Community Doula

January 2018 – December 2020

Summary:
This pilot facilitates the recruitment, training, and reimbursement of birth doulas to serve pregnant members of IHN-CCO. The target population is pregnant people in Benton, Lincoln, and Linn counties who have been identified as priority populations by the Oregon Health Authority (OHA). Birth doulas build trusting relationships with pregnant women and provide physical, emotional, and informational support during labor and birth. The Community Doula Program builds relationships and strengthens connections with providers and key stakeholders, recruits and trains trusted community members to become doulas, connects doulas to pregnant women and facilitates reimbursement for services. The goals of the pilot are to increase the number of perinatal Traditional Health Workers doulas and to improve health outcomes for pregnant members of IHN-CCO through comprehensive, culturally concordant doulas services.

Budget:

- **Total amount of pilot funds used:** $264,488.54: $189738.50 (2018-2019), $74750.04 (2020)
- **Please list and describe any additional funds used to support the pilot.**
  American Institute of Research—Maternal Respect and Autonomy Scale Pilot
  Linn Benton Health Equity Alliance Capacity Funds
  Private donations
  In-kind salary support for OSU evaluation team

B. Provide a brief summary of the goals, measures, activities, and results and complete the grid below.

The original goals of our program were:

- To recruit, train, and reimburse culturally- and socially-diverse birth doulas to serve pregnant members of IHN-CCO in 3 counties in Oregon (101 trained, 32 on THW registry, 2 THW applications submitted).
- To improve birth outcomes and reduce health inequities through one-on-one support and advocacy offered by birth doulas (lower cesarean birth rates, higher breastfeeding initiation rates and lower preterm birth rates).
- To offer doula support services to all who qualify and consent and to track outcomes for the doula-supported group relative to standard care (>400 referrals, >200 clients served, outcomes described in more detail below). Clinical and psychosocial outcomes will be tracked using a mixed methods approach.
- To train bilingual Spanish, Mandarin and Arabic speaking doulas (28% of CDP doulas are bilingual, 10 languages offered).
- To train a subset of multi-lingual doulas as State Qualified or Certified Health Care Interpreters (3 completed, 6 intended but classes delayed due to COVID-19).
- To develop a community college curriculum for training community doulas, using a CD-led approach (Done! Ready for state TEMPS committee)

Goals added as part of task shifting in response to Covid-19:

- To offer multilingual Pandemic Parenting support groups online group (Samaritan, Healthy Families, CDP, 9 English groups June-August 2020, Spanish ongoing)
- To lead community testing and contract tracing teams through TRACE (11 doulas as team leads).
- To continue to provide prenatal and postpartum care, despite Covid-19 precautions in place since March 2020, via telehealth (all doulas were able to provide telehealth visits within 3 days of the state's restrictions)

Goal	Measure(s)	Activities	Results to Date
Document all IHN-CCO members served by the pilot.	IHN-CCO members served by the pilot.	Referral services, doula care provided, training and supports for THW Registry Qualification	Members engaged: >400 Courses of care: >200

			Also, 25% **of doulas** are IHN-CCO Members
Actively participate in at least 1 DST workgroup; DST recommends Traditional Health Worker (THW) workgroup.	Attend either by phone or in person.	Traditional Health Worker Workgroup Health Equity Workgroup	Alicia and Roslyn attend THW workgroup regularly with report back at CDP leadership team meetings . Alicia attends all DST meeting (Missy as alternate). Alicia is Co-chair of the Health Equity workgroup
30 community members will complete requirements to become birth doulas.	# of women trained to meet THW registry requirements as doulas.	The CDP provided 4 initial doula trainings, developed and provided state-approved versions of all other training requirements 4-6 times each as needed by doulas, assisted doulas with the THW registry application process, complied application packets and submitted them to the state, and navigated OHA bureaucracy to register doulas	101 Doulas trained 32 THW Registry completed (our doulas comprise 30% of total THWs on the registry), 2 submitted and under review with more in preparation. 25% of total doulas trained are also IHN-CCO Members
Client satisfaction with Community Doula program.	Reported satisfaction with birth experience, including measures of autonomy and respect.	Qualitative interview process assessing client experience (n=16 completed, 9 additional scheduled. Preliminary data analysis completed, further data analysis and peer-reviewed publication planned) Mothers Autonomy in Decision Making (MADM) and Mothers on Respect Index (MORi) scales administered	Interviews indicate increased understanding of doula care, very high satisfaction with care. MADM: 95% of CDP clients reported high or very high autonomy (72-88% expected) MORi: 97% of CDP clients experienced high or very high respect (72-88% expected)
Doula satisfaction with training and support.	Reported satisfaction participating as a doula.	Qualitative interview process assessing doula experience (n=25 interviews completed and	Doulas are experiencing the program as personally transformative; program was responsive to needs and barriers; appreciated

		analyzed; peer-reviewed publication in preparation)	peer to peer training; felt more than prepared to attend IHN members; positive responses to reflective supervision/peer review model; are highly self-motivated to develop their Trauma Informed practice models; the singular complaint among CDP doulas is low reimbursement rates.
Improved health outcomes compared to non-doula group.	Birth outcomes (cesarean birth, preterm birth, breastfeeding, service user experience/autonomy and respect).	Doulas collect over 60 data points for each course of care (n=208) which allows us to track commonly reported outcomes.	Reduced cesarean rate (15% vs. 23% expected); Reduced pre-term birth overall (5% vs. 9% expected), substantially reduced preterm birth among women of color (2% vs. 11%); Near universal initiation of breastfeeding at 98% (60-70% expected); high rates of maternal perceptions of respect and autonomy reported (see above).

C. What were the most important outcomes of the pilot?

- Increased the number of bilingual and culturally diverse doulas on the state registry (400% increase)
- Built a culturally and socially diverse workforce with extensive training in Trauma Informed Care and Health Equity.
- Provided an evidence-based service (doula care) to over 200 families who would not otherwise have had access.
- Created the first known community doula-directed curriculum for doula training, to be implemented at low or no-cost via Community Colleges in Oregon. Curriculum will also be shared with other Community Based Organizations nationwide.
- Established and enhanced partnerships with over 20 organizations statewide
- Able to provide doula care in 10 languages—28% of doulas trained are bilingual
- Subset of bilingual doulas trained as state qualified or certified medical interpreters
- Established pandemic parenting groups in English and Spanish
- Demonstrated resilience transferring to telehealth services with zero interruption to members
- Task shifted THW Doulas to be leads for community testing and contact tracing through OSU TRACE
- Hosted a statewide doula summit for THW Doula care (October 2019)
- Negotiated a contract for doula reimbursement
- Developed a model Doula Hub with training, referral, and billing capacity

- Improved birth outcomes for IHN-CCO Members, including reduced rates of cesarean and preterm birth, and increased rates of breastfeeding, as well as increased service users' experiences of autonomy and respectful care.
- Provided vocational training and support for 26 IHN-CCO Members from minoritized communities to become doulas

D. How has the pilot contributed to the Triple Aim of improving health; increasing quality, reliability, and availability of care/increasing patient satisfaction with care; and lowering or containing the cost of care?

The Community Doula Program addressed all aspects of the Triple aim by:

Improving health as evidenced by the outcomes reported above;

Increasing the quality, reliability, and availability of doula care as an evidence-based maternity care best practice to a population that has traditionally not had access to it. The CDP has expanded access through workforce development, community and provider education, and the assumption of administrative tasks (billing, credentialing, data collection) not normally required of health care providers;

Increasing client satisfaction with their care, demonstrated both via the qualitative interviews and the substantial improvements in the proportion of Members who reported receiving respectful care and maintaining autonomy during the birthing process;

Lowering Costs via decreasing the cesarean and preterm birth rates, and increasing breastfeeding.

We also improved provider resources with the integration of culturally and linguistically matched doulas as part of the maternity care team.

E. What has been most successful?

In addition to the health and member satisfaction outcomes highlighted, The Community Doula Program has integrated our services into maternity care workflows and teams to the extent that area hospitals were among the first to allow doulas (and only CDP doulas) back into labor and delivery as part of their COVID-19 protocols. Doulas were recognized as part of the maternity care team rather than a barrier to the provision of clinical care, and, after nearly six weeks without doulas, Samaritan hospital nursing staff was thrilled to welcome doulas back highlighting the essential role they play in supporting both families and hospital teams.

Additionally, we are particularly proud of the adoption of the CDP within Latinx and other BIPOC communities. Knowing that building community trust was essential, we expected an initially lower utilization of services, but were able to serve a higher than expected percentage of POCs (>40% of clients cared for during the pilot). We attribute this to the tireless work of CDP doulas and the Maternity Case Managers in all three counties.

F. Were there barriers to success? How were they addressed?

Low reimbursement rates and lack of infrastructure support have remained the primary barriers to successful establishment of universal doula care. The current state rate of $350 for a complete course of care does not allow doulas to treat doulas work as anything but a hobby, and indeed constitutes poverty wages given the substantial amount of uncertainty involved in a profession that requires being on call. The CDP negotiated a higher rate of reimbursement, via contract with IHN-CCO, effective January 2020, but we have yet to successfully get reimbursed at the agreed-upon rate. We are currently using DST grant dollars to make up the difference for doulas; this is not sustainable.

Some of the training (training beyond the initial training and continuing education), referrals, and doula support services remain reliant on the precarity of grant funding because doulas are not yet integrated into existing

maternity care systems that have these supports in place. Rather, the CDP has used DST funding to provide all administrative, referral, and billing supports to the doulas; this model is not sustainable.

Additionally, the administrative burden placed on Traditional Health Worker Doulas to navigate Oregon Health Authority and Medicaid rules has had to be addressed through extensive support provided by the CDP, particularly for immigrant and multilingual doulas. The Community Doula Program is engaged with statewide advocacy to address the variety of regulatory and systemic barriers to both doulas and members. The current system, however, is not sustainable (nor just, nor equitable) .

G. How readily would the pilot be scalable or replicable? Describe cautions and considerations when considering scaling, or replicating the Pilot. (i.e. Success dependent on personality/skills set, or activities appropriate under certain conditions like size, target population, etc.)

The Community Doula Program built on the experience and relationships of our leadership team to address barriers as they arose. Our ongoing commitment to democratizing knowledge and experience will aid replicability as we are dedicated to sharing both our knowledge and materials developed (training curriculum, data collection tools, charting materials, policies and procedures, etc.) to increase access to THW doulas. Universal doula care has a strong evidence basis; its primary barriers are not research, but the systemic devaluation of community-based care, low reimbursement rates, and lack of infrastructure to support doulas in practice. This project is replicable and sustainable where there is political will to integrate doulas into standard care, establish training and certification programs based in diverse communities of care, and compensate both doulas and programs commensurate with their actual value.

H. Will the activities and their impact continue? If so, how? If not, why?

The Community Doula Program is dedicated to continuing to provide services; however we are dependent on grant funding to do so.

By functioning as a provider hub, the CDP has trained and supported a community-based THW workforce with extensive health equity and trauma-informed care training, built relationships with local care providers, and established credibility with IHN-CCO Members (as evidenced by repeat clients) which has led to demand for doula care. As one of the most established doula hubs billing Medicaid in Oregon, the CDP continues to advocate for the removal of systemic barriers, including low reimbursement for doulas, limited understanding of the role of doulas withing the maternity care team, lack of funding for administrative supports for Doula Hubs, and limited availability of grant funding dollars outside of DST.