

ADVERSE BIRTH OUTCOMES DISPARITIES RECOMMENDATIONS

The Governor's Interagency Council on Health Disparities, in its previous report to the Governor and Legislature, submitted three recommendations to work toward the elimination of disparities in adverse birth outcomes. In brief, those recommendations were to:

- Fund local communities at high risk for adverse birth outcomes to develop and implement community-driven prevention programs.
- Increase funding for First Steps to enhance the Maternity Support Services program.
- Promote equity in state government through cultural humility and Government-to-Government training for state employees, the use of equity assessment tools in agency decision making, and increased capacity for Health Impact Reviews.

More detailed information on those recommendations, including evidence for their effectiveness, as well as background information and data on adverse birth outcomes is included in the [June 2015 Update](#) report. As a brief summary, racial/ethnic disparities in low birthweight, infant mortality, and other adverse birth outcomes persist for Washington's communities of color, particularly African American and American Indian/Alaska Native populations. As a result, Governor Inslee has made the elimination of disparities in low birthweight a priority in Results Washington.

Results Washington Indicator:
Decrease the percentage of infants born with low birthweight among Blacks from 9.6% in 2011 to 9.3% in 2016 and among American Indian and Alaska Native populations from 8.7% in 2011 to 8.5% in 2016.

Adverse Birth Outcomes Disparities Advisory Committee

In order to contribute to ongoing efforts in the state to address adverse birth outcomes (also detailed in the June 2015 Update), the Council convened an advisory committee to assist with developing recommendations. The committee represented community-based organizations and coalitions, health care practitioners, state and local governmental organizations, tribal organizations, and other nonprofit entities. The committee originally met six times from February through April 2015 and presented its recommendations to the Council at its May 13, 2015 meeting. It then decided to continue working to develop further recommendations and met four more times from June through October 2015. Table 1 includes a list of committee members and consultants who participated in the process, either in the development of the first round of recommendations, the second, or both.

DRAFT

For Consideration by the Governor’s Interagency Council on Health Disparities on 12/9/2015

Table 1: Adverse Birth Outcomes Disparities Advisory Committee Members and Consultants	
Name	Organization/Affiliation
Laura Alfani	Department of Early Learning
Sofia Aragon	Commission on Asian Pacific American Affairs (formerly with)
Vazaskia Crockrell	Governor’s Interagency Council on Health Disparities
Sheila Capestany	King County Department of Community and Human Services
Maria Carlos	Public Health—Seattle King County (formerly with)
Kathy Chapman	Department of Health
Nora Coronado	Commission on Hispanic Affairs
Marsha Crane	American Indian Health Commission
Emma Medicine White Crow	Governor’s Interagency Council on Health Disparities
Meghan Donohue	Qualis Health
Stephanie Dunkel	Department of Health (formerly with)
Sharon Eloranta	Qualis Health
Cindy Gamble	American Indian Health Commission
Neve Gerke	Midwives Association of Washington State
Kelly Reese Harmon	Open Arms Perinatal Services (Board)
Lori Hernandez	Department of Early Learning
Katie Hess	United Indians of All Tribes Foundation
Kim James	DoulaMatch
Lonnie Johns-Brown	Office of the Insurance Commissioner
Lea Johnson	Tacoma Pierce County Public Health
Annie Kennedy	Simkin Center for Allied Birth Vocations, Bastyr University
Judy King	Department of Early Learning
Michelle Kinne	St. Joseph Medical Center
Gina Legaz	March of Dimes
Laurie Lippold	Home Visiting Coalition
Devon Love	Center for MultiCultural Health (formerly with)
Shelley Means	Native American Women’s Dialogue on Infant Mortality
Marcy Miller	Thrive Washington
Ann Mumford	Black Infant Health Program
Sharon Muza	Certified Birth Doula and Lamaze Certified Childbirth Educator
Jan Olmstead	American Indian Health Commission
Dila Perera	Open Arms Perinatal Services
Michelle Sarju	Open Arms Perinatal Services
Leah Tanner	Global Alliance to Prevent Prematurity and Stillbirth
Polly Taylor	Department of Health
Crystal Tetrick	Public Health—Seattle & King County
Heather Weiher	Health Care Authority
Laura Wells	Home Visiting Coalition
Eva Wong	Public Health—Seattle & King County
Liv Woodstrom	Thrive Washington
Casey Zimmer	Health Care Authority

New Recommendations

Recommendation 1 —Medicaid Reimbursement for Doula Care

The Legislature should provide the Health Care Authority funding to provide Medicaid reimbursement for doulas as Community Health Workers or Community Health Representatives. When integrating doula care, the Health Care Authority should:

- Allow reimbursement for prenatal visits, attending the birth, and postnatal follow-up.
- Ensure that qualified doulas meet the following criteria:
 - Must receive professional doula training.
 - Must be certified through a certifying organization such as PALS Doulas or DONA International.
- Contract with Tribal or Urban Indian Health Organizations or accredited **community-based doula programs** that ensure competency and appropriately match childbearing individuals to doulas that align with their culture, language, religion, and other characteristics.

Community-based doula programs meet five essential components: (1) employ women who are trusted members of the target community, (2) extend and intensify the role of doula with families from early pregnancy through the first months postpartum, (3) collaborate with community stakeholders/institutions and use a diverse team approach, (4) facilitate experiential learning using popular education techniques and the HC One training curriculum, and (5) value the doula's work with salary, supervision and support. *Source: [Health Connect One](#).*

In addition, the Legislature should explore options for funding and/or incentivizing the development of more community-based doula programs and a more diverse doula workforce.

How does doula care reduce disparities in adverse birth outcomes? And how can Medicaid reimbursement for doula care generate cost-savings?

- A birth doula is a "trained and experienced professional who provides continuous physical, emotional and informational support to the mother before, during and just after birth."¹
- A 2013 Cochrane research review concluded that, "Continuous support during labour has clinically meaningful benefits for women and infants and no known harm. All women should have support throughout labour and birth." The review found doula support was associated with lower rates of cesarean births and lower use of pain medications and vacuum extraction or use of forceps. Those who received doula care had slightly shorter labor and were more likely to report being satisfied. Babies born to individuals receiving doula care were less likely to have low five-minute Apgar scores. Doula care was not associated with any adverse effects. The review also found that doula support was most effective when the doula was not affiliated with the hospital nor a part of the childbearing person's own social network."²
- In 2014, the American College of Obstetricians and Gynecologists released a consensus statement that concluded, "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...Given that there are no associated measurable harms, this resource is probably underutilized."³
- Women of color and those with public health insurance are more likely to experience adverse birth outcomes and are more likely to desire but not have access to doula care."⁴

For Consideration by the Governor's Interagency Council on Health Disparities on 12/9/2015

- Recent research compared birth outcomes for Medicaid recipients in Minnesota who received coverage for prenatal and birth support from doulas to outcomes from a national sample of Medicaid recipients. The study found that cesarean rates were significantly lower for women receiving doula care (22.3% vs. 31.5%). Preterm birth rates were also lower for those receiving doula care (6.1% vs. 7.3%); however the differences in preterm birth rates were not statistically significant. The authors conclude that, "Among vulnerable subgroups, such as Black women, lower cesarean and preterm rates for doula-supported births are indicative of the role doulas could play in reducing persistent racial/ethnic disparities in these outcomes if high-quality doula services were made financially and culturally accessible to women at highest risk of poor outcomes."⁵
- The study in Minnesota also modeled cost-savings associated with reduced cesarean rates for state Medicaid programs, including Washington State. The models estimated that at a \$200 reimbursement rate for doulas, the Washington State Medicaid program could save between \$286,442 and \$14,721,406 per year depending on the percent reduction in cesarean deliveries achieved.⁶
- Community-based doula programs are evidence-based, culturally appropriate programs that match childbearing persons to doulas from their community. Evidence shows their effectiveness, particularly in lowering cesarean rates and improving breastfeeding rates.⁷

Recommendation 2—Support the American Indian Health Commission's Maternal-Infant Health Strategic Plan

In an effort to improve access to services and improve birth outcomes for American Indian/Alaska Native women, as well as other people of color, the Legislature should support the recommendations outlined in the American Indian Health Commission's Maternal-Infant Health Strategic Plan.

How will supporting the American Indian Health Commission's Maternal-Infant Health Strategic Plan improve birth outcomes and reduce disparities experienced by American Indians/Alaska Natives?

- The American Indian Health Commission (AIHC) is a Tribally-driven, non-profit organization in Washington State. Its mission is to improve health outcomes for American Indian/Alaska Natives through a health policy focus. The AIHC includes delegates from the 29 federally recognized Tribes and two Urban Indian Health Organizations in Washington State.⁸
- In December 2010, the AIHC released its Maternal-Infant Health Strategic Plan,⁹ following two years of careful research and development strategies. To develop the plan, the AIHC created a Maternal-Infant Health Workgroup; reviewed literature and data; conducted interviews with key informants; surveyed Tribal and Urban Indian Health Organization directors; conducted interviews with Tribal Women Infants and Children program staff; held nine meetings of the Maternal-Infant Health Workgroup to facilitate review and discussion of recommendations; and held focus groups with women and teen Tribal members and Urban Indians. The AIHC reviewed portions of the plan at meetings and in October 2010 passed a resolution accepting the Maternal-Infant Health Strategic Plan for presentation, review, and discussion at the Tribal Leaders Health Summit later that year.

The Maternal-Infant Health Strategic Plan was developed using the following guiding principles: (1) to identify the most significant problems where interventions can make the greatest

DRAFT

For Consideration by the Governor's Interagency Council on Health Disparities on 12/9/2015

difference, (2) to create measurable goals to eliminate disparities, (3) to adopt strategies using approaches proven to be effective, (4) **to recognize that Tribes and Urban Indian programs can deliver the most culturally appropriate and geographically accessible programs to American Indians**, (5) to recognize that each Tribe and Urban Indian program must prioritize the actions they will take, (6) to look for solutions that are cost-effective, (7) to recognize that state investment in maternal and infant health for American Indian/Alaska Natives will reduce Medicaid costs, and (8) to integrate state-funded and federally funded programs with existing Tribal, Urban Indian, and Indian Health Services programs.

¹ DONA International. Accessed at: <http://www.dona.org/mothers/> on 11/24/2015.

² Hodnett et al. (2013). Continuous support for women during childbirth. Cochrane. Accessed at: http://www.cochrane.org/CD003766/PREG_continuous-support-for-women-during-childbirth on 11/24/2015.

³ Caughey et al. & American College of Obstetricians and Gynecologists (2014). Safe prevention of the primary cesarean delivery. *American journal of obstetrics and gynecology*, 210(3), 179-193.

⁴ Kozhimannil et al. (2014). Potential Benefits of Increased Access to Doula Support During Childbirth. AJMC. Accessed at: <http://www.ajmc.com/journals/issue/2014/2014-vol20-n8/potential-benefits-of-increased-access-to-doula-support-during-childbirth/P-7> on 11/24/2015.

⁵ Kozhimannil et al. (2013). Doula Care, Birth Outcomes, and Costs Among Medicaid Beneficiaries. *American Journal of Public Health*. 103(4):e113-e121.

⁶ Ibid.

⁷ Health Connect One (2014). The Perinatal Revolution: New research supports the critical role Community-Based Doula Programs can play in improving maternal and child health in underserved birthing populations. Accessed at: http://www.healthconnectone.org/pages/new_study_the_perinatal_revolution/362.php on 11/24/2015.

⁸ American Indian Health Commission Web site. Accessed at: <http://www.aihc-wa.com/about-us/who-we-are/> on 11/24/2015.

⁹ American Indian Health Commission (2010). Healthy Communities: A Tribal Maternal-Infant Health Strategic Plan. Accessed at <http://www.aihc-wa.com/about-us/who-we-are/> on 11/24/2015.