HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

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A Sustainable Model for Doula Care?

Overview

The leadership at Brisby, a mid-sized health insurance company, is puzzled. Two years ago they had tasked Brittany Harden, their Accountable Care Organization's (ACO) Maternal and Newborn Health Program Manager, with developing a doula program for women enrolled in their ACO. Doulas, lay birth support professionals, had been enthusiastically embraced by both lawmakers and health professionals as a potential solution to racial and ethnic health disparities in maternal mortality and morbidity.

Brisby's doula program was meant to be a preemptive response to mounting political pressure for healthcare reform following high-profile stories of hospital failures to respond adequately to Black birthing women's health crises as well as pieces by ProPublica and CNN about the Black maternal mortality crisis. Yet, just two years in, it was obvious to Brisby's leadership that something was wrong. While patients and even many doctors liked the program, it had serious sustainability issues, accusations from patients of bias in the allocation of doulas, and had even increased reporting of disrespect and abuse as well as substandard care.

Worried about their public image, Brisby's leadership have contacted you and several other experts to join an upcoming meeting with Brittany, who manages the doula program, and Brisby leadership as a consultant. You are an Ob/Gyn at the local teaching hospital and professor of Maternal and Child Health at the State University who has published on racial disparities in maternal mortality. Brisby's leadership has communicated that they are considering shuttering the program, but first want answers as to why the doula program is *increasing* reports of disrespect and abuse rather than decreasing them. They are also interested in any opinions you might have as to whether the doula program is structured appropriately and what expectations they should have in terms of health outcomes for patients receiving doula care compared to patients who do not.

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Over the course of several calls and two in-person meetings, Brittany filled you in on the development of the program as well as the successes and challenges the program faced over its first two years of operation. Using the information from these meetings (detailed below), how will you respond to claims that the doula program is increasing reporting of disrespect and abuse? What will you suggest to improve the sustainability of the program? What will you recommend Brisby do to improve the doula program? Or should the doula program exist at all?

Supported Start

The following summarizes the past three years leading up to the "present day" of the case. Brittany Harden, the Program Manager of Maternal and Newborn Health at Brisby tells the story of the development of the doula program, and it's rocky first two years. This information was given to you over the course of several meetings with Brittany, and for convenience is summarized below.

The meeting is scheduled

Brittany Harden was intrigued about a meeting she was invited to next week with Brisby leadership, including the president of Brisby's national managed care organization, the Medicaid director, and other senior leaders of the company's ACO. Brittany had recently accepted her position at the insurance company's ACO, one of the first offered to Medicaid patients.

ACOs, originally created for Medicare beneficiaries, are an innovative strategy to reduce cost and improve care quality in which doctors, hospitals, and other care providers voluntarily coordinate with each other to offer enhanced care. By ensuring that a patient's healthcare providers are in conversation with each other and providing wraparound care that includes transportation, mental health, or even help with food access, ACOs seek to provide the right care at the right time while at the same time reducing cost[1]. Brisby, which largely serves patients in states that expanded Medicaid, was an early adopter of the ACO model.

Brittany, who had completed her MPH with a concentration in maternal and child health just four years ago, had been thrilled to accept her current position, especially by the prospect of providing high-quality care to low-income women during their pregnancies, the birth of their children, and the postpartum period. She was proud that not only were her and her team able to ensure that their patients had access to medical care, they were also, through community health workers, social workers, and nurses, able to provide needed supplies like car seats and pumps, and even help patients with issues of poor transportation, legal problems, substance use, and support by phone for patients with complex conditions.

Brittany knew that for many Medicaid patients dealing with poverty, housing insecurity, and

[1] https://innovation.cms.gov/innovation-models/aco

discrimination on top of any health conditions they might have, these "wraparound services" were key to good health outcomes. She also knew that the upcoming meeting with leadership was about a new program for pregnant and parenting patients, one that leadership felt would help the ACO respond to rising public outrage over persistent racial and ethnic disparities in maternal health outcomes, including mortality and morbidity. She was excited to expand the programming offered to her clients.

The first meeting: "Doulas are key to curbing maternal mortality"

Two weeks later, Brittany was feeling nervous. At the meeting with Brisby leadership she had been pleasantly surprised that they wanted to pursue developing a doula program for ACO patients, but daunted by the task of developing a program with little funding. Brittany was familiar with the concept of doulas; her sister had briefly worked as a doula before applying to midwifery school, and knew there would be several serious challenges in developing a program that would adequately serve her clients.

Doulas are lay support people typically without medical training, who act as an emotional support person and can use non-medical techniques to help with pain management[2]. The professional doula is a very recent, and largely American phenomenon. Before the advent of standardized medical care, most women gave birth at home, surrounded by female relatives who had themselves experienced childbirth and (if available) a local midwife. In the early 20th century, doctors practicing the emerging field of obstetrics and gynecology began to take over as the preferred birth attendant, and successfully lobbied to prevent the education and licensing of midwives. Still, in the early 1900s the vast majority of births occurred at home, surrounded by relatives, however, between the 1920s and the 1950s birth almost completely shifted to hospitals. With this shift and the overall medicalization of childbirth, birth companions present during a woman's entire labor were largely dropped in favor of doctors and nurses, who would typically not be present with a patient during her entire labor[3].

The medicalization of birth brought incredible gains in quality of care, including a rapid drop in both neonatal and maternal mortality, but came with unintended outcomes, such as higher rates of unnecessary interventions including forceps delivery and Cesarean-sections[3]. Along with unintended medical consequences, some women felt a loss of autonomy over the birthing process. A growing group of women, dissatisfied with the notion of treating birth like a medical condition, formed a movement to reclaim childbirth as a normal process. With this movement came the use of the term "doula" in its modern form and doulas rose in popularity as a way to inject continuous maternal support into a healthcare system in which 98% of U.S. births still take place in the hospital and 87% are presided over by an Ob/Gyn[4]. Doula fees, ranging from

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[2] https://www.dona.org/what-is-a-doula/

[3] McCool, W., Simeone, S. (2002). Birth in the United States: an overview of trends past and present. *The Nursing Clinics of North America, 37* (735-736). https://doi.org/10.1016/S0029-6465(02)00020-8

[4] https://www.birthbythenumbers.org/midwifery/

several hundred dollars to several thousand dollars, are not typically covered by insurance, and thus are largely only accessible to upper-class women.

Currently, doulas are experiencing their heyday. With rising national concern over racial and ethnic disparities in maternal health outcomes, especially maternal mortality, doulas are being touted as a potential solution to a myriad of problems including disrespect and abuse of birthing women of color, maternal morbidity, and even maternal mortality. Brittany had seen several recent headlines of news articles with splashy titles like "Doulas are key to curbing maternal mortality" and "How doulas are saving black women one birth at a time." Some clinicians and public health experts felt that having an outside presence to advocate for the mother's needs would help prevent situations in which women's symptoms (especially women of color) were dismissed by healthcare providers, a hunch yet to be adequately supported by scientific evidence. Yet, lawmakers across the country were jumping on the bandwagon, introducing bills that would reimburse doulas through Medicaid[5].

It was in this cultural climate that Brisby's leadership had suggested starting a doula program. Brittany had the distinct impression that Brisby's leadership saw the program as an easy and cheap way to respond to the public and lawmaker's outcry over health disparities and ride the enthusiasm over doulas. In fact, a vocal group of patient advocates in the community, including several doulas, had criticized some of Brisby's partner birthing hospitals for failing to respond to racial disparities in birth outcomes, even holding a small protest that was covered by local newspapers. Furthermore, the rumor being passed around by those in the state's insurance industry was that lawmakers were seriously considering proposing legislation that would mandate doula reimbursement through Medicaid.

Brittany's suspicions were confirmed at the first planning meeting, attended by her, Brisby's CEO, Brisby's Director of Medicaid Programs, the Director of Marketing, and several administrative staff people. "I want to get ahead of this potential legislation," said Grace, the Director of Medicaid, at the beginning of the meeting. "We can either be seen as being in the vanguard, an early adopter, or as one of the dinosaurs. None of us wants to be a dinosaur." Brisby's CEO was more skeptical, "I don't see how a bunch of doulas with no medical training are really going to improve outcomes." He said. "I'm not going to pour a bunch of money into a program if it won't improve outcomes. If we want good press, we should be talking to our marketing department." At this point the Director of Marketing chimed in. "I actually see this as a low-cost solution that would garner quite a bit of positive publicity, even if it has no effect on outcomes. People want to see that we're doing something, and almost everyone's on board with doulas as a potential solution. We can be ahead of the curve here in a very good way." The Director of Medicaid added that she had read some of the literature on the effect of lay support during childbirth, and while modest, they could potentially expect to see a reduction in operative birth. "At least the program won't do any harm," she said.

By the end of the meeting Brisby leadership had tasked Brittany with building a doula program

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[5] https://www.mhtf.org/2020/01/08/expanding-access-to-doula-care/

that could serve at least 150 clients a year and gave her a modest budget of $150,000. They expected her to have a plan for the program within the next several months. She was to report directly to Grace and schedule ad-hoc meetings and calls as needed with her to receive approval on the structure and policies of the program. Brittany knew she had her work cut out for her.

Learning from doulas-the challenges of developing a program

Brittany's first step was researching the benefits of doula care as well as some of the typical models of doula programs. She learned that research has found some improvements in birth outcomes when doulas are present, although the quality of evidence is low. Doulas may reduce the use of pain medication, cesarean section and other instrumental delivery (forceps or vacuum extraction), and increase the number of women satisfied with their birth experience[6]. However, a 2017 Cochrane review found no difference in breastfeeding rates, NICU admission, or postpartum depression. As she read, she was surprised that so many respected members of the healthcare community were proposing doulas as a potential solution to racial and ethnic disparities in maternal health outcomes. While the concept of doula care sounded like a wonderful way to provide emotional support during birth, she could find no studies that linked the use of doulas to any specific factor, whether physical or structural, that might reduce maternal mortality and morbidity.

Next, she started to look at models of similar doula programs and to meet with doula leaders in her community. In multiple conversations with doulas and other MCH experts, several key considerations for the success of a program emerged: choosing the right staffing strategy, recruiting a diverse group of doulas, appropriate scope of doula work, training requirements, reimbursement, and retainment.

By reading and speaking to several managers of doula programs, including the director of an insurance-based program serving high-risk Medicaid beneficiaries in another state, Brittany learned that there are two basic models of staffing doula programs, each with their pros and cons. Many nonprofit doula programs followed a volunteer or near-volunteer model: recruiting many doulas and either not paying for their services or paying a fee that was much lower than the typical private fee. In order to ensure an adequate volunteer base, these programs often lowered the threshold for training-accepting doulas who had not been formally certified through a reputable doula organization or even those who had received no formal training. Retention of doulas in this model was typically very low, and a lot of effort was needed to continuously recruit doulas and orient them to the model. However, these programs are able to operate on a very limited budget, especially necessary for small nonprofits or grass roots efforts providing doula care.

Other programs were staffed by recruiting and retaining a core group of doulas. These programs necessarily paid their staff more, but in turn were able to require that their doulas were certified

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[6] Bohren MA, Hofmeyr G, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 2017, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6

or otherwise highly qualified. They also typically had higher retention rates for doulas, and often more satisfied clients. The price tag for this staffing model was high, often unattainable for small nonprofits, and sustainability was an issue. For either model, recruitment of the right cadre of doulas was key.

Recruiting a group of doulas that was as diverse as her clientele would be difficult, she was told, but the payoff would be huge. "The power of having doulas who look like you, sound like you, speak your language, it's not to be underestimated," the leader of a local nonprofit who offered doulas to clients in homeless shelters told her. The difficulty was, the doula profession was not an easy or financially lucrative one. Doulas have long on-call hours, physically and emotionally demanding work, unpredictable schedules (making childcare especially difficult to find), and pay that although out of reach for most birthing clients, amounted to a modest monthly salary even with a full client list. As such, the profession mostly attracted middle-class white women who had the financial and personal flexibility to support a maximum of 4 clients per month. For doulas that worked with higher-risk clients (usually for much less pay), burnout was high, as they often became trusted confidants on speed-dial for crises not directly related to pregnancy and birth. Brittany was especially concerned about recruiting and retaining a diverse staff, a concern that was intensified when she learned from a colleague that many doulas had to hold other part-time or full-time jobs to make ends meet.

Beyond recruitment, the amount and content of doula training that the program should require was an open question. There is no national licensing body for doulas and no standardized training to become one, the field is both unlicensed and unregulated. Several reputable training and certification organizations exist, including DONA International, but completing training and apprenticeship requirements through these organizations costs upwards of $1,000 and the process of achieving certification can take up to two years, unreachable for many lower-income people wishing to become doulas. Brittany would have to balance her wish to provide Brisby clients with high-quality and consistent service while also honoring the deep experience of many doulas who had never been formally trained.

Reimbursement was also a major issue. While bills including doula reimbursement through Medicaid were being passed throughout the country, they often came with ludicrously low reimbursement rates, in some states only several hundred dollars[5] for 6 prenatal visits and support throughout labor (often 10 or more hours). Several doulas Brittany spoke to cautioned her that she would have to set reimbursement rates at $700 minimum per birth to recruit and retain doulas. Brittany knew this would be impossible given her budget.

Another budgetary consideration would be the scope of work required of doulas. A traditional labor doula for a client paying out of pocket would meet with the client 1-2 times before labor, support the client from active labor until a few hours after the birth of her child, and would return for one postpartum visit. Brittany realized that for her clientele, this might not be enough time to establish the relationship necessary for trust. Luckily, Brisby already employed community health workers and social workers who were actively working with clients in need. Some programs serving low-income or otherwise vulnerable populations had chosen to have doulas act more as community health workers or home visitors, taking on duties well beyond the

typical private doula. While clients liked this model, doula burnout was particularly high.

Developing the Program

Brittany took the information back to Grace, and together over several meetings they developed the key constructs of the program. They named the program "Supported Start" and planned to use Brisby's existing community support resources to ensure that it offer a comprehensive set of services. Of course, if the program could only serve 150 clients a year, there would have to be some way to select participants among the ACOs pregnant clients. At first, Brittany advocated for opening the program exclusively to women of color. "Supported Start is meant to be in response to racial and ethnic disparities in maternal and newborn health outcomes." She argued. "Why not directly target the population we're trying to help?" Grace was against the idea. She worried the ACO would get pushback from white clients, especially those who were medically high-risk. She was also leery to set guidelines that required the ACO to weigh in on race and ethnicity, anticipating tricky scenarios like whether to include patients who were mixed race or from minorities that on average have better birth outcomes, like women of Asian descent[7].

Together they decided that patients eligible for doula services were any Brisby ACO member giving birth in two of Brisby's four birthing hospitals. Additionally, the program would offer doula services to any ACO member birthing at any hospital, whether or not in the Brisby system, if they were considered "high risk"—a broad category defined as anyone who would benefit extra from doula support, such as women dealing with pregnancy-related health issues (preeclampsia, gestational diabetes), were housing insecure, or in need of social support. If demand was higher than spots in the program, they would institute a pure lottery.

Since the ACO already counted on wraparound services and employed social workers and community health workers, Grace and Brittany decided Supported Start would focus exclusively on pregnancy, birth, and the postpartum period, serving patients from whenever they were reached during pregnancy until after birth. Through the program, doulas would meet with their clients at least once during pregnancy, be present from active labor until the birth of the child, and offer at least one postpartum visit. The other services the program offered: a free infant car seat, free childbirth and breastfeeding education, and a $25 gift card incentive for prenatal care visit during the first trimester, would be handled by community health workers. The program also offered a mothers' support group, run by a mental health professional, for two to three months after birth and a six-month follow up after birth, with referrals to behavioral health for mothers facing post-partum depression.

However, Grace and Brittany did not see eye-to-eye on how to staff the doula program. Grace preferred a near-volunteer model, which would keep the cost of the program low and thus increase the likelihood that the model would be sustainable over time. Brittany was concerned about this approach, worried that doula services would be low quality and that retention would

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[7] Dominguez, Tyan & Parker PhD, MPH. (2008). Race, Racism, and Racial Disparities in Adverse Birth Outcomes. *Clinical Obstetrics & Gynecology*, ***51***, 360-370. https://doi.org/10.1097/GRF.0b013e31816f28de

be devastatingly low. Over the course of several meetings (and with some cost analysis she was able to draw up comparing the two models), she was able to convince Grace that the cost of a dedicated volunteer manager and other training and recruitment activities would be almost equal to paying a smaller staff a more livable wage and would save Brisby quite a few headaches and liabilities.

However, to ensure the recruitment of as diverse as possible doula staff, Brittany and Grace agreed that they would likely have to compromise on some credentials. They decided not to require the doula staff to have any formal doula training, but did require that they had attended at least 3 births, a typical certification step, with the ability to provide positive references from clients. Brittany was able to work with another insurance-based doula program to adapt their staff training, and would require hired doulas to go through this week-long training as well as attend monthly meetings to discuss challenges with both supporting clients and recording case notes and birth outcomes in the Electronic Medical Record (EMR) system.

Given the constraints of the budget, Brittany set a flat reimbursement rate of $650 a birth, for that fee, doulas would agree to support the client in-person at least once prenatally, during the entirety of their active labor and the birth of her baby, and at least once postpartum. She knew that the reimbursement fee was nowhere near what doulas could charge for private clients, but hoped she could recruit those willing to take a pay cut to work for lower-income clients. Care coordinators and social workers at Brisby were expected to be called in if the client was having issues outside of the scope of the doula's expertise or issues not related to her pregnancy. With policies in place, Brittany was ready to recruit doulas and roll out the program.

"Supported Start is a publicity nightmare!"

Two years later, Brittany was irate. Another meeting had been scheduled about the doula program with Brisby leadership, but Brittany knew it would be very different from the first. Brittany was aware that Brisby leadership wasn't happy with how things were going, a fact that she thought was a little more than unfair. The last two years had certainly brought challenges. Recruiting and retaining doulas had been a huge hurdle. Elsewhere, doulas often were paid nearly twice the rate she was able to reimburse, and while many doulas were interested in working with lower-income clients, they still had bills to pay. For the first several months, Supported Start worked on a skeleton crew of just 5 doulas. Brittany frantically sought more funding to recruit other doulas. Her initial attempt to find more funding from Brisby was unsuccessful, but she was able to procure a small community grant that supplemented the doula's fees by the time Supported Start was entering its sixth month of existence, enabling her to raise reimbursement rates to $750 a birth.

Grace, Brisby's Medicaid Director, felt that the need for outside funding to support the program was a sign that Supported Start was unsustainable. She had pushed early for a more volunteer-based program, which Brittany had resisted. She saw the need for outside funding as proof that Brittany should move to re-work her staffing model. Brittany felt strongly that lowering reimbursement fees would only make the retention problems she already had much worse.

While recruitment was easier once the doula reimbursement amount was raised, turnover in the first year was high, very high. Out of 15 doulas recruited in the first year, 5 left by the end of the first year, and three more by the end of the second. While all of the doulas she had recruited were passionate about their work, for many the lifestyle just wasn't sustainable. Difficulty finding stable childcare, car problems, and the strain of long hours with sometimes difficult clients were common reasons for quitting. For several others, working as a doula had served as the stepping stone to midwifery school, after which they could hope to support women during their birth in a role that came with more responsibility, higher pay and much more respect.

Yet, despite high doula turnover, Brittany had felt that the program was modest success. Clients were overwhelmingly happy with the services they had received, and at least by comparing claims data from births that had utilized the doula program vs. those that had not, they had seen a drop (albeit small) in the number of women using an epidural and a slight rise in the number of vaginal births among the doula clients. This shift even translated into modest cost-savings for Brisby. Brittany was especially proud of the stories coming out of the program - of teen mothers, whose parents refused to be present, getting the support they needed during a difficult time, or of clients bonding with their doulas so much they were inviting them to their children's first birthday parties. These stories were hard to communicate to Brisby leadership. While Brittany had developed a satisfaction survey meant to be filled out online by Supported Start's clients after their birth, response rate was abysmal. Brittany wished she had better data to show Brisby's leadership, especially given two unfortunate developments that had Brisby apprehensive that their investment in good publicity would backfire.

At first, Brittany was happily surprised by how providers at Brisby's partner hospitals welcomed doulas onto their care teams. She had heard (from her sister and other doulas she had talked to) how doulas could sometimes come into conflict with other providers, but the response from medical staff had been largely positive. One doula told her the doctor said, "Thank God you're here," when she arrived to support a woman in labor. Doctors and nurses largely seemed relieved that there was someone in the room to handle the emotional side of labor, especially when patients are scared, unsupported, or alone.

But one unexpected, complex challenge Supported Start encountered was what doulas sometimes witnessed in the delivery room. Brittany recalled one emotional doula meeting early in the program, when two of her doulas broke down in tears over separate incidents of non-consensual procedures and racist treatment they had witnessed. One doula quit shortly after that meeting saying, "I can't un-see it; it's too much." While Brittany had hoped that these were isolated incidents, they cropped up two more times over the next 18 months. Brittany did what she could to support doulas who witnessed traumatic situations, sometimes sitting on the phone with a doula for hours to work through it, listening to their anger and feelings. It was exhausting, but necessary work.

Typically, in the U.S. healthcare system, episodes of disrespect and abuse, when not leading to severe physical damage to the mother or her baby (in which case many patients would choose to pursue a medical malpractice suit), would be handled by Patient Advocates, staff employed by the hospital to collect patient complaints and communicate them to hospital or insurance

company leadership. This system did not lend itself to widespread knowledge that these incidents occurred among hospital clinicians or the insurance companies that reimbursed them. Hospitals typically dealt with complaints internally, and many patients weren't aware of what, if anything, was changed based on their feedback.

Since the doulas of Supported Start were employees of Brisby and used the hospital's EMR to record case notes, episodes of non-consensual procedures and racially insensitive or discriminatory care were making it into the patient records and were being reported directly to Brisby's leadership in the monthly reports Brittany sent. Inadvertently, Supported Start had brought more visibility to an issue that it had been created to address, making it seem to many hospital and insurance company leaders like the problem was on the rise. Brisby leadership feared these accounts would make it to the public eye, damaging their partner hospital's and perhaps even Brisby's reputation.

Furthermore, Supported Start's method of selecting clients eligible for doula services was coming under fire from two vocal patients. Both patients were women of color who had signed up for Supported Start early in their pregnancies. However, as demand for the program was high, neither client ended up being selected in the blind lottery system Grace and Brittany had devised. One of the clients took her frustration to a popular Facebook group used by pregnant women in the state, and accused Brisby of withholding services from women of color while the company claiming that Supported Start was meant to fight racial inequities in birth outcomes. Worse, for Brisby, the other patient wrote a negative review on the birthing hospital's website, naming Brisby and Supported Start.

Brittany had already fielded several tense calls from Grace as well as Brisby's Marketing Director, who practically yelled "Supported Start is a publicity nightmare!" She was sure that any modest gains in cost-savings wouldn't save the program from Brisby's fear of liability. The writing was on the wall, and although Brittany planned to make a case for keeping Supported Start, she was fearful that the outcome of the upcoming meeting wouldn't be favorable.

At a crossroads

Supported Start is at a crossroads. On one hand the program has offered an extra layer of support to vulnerable clients, who are happy with the program, and has achieved some modest reductions in C-section rates and rates of analgesic use during birth, saving Brisby money. On the other hand, Brisby leadership had hoped the program would put them ahead of the trend of including doula services in Medicaid, and by doing so gain them positive publicity. Given the threat of accounts of disrespect and abuse witnessed by doulas coming to light, and the negative public reactions of two clients who were not included in Supported Start, Brisby is worried that the expected positive publicity will in fact turn into a publicity nightmare.

As a local Ob/Gyn and Professor of MCH at the State University who has been called in as a consultant on MCH-related programming at Brisby in the past, you are seen as a neutral third party. You have heard Brittany's account of the development of the program as well as some of its successes and challenges. Brisby's leadership is looking to you to guide them on potentially shuttering Supported Start, or if not, what changes to make if any to turn the program around.

How will you address the concerns of Brisby leadership regarding Supported Start? What changes will you suggest to the program, if any, to improve the program itself and how it's received?