism and aggravated risks for specific local challenges."[55, 56]

Birth Equity - The assurance of the conditions of optimal birth for all people, with a willingness to address racial and social inequalities in a sustained effort.[57]

Structural Racism - The systems in which public policies, institutional practices, cultural representations, and other norms and ideologies work in various, often reinforcing ways to generate or perpetuate racial group inequity. Structural racism is not something that a few people or institutions choose to practice and does not require individual intent or action. Instead it has been a feature of the social, economic, and political systems in which we all exist.[58]

Trauma Informed Care - An organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.[59]

Community-Based Doula Model (CBD) - An expanded care model that includes preconception, interconception and pregnancy-related care. Incorporating up to seven (or even more) prenatal visits, labor assistance, and extensive postpartum visits based on birth outcome for up to one year of the child's life. CBD programs are based in underserved communities, are explicitly developed to meet the needs of communities of color and low-income communities, and often hire doulas from the communities they will be serving.

Traditional Doula Model (TDM): Typically, traditional doula models provide one to two prenatal visits, labor and birth support, immediate postpartum support, and one to two postpartum home visits.

End Notes

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TABLE 2:
TIME AND COMPENSATION OF KINGS COUNTY COMMUNITY-BASED DOULAS BY PROGRAM

Time + Compensation	NY Doula Pilot					Ancient Song Doula Services					By My Side Birth Support Program					Healthy Women Healthy Futures				
	# visits	hrs/ visit	hrs total	$/ visit	**Total**	# visits	hrs/ visit	hrs total	$/ visit	**Total**	# visits	hrs/ visit	hrs total	$/ visit	**Total**	# visits	hrs/ visit	hrs total	$/ visit	**Total**
Prenatal Visits	4	2	8	$30	$120	5	2	10	$70	$350	3	2	6	$75	$225	5	2	10	$50	$250
Postpartum Visits	4	2	8	$30	$120	varies	varies	18	$35/hr	$630	4	2	8	$75	$300	3/10	2	6/27	$25/hr	$150/ 675
Labor/Birth	1	18	18	$300	$360	1	18	18	$575	$575	1	18	18	$500	$500	1	18	18	$500	$500
Remote client support - phone, text, email	10	0.2	2	$0	$0	15	0.2	3	$0	$0	10	0.2	2	$0	$0	10	0.2	2	$0	$0
Time + Compensation			**36 hrs**		**$600**			**49 hrs**		**$1,555**			**34 hrs**		**$1,025**			**36/ 57 hrs**		**$900/ 1425**
Time + Compensation Including Travel																				
Time transportation - home visits + birth	9	1	9	0	0	8	1	8	0	0	8	1	8	0	0	9	1	9	0	0
Expense: Transport to home visit, round trip	8			-$5.50	-$44	7			-$5.50	-$39	7			-$5.50	-$39	8			$0	$0
Expense: Transportation to birth	1		1	-$40	-$40	1		1	-$40	-$40	1		1	-$40	-$40			1		
TOTAL incl. travel time + expenses			**45 hrs**		**$516**			**58 hrs**		**$1,477**			**43 hrs**		**$947**			**46/ 67 hrs**		**$900/ 1425**

TABLE 3:
SAMPLE COMPENSATION RATES & REIMBURSEMENT CATEGORIES FOR COMMUNITY-BASED DOULA PROGRAMS IN DIFFERENT LOCATIONS

Location	Program	Rates for Doula Services				Additional Compensation/ Reimbursement to Doulas					Payments to Programs	
		# Home Visits	Home Visit Rate	Birth Rate	Total	Paid Mentors	Meeting Time	Travel Time	Travel Expenses	Data Entry	Doula Trainings	Program Administration
NY State	NY Medicaid Pilot	8	$30	$360	$600							
Kings County	Ancient Song Doula Services	10+	$70	$575	$1,555	✓						
	By My Side Birth Support Program		$75	$500	$1,025	✓	✓		✓	✓	✓	✓
	Healthy Women Healthy Futures	8-15	$50	$500	$1,425	✓	✓		✓	✓	✓	✓
Other States	HealthNet Pilot Los Angeles, CA	6	$100	$1,250	$1,850	✓	✓				✓	✓
	Minnesota Legislation, Re-introduced 2019*	6	$47	$488	$770							
	Massachusetts Legislation, Introduced 2019*				$1,500			Explicitly included in doula fee				

* Minnesota and Massachusetts rates are those proposed in legislation that has not yet passed.