


Policies that shape maternity care: midwives and doulas

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October 2, 2015

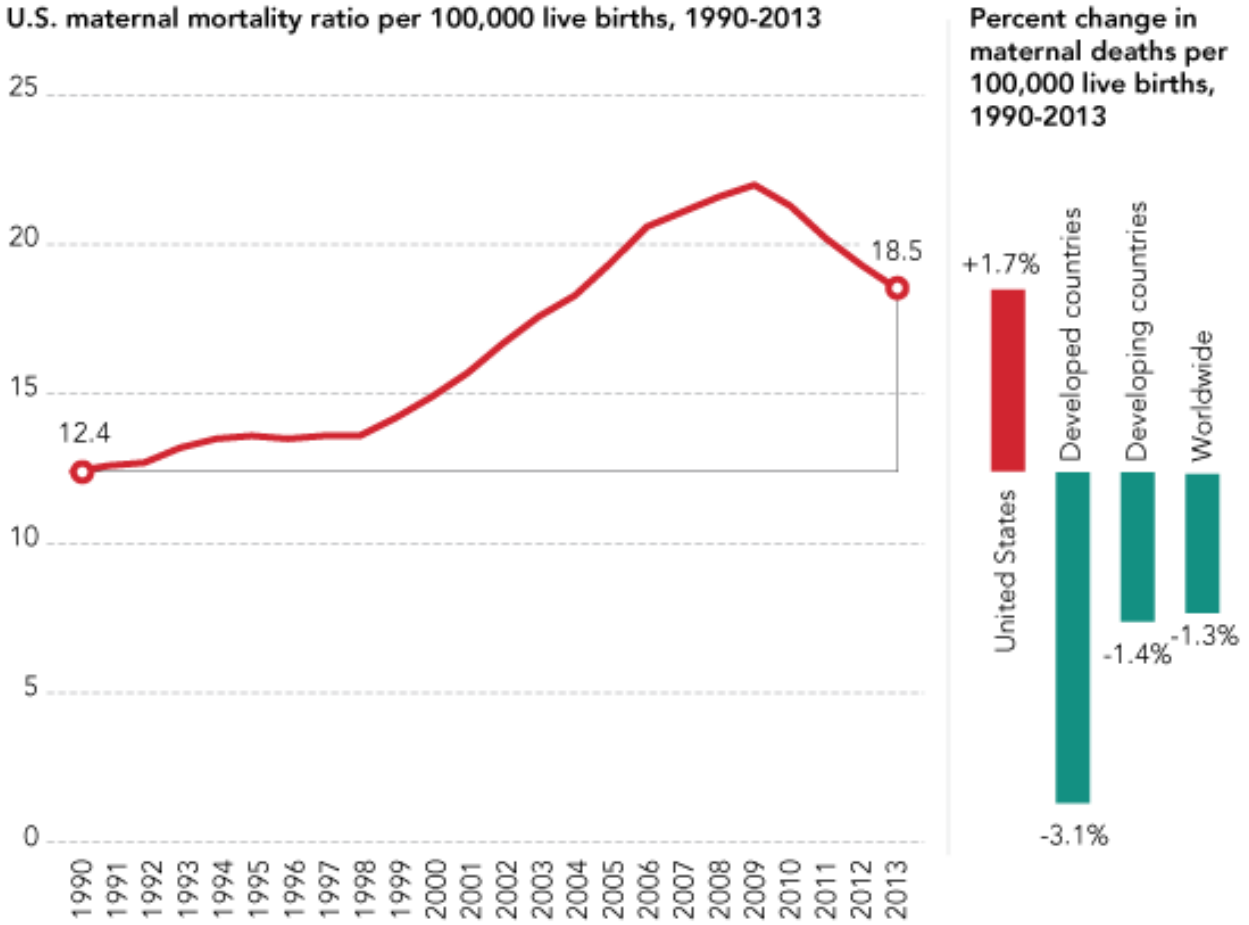
Objectives

1. To provide an overview of trends and costs in US maternity care
2. To provide a broad overview of state laws regarding autonomous midwifery practice and the association between these laws and maternity care
3. To describe a the role of a doula in childbirth and to review relevant research findings about doula-supported births
4. To understand Minnesota's current law about Medicaid payment for doula services

Being pregnant and welcoming a baby can be a joyful time in a woman's life.

But, as a country, we've got some problems.

U.S. Sees Biggest Increases In Maternal Death Rates In Developed World Since 1990



Source: The Institute for Health Metrics and Evaluation/The Lancet

THE HUFFINGTON POST

U.S. maternal health outcomes

- U.S. public health goals
  - High expectations: Healthy People 2010 goal of 3.3 deaths per 100,000 live births
  - Reality: 12.7 maternal deaths per 100,000 live births occurred in 2007
  - Healthy People 2020 target: 11.4 maternal deaths per 100,000 live births (10 percent improvement)
- Racial/ethnic disparities
  - Black women are 3 times more likely to die in childbirth than white women, unchanged for 20 years

Are there appropriate solutions?

Midwifery in the United States

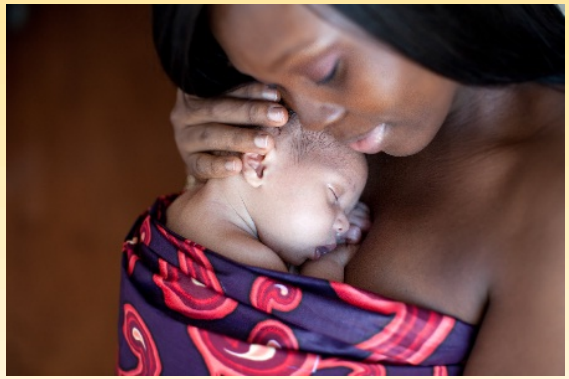
20th Century

Attended ~50% of all births

Today: 7.9% of Births

Documented benefits

- ↓ perinatal death, instrumental birth, and cesarean delivery
- ↓ antenatal hospitalization
- ↓ Hospital stays
- ↓ costs of care
- ↑ patient satisfaction



Sandall 2013 Cochrane Collaborative. http://dx.doi.org/10.1002/14651858.CD004667.pub3

Laws matter: our recent analysis

OBJECTIVE: document state scope-of-practice laws related to the autonomy of midwifery

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DATA

- 2009-2011 Natality Detail File (NDF)
- Sample Size: 12,106,161 births

Measurement

INDEPENDENT VARIABLE: State policy

- Autonomous Practice
- Collaborative Agreement

DEPENDENT VARIABLE: % Births attended by CNM

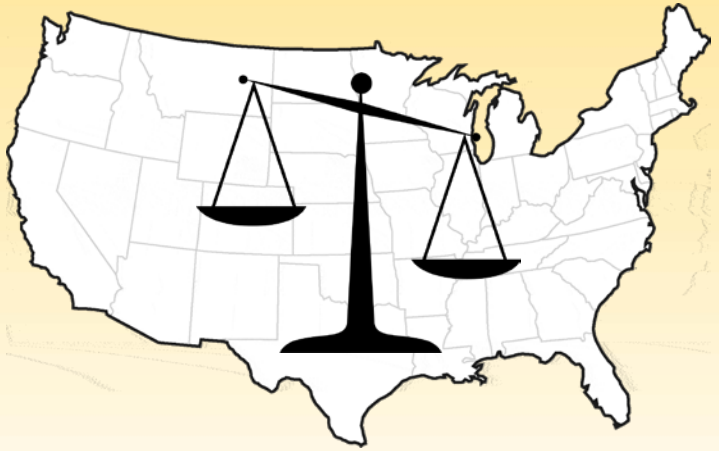
COVARIATES:

- maternal age, education
- race/ethnicity
- marital status
- parity
- potential risk factors

- Findings to be presented (manuscript is currently under peer review, and specific findings cannot be distributed at this time).

Will policy and legislation help?

- State policies that support midwifery:
  - greater % women with midwives attending births
  - lower % cesarean deliveries
  - fewer infants born low birth weight or preterm
  - fewer medical procedures and better outcomes
    - ↳ lower costs
  - better communication



****Causal analyses of the effects of policy changes are needed!!**

Are there other policy solutions?

What is a doula?

- The Doula Organization of North America (DONA), defines a doula as a "trained and experienced professional who provides continuous physical, emotional and informational support to the mother before, during and just after birth; or who provides emotional and practical support during the postpartum period."
- Unlike physicians, midwives, and obstetrical nurses who provide medical care, a doula provides support in the nonmedical aspects of labor and delivery.

The evidence is clear.

- Women with continuous labor support have:
  - higher rates of spontaneous vaginal birth
  - lower odds of cesarean delivery
  - lower rates of regional anesthesia (i.e. epidural)
  - lower rates of instrument-assisted delivery (i.e. forceps and vacuum)
  - shorter labors
  - higher levels of satisfaction

Hodnett, 2013 Cochrane Collaborative.
http://dx.doi.org/10.1002/14651858.CD003766.pub5

Obstetric Care Consensus: Safe Prevention of the Primary Cesarean Delivery

American College of Obstetricians and Gynecologists and the Society for Maternal Fetal Medicine (March 2014):

"Published data indicate that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula. A Cochrane meta-analysis of 12 trials and more than 15,000 women demonstrated that the presence of continuous one-on-one support during labor and delivery was associated with improved patient satisfaction and a statistically significant reduction in the rate of cesarean delivery. Given that there are no associated measurable harms, this resource is probably underutilized."

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine

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Access to doula care

- Financial access
  - Doula care packages costs range from $500-$1500
  - Health insurance typically does not cover doulas
- Cultural access
  - Most doulas are white, upper-middle class women
  - Most clients are white, upper-middle class women
- Geographic access
- Women at risk of poor birth outcomes
  - Racial/ethnic and cultural minorities
  - Low-income (Medicaid recipients) and uninsured

Spotlight on findings: Who wants doula support but doesn't have access?

- Black women (vs. white)
  - AOR = 1.77
- Women with public or no health insurance coverage (vs. private coverage)
  - AOR = 1.83, 2.01
- Women having a planned cesarean delivery
  - AOR = 1.83

Findings from our research:

- Women supported by doulas had significantly lower cesarean rates.
- Doula support reduces racial/ethnic disparities in breastfeeding initiation.
- The preterm birth rate was lower for women who received prenatal doula support than for Medicaid beneficiaries generally.
- Potential cost savings to Medicaid programs associated reductions in preterm birth and cesarean rates are substantial.
- State Medicaid programs should consider offering coverage for birth doulas

See References slide for detailed citations

Advice from Suze Orman:

Financial analyst Suze Orman hosts a show called Can I Afford it? On this show, people call in asking if various things they want to buy are things they can afford or if they would be good financial decisions.

On 4/20/2013, a caller named Bethany asks if she can afford a birth doula.

Suze's response: "You cannot afford to NOT get a doula, it is a NEED not a want."

http://video.cnbc.com/gallery/?video=3000162344

Who follows Suze's advice?

Minnesota Statues Chapter 108, Sec. 11

Sec. 11. Minnesota Statutes 2012, section 256B.0625, is amended by adding a subdivision to read:

Subd. 28b. Doula services. Medical assistance covers doula services provided by a certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For purposes of this section, "doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum.

Implementation – Payment (DHS)

- Setting up payment structure
  - Enrollment of providers
  - Clinical supervision/NPI number
  - Confusion among women, clinicians, health plans
- Current status
  - State Plan Amendment approved on 9/25/2014
  - Reimbursement rate ($411/6 visits + birth)
  - First reimbursement paid on 9/10/2015 – 50 weeks after effective date of law

Implementation – Certification (MDH)

- Quality assurance mechanism
- Minnesota State Doula Registry
  - Registration fee ($136)
- Certified doulas must be trained by one of 7 entities
  - Currently named in statute, but plans to change to reflect competencies, not organizations
- How to ensure quality of training and documentation without a huge burden on doulas, clinicians, and government entities?

Fixes in the works

- Clarification regarding “supervision” requirement and role of supervising clinicians
  - Or….should doulas be “licensed” so that they can bill Medicaid directly?
- Defining certification requirements as core competencies, not organizations
- Registry access for organizations Fee waivers, addressing barriers to entry
- Education/outreach to clinicians and health systems

Our research: Doula Access Project

- Purpose:
  - To document the challenges, opportunities, and effectiveness of Minnesota's policy extending Medicaid coverage to include doula care
  - Specifically:
    - Understand demand for and barriers to doula care
    - Train culturally-competent doulas from under-represented communities
    - Document the challenges and opportunities presented by Medicaid reimbursement

Project activities

- Recruit women from diverse communities to become certified Doulas (completed Oct 2014)
- Conduct focus groups with a diverse group of pregnant women (completed Jan 2015)
- Interview our new doulas, doula program administrators, health plan CEOs (completed April 2015)
- Interim report (completed July 2015)
- Collect and analyze data about doulas and about the births they support (ongoing)

Focus Group Findings

A Good Birth

- **Agency** - *"[having a doula] helps prepare you mentally; like it's gotten me more in the mindset of…the confidence throughout the pregnancy knowing that I can do this*."
- **Security** – *"I'm scared…And [the doula] is like, oh, no don't be…It's very comforting to know that you have somebody has your back"*
- **Connectedness** – *"…it's good to have a doula because the doctors will say this and your family may say this, but the doula is mindful of who you are."*
- **Respect** – *"Someone that is not only knowledgeable, but can put things I guess in layman's terms, but also in a way that you understand it and respects your culture."*
- **Knowledge** – *"My reasons for wanting a doula. [It's] because I don't have nobody right now, and if I go into labor,…I don't know the techniques or how to calm down"*

More information: Interim report

Kozhimannil KB, Vogelsang CA, Hardeman RR. Medicaid Coverage of Doula Services in Minnesota: Preliminary findings from the first year. Interim Report to the Minnesota Department of Human Services. July 2015. Available at: http://sph.umn.edu/faculty1/hpm/name/katy-kozhimannil/

Acknowledgments

- **Funding support**:
  - Eunice Kennedy Shriver National Institutes of Child Health and Human Development (NICHD; grant number R03HD070868)
  - Building Interdisciplinary Research Careers in Women's Health Grant (grant number K12HD055887) from the National Institutes of Health.
  - University of Minnesota, Clinical Translational Sciences Institute (CTSI) Community Health Collaborative Grant
  - American College of Nurse Midwives (ACNM) Foundation Thatcher Grant
- **Acknowledgments:**
  - Co-authors (listed on References slide)
  - Community collaborators: Everyday Miracles, HCMC, Mewinzha, Cultural Wellness Center

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Thank you

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Additional information from DHS interim report (July 2015)

Interim report: Barriers and challenges

- Low reimbursement rates are a significant barrier to entry for doulas, an obstacle to sustainability and retention of doulas, and a financial feasibility challenge for doula program administrators.
- Doulas have had difficulty becoming enrolled providers.
- Medicaid programs must pay licensed providers in order to receive federal matching funds. Doulas are not licensed in Minnesota, so – to be reimbursed by Medicaid - doula services must be provided under the supervision of a licensed clinician and billed through that clinician's National Provider Identification (NPI) number.
- Lack of awareness of doula coverage among Medicaid beneficiaries, maternity care clinicians, and health care delivery systems.

Interim report: Barriers and challenges

- Lack of information among health plan customer service representatives to assist women who inquire about coverage.
- Doula training, certification, and registration are costly, and many low-income women and women from communities of color have limited financial access to the doula profession.
- Limited representativeness of communities of color among doula trainers and doulas.
- Topics that are crucial to doula care for Medicaid beneficiaries – including trauma, infant loss, poverty, intimate partner violence, structural racism, etc. – are not sufficiently covered in all doula certification courses.
- The purpose and utility of the state doula registry was questioned by doula organizations and managed care organizations

Interim report: Recommendations for legislative change

- Create a licensure process for doulas in Minnesota.
- Modify the Minnesota state doula registry to allow for non-profit organizations to be listed.
- Establish a fee waiver process for fees for doula certification and registration for low-income applicants, and also establish a separate fee for organizations to apply to appear on the registry.
- Allow payment for travel mileage as part of doula services reimbursement
- Augment doula certification (or licensing) requirements to include education on trauma-informed care and on social and structural determinants of pregnancy and childbirth care.
- Enhance diversity and capacity by creating a grant program to support doula training to increase the available doula workforce to support pregnant Medicaid beneficiaries.

Interim report: Recommendations for improving implementation

- DHS (MN Medicaid program) should review currently-available evidence and reassess the reimbursement rate for doula services
- DHS should provide clear information about all of the documentation required for payment of claims for doula care.
- DHS and MDH should establish a formal coordination structure to interface with one another on issues related to the registry/credentialing (MDH) and payment (DHS).
- This joint coordinating group should serve as a resource for doulas, maternity care clinicians, and managed care organizations so that shared information is clear and transparent.
- DHS should provide education to clinicians and hospitals about the role of a doula and the content of the statute that requires Medicaid payment for doula services.