

DOULA SERVICES FOR IMPROVING BIRTH OUTCOMES



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**PREPARED AND PRESENTED BY:
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Doula (DOO-lah) n. A person trained to provide information, emotional and physical support to a mother before, during, and shortly after

INTRODUCTION

There are many factors that contribute to maternal mortality including cardiovascular events, infection and hemorrhage. Each of these outcomes is driven by social determinants of health, and the individuals affected are embedded in communities and served by systems with a history of unequal access and treatment that make these outcomes staggering.

Evaluation of interventions to address maternal mortality and morbidity requires thoughtful examination of new, and not so new, ideas and of medical and community-based services.

This brief examines doulas as one such intervention. Doulas provide information, education, emotional support and physical comfort to a pregnant woman and her family before, during and/or after childbirth also known as the perinatal period (7,8).

Doulas have proven to be safe with potential to prevent costly complications and perinatal health disparities, but they remain under-utilized and misunderstood.

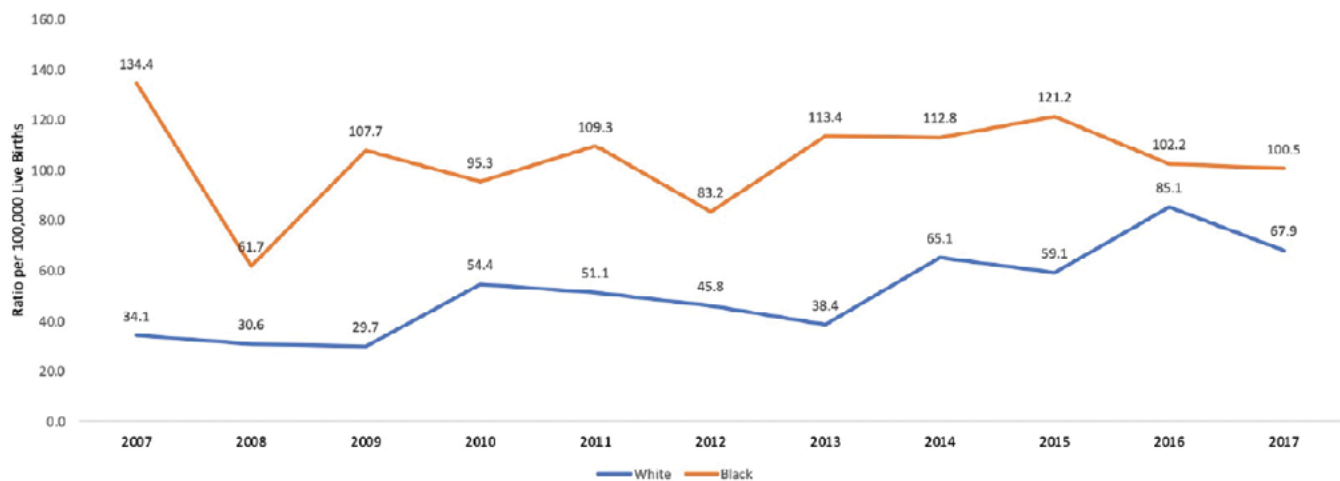
The United States has one of the highest rates of maternal mortality and morbidity among developed countries (2,3).

Maternal mortality is the rate of individuals per 100,000 who give birth to a live infant who die as a result of pregnancy, childbirth or within one year postpartum.

Maternal morbidity is the much larger group that similarly have serious complications that require significant intervention and may have life-long or life-limiting impacts.

Both rates—in the U.S. and in Michigan—are marked by egregious racial and ethnic gaps. To put it simply, Black and Indigenous women are dying at three to eight times the rate of White women, respectively (4,5). Please note: due to the smaller numbers other race/ethnicities could not be displayed.

Pregnancy-Associated (Total) Maternal Mortality by Race, Michigan 2007-2017



Pregnancy-Associated (total) maternal mortality includes pregnancy-related deaths (directly related to or aggravated by pregnancy), pregnancy-associated, not related deaths (unrelated to pregnancy), and deaths where pregnancy-relatedness was unable to be determined that occur during pregnancy or within a year of the end of pregnancy.

Data Source: Michigan Maternal Mortality Surveillance System, 2007-2017

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THE ISSUE

Doulas have existed for millenia. They came to be commonly known by the term ‘doula’ in the 1960s and have experienced various degrees of acceptance and utilization particularly among individuals seeking compliments to medical care.

While doulas do not provide clinical care, they do improve clinical outcomes. Evidence shows that individuals who utilize a doula have fewer invasive procedures such as Cesarean surgery, induced births, pain medication and other interventions that can lead to adverse outcomes, even maternal death (6,7).

Doulas serve a valuable advocacy role focused on the woman, in the context of her family and consistent with her values. Doulas help their clients communicate with medical providers, articulating questions and providing cultural interpretations about birthing. Doula services increase patient satisfaction with the birthing experience, increase the likelihood of a vaginal delivery, decrease preterm birth, and decrease postpartum depression while posing no risk to mother or baby (7,9,10).

Doulas have drawn the interest of public health and medical providers looking beyond structured, medicalized systems to improve outcomes and address racial disparities as they become aware that Black mothers with a doula-assisted birth were less likely to experience birth

complications and adverse outcomes (11,12). This motivation highlights the need to promote implementation in such a way that will increase access to doula care to confront geographic, cultural and racial/ethnic inequalities.

Doulas are a very personalized support, responsive to the needs of each woman within the context of their own experiences and community. They do not all operate with the same business model. Traditional doulas tend to take on a small number of clients and operate as sole proprietors accepting direct payment.

Community-based doula programs are focused training and utilizing doulas from the community to offer an expanded model including coordination with other community services, such as home visiting and nutrition supports, designed to support the family and healthy birth outcomes. As we examine the potential for impact on reducing disparities, we recognize the role of all doulas but evidence points to community-based doula programs as effective in specifically addressing racial inequities.

The door is not always open to doulas even with proof of good outcomes. Hospitals and medical providers do not always readily accept doula services as part of a patient’s care team. Doulas have been excluded from birthing experiences due to stigma and a lack of awareness of the full scope of support they can offer. For instance, during the COVID-19 pandemic many doulas have been banned from attending hospital births due to restrictive visitor policies, despite early guidance from the State of Michigan clarifying doulas should be considered part of the care team (12).

Doulas across Michigan confirm a general lack of recognition by managed care organizations, hospital administrators, clinicians, and the public. These entities consistently neglect to share doula program information with pregnant women and their families. As a result, women do not know about or seek services even if doulas are readily accessible in their community. As a result, medical providers and expectant and new mothers are deprived of the important benefits of a doula to reduce racial and ethnic disparities in poor birth outcomes.

Despite the ability of doula services to affordably address serious birth equity outcomes, doula services are rarely reimbursed by health insurance providers creating affordability issues for women and viability issues for the doulas themselves (1).

“I knew what doulas were but, like most people, I didn’t fully appreciate what they do. I knew postpartum was what I wanted to focus on because of my daughter’s situation. There was no circle of family there, no circle of women to help, and that’s true for so many women today. You live across the country from your family, your parents may still be working. There are a whole host of reasons why the old, traditional practices of supporting new mothers aren’t there.”

—LaTonya M. Baldwin, Postpartum Doula, Doula Me, Love

MICHIGAN DOULA PROGRAMS

Michigan has multiple examples of effective community-based doula programs, primarily developed through partnership with HealthConnect One (24).

HealthConnect One is a national organization promoting intensive peer-to-peer support to families during pregnancy, labor, birth and into the postpartum period. The program is successful because doulas are an integral part of the same community that women live, work and seek healthcare, bridging the cultural barriers to optimal birth outcomes.

The Black Mothers' Breastfeeding Association established its HealthConnect One accredited Community-Based Doula Program in 2014 and serves approximately 50 families each year. Doulas Ashli Burney and Robena Hill said their work focuses on education, better birth outcomes and connecting families to any resources they need.

BMBFA's Community-Based Doula Program has resulted in more families advocating for their desires and needs in birth, more moms are breastfeeding, dads are helping support breastfeeding, and families are more aware of different birthing methods.



“Doulas bring a wealth of knowledge on ways to mother the mother, how to equip partners in knowing how to support their significant other, as well as providing knowledge on informed consent and honoring autonomy. I’d love to see more integration of doulas within health care systems and policy around the benefits of doula support, especially as a means to address the disparate outcomes we see for families of color.”

— Kiara Baskin, Founder, Bump to Birth Doula Services

Kiara Baskin CD, CLC, the Community-Based Doula Program Manager for Baxter Community Center in Grand Rapids, said their community-based doula program is working to reach mothers at risk for having low birth weight babies while training women of color for careers as doulas.

This initiative, also in partnership with HealthConnect One, is the Day One Doula Collective—a system-level response to the inequities around low birth weight and the need to diversify the healthcare system with a two-strategy approach: first, connect expectant women of color in Kent County with doula services, specifically prioritizing women who may be at risk of having a low birth weight baby. The goal is to increase the likelihood of women of color to have a baby that is over 5.5 pounds. Second, equip a cohort of women of color in Kent County with the skills and certifications needed to achieve a career as a doula that allows them to earn a sustaining wage. The program's first cohort will launch in early 2021 and is anticipated to serve approximately 275 mothers per year.

POLICY IMPLEMENTATION IN OTHER STATES

Doulas and their positive impact on birth and postpartum outcomes have caught the attention of policymakers. The vast majority of current policy efforts are directed towards reimbursement, specifically coverage through state Medicaid programs. In 2017, the American College of Obstetricians and Gynecologists (ACOG) recognized improved maternal and fetal health outcomes from doula support during labor (13). In 2018, the World Health Organization listed doulas as an important part of childbirth (14). The Maternal Infant Health and Equity Improvement Plan (MIHEIP) supports access to enhanced care coordination models that include doulas, yet access to doula services remains inconsistent across the State and call for more coordinated strategies and policy changes (4).

In 2019, six federal bills relating to Medicaid coverage for doula care were introduced in Congress. In 2020, four additional federal bills and more than 25 state level bills were introduced related to Medicaid coverage for doula services, including one in the Michigan Senate (15). Several states have attempted to incorporate reimbursable doula services into existing maternal health insurance benefits. In 2019, New York launched a doula pilot program that provides reimbursement for doula services.

New York requires doula training without certification but requires the doula to contract with a managed care organization (16). Despite the intent of the pilot program to reduce maternal mortality and perinatal health disparities, the program lacked significant uptake due to low reimbursement rates for doulas and a lack of provider and public education.

When Medicaid reimbursement policies were first developed in Minnesota, Vermont and Oregon, certified doulas could receive reimbursement only through supervising clinicians (17,18). Other requirements, such as specific documentations and trainings, certification with a state-approved doula organization and listing on the statewide doula registry are commonly utilized administrative controls (19). In 2018, Oregon changed the reimbursement process to allow doulas to bill independently or as part of community organizations with Oregon's Coordinated Care Organizations (20). As demonstrated by these early efforts, coverage could come with trade-offs, including concerns over a loss of autonomy and the exclusion of birth workers who do not meet the certification requirements such as those trained in traditional practices (21).

Examples from Other States

| STATE | WASHINGTON | OREGON | MINNESOTA | NEW YORK | VERMONT | INDIANA | MISSISSIPPI | KENTUCKY | NEBRASKA |
|--|---|------------|---|-------------|-------------------------------------|-----------------------|---|---|---|
| MEDICAID REIMBURSEMENT | Up to \$1606. | Up to 800 | \$47 per prenatal and postpartum session and \$488 for labor and delivery | Up to \$510 | Up to \$750 | Yes | No | Yes | Yes |
| NUMBER OF VISITS, PLUS BIRTH ATTENDANCE | Pay for up to four prenatal and postpartum visits as well as attendance at labor and delivery | 4-7 visits | Up to 7 visits | 8 visits | Up to 6 hours plus birth attendance | At least two prenatal | Before, during and after pregnancy visits | Before, during and after pregnancy visits | Pay for up to four prenatal and postpartum visits as well as attendance at labor and delivery |
| CURRENT PROGRAM STATUS | Proposed | Mandated | Mandated | Pilot Study | Proposed | Pilot Study | Grant from Magnolia Medical Foundation from W.K. Kellogg Foundation | Humana Coverage | Pilot Study |

STATE EXAMPLES

[HTTPS://WWW.KFF.ORG/WOMENS-HEALTH-POLICY/REPORT/MEDICAID-COVERAGE-OF-PREGNANCY-AND-PERINATAL-BENEFITS-RESULTS-FROM-A-STATE-SURVEY/](https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/)

[HTTPS://WWW.NASHP.ORG/FOUR-STATE-STRATEGIES-TO-EMPLOY-DOULAS-TO-IMPROVE-MATERNAL-HEALTH-AND-BIRTH-OUTCOMES-IN-MEDICAID/#TOGGLE-ID-3](https://www.nashp.org/four-state-strategies-to-employ-doulas-to-improve-maternal-health-and-birth-outcomes-in-medicaid/#TOGGLE-ID-3)

SUMMARY

In order for pregnant and postpartum women and their families to experience the benefits of a doula in Michigan, services must be more accessible and affordable. Providing reimbursement for doula services gives women the autonomy to take personal responsibility for their birthing experience and have their companion of choice during labor and childbirth.

Doulas in Michigan are not readily reimbursed and are sustained by grants, community-based efforts or private payments. This lack of stability creates barriers for community-based doulas and contributes to insufficient support networks and organizational infrastructure. Even when doula services are built into a larger organization it is difficult for doula programs to survive and provide full services without a sustainable payment structure. As our state considers reimbursement mechanisms, experiences from other states highlight the need to be wary of how reimbursement structures and policies can hinder promotion of community-based doulas who resemble the individuals they serve (19,22).



Further, data demonstrates race impacts birth outcomes regardless of income, so reimbursement strategies must extend beyond Medicaid.

The advantage of doulas is their unique approach to serve women and families, yet the lack of awareness, consistency in approach, and reimbursement presents significant challenges in crafting a cohesive strategy to improve utilization within systems. Coordination within the doula community and collaboration with other partners interested in policy is necessary for improving the lives and experiences of pregnant and postpartum families. It is critical for the advancement of doula services in our state to reduce health disparities and improve birth outcomes.

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