

**Report Title:** Advancing Health Equity for Childbearing Families in Oregon: Results of a Statewide Doula Workforce Needs Assessment

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**Author Information:** Courtney L. Everson, PhD.<sup>a, b, ±</sup>, Courtney Crane, MS, MPH<sup>c</sup>, & Raeben Nolan,<sup>a, d</sup>

<sup>a</sup> Oregon Doula Association, 789 NE Edgehill Drive, Estacada, OR 97023

<sup>b</sup> Midwifery Sciences Program, Midwives College of Utah, 1174 East Graystone Way STE 2, Salt Lake City, UT, USA, 84106

<sup>c</sup> Oregon Health Sciences University and Portland State University, School of Public Health, 840 SW Gaines Street, Room 230, Portland, OR, USA, 97239

<sup>d</sup> Doula Program, Birthingway College of Midwifery, 12113 SE Foster Road, Portland, OR, USA, 97266

**± Corresponding Author:** Dr. Courtney L. Everson, Midwives College of Utah, 1174 East Graystone Way STE 2, Salt Lake City, UT, USA 84106 (address); 801-649-5230, ext. 806 (phone); 866-207-2024 (fax); Courtney.Everson@midwifery.edu (email)

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## Executive Summary

This report, entitled *Advancing Health Equity for Childbearing Families in Oregon: Results of a Statewide Doula Workforce Needs Assessment*, documents the first-ever workforce needs assessment of the doula landscape in the State of Oregon. In 2013, Oregon became the first state in the nation to designate birth doulas as eligible for Medicaid reimbursement. This landmark legislation was envisioned as a health equity measure, given the grave maternal and neonatal health inequities experienced by childbearing families of color, both nationally and in Oregon. The Oregon Doula Association (ODA) was commissioned by the Oregon Office of Equity & Inclusion (OEI) to complete this workforce needs assessment. OEI provided a grant to ODA to accomplish project objectives. Using a mixed methodology and community-engaged approach, perspectives of doulas, employers, and key informants provided rich data for understanding the complexity of the landscape. Specifically, this project employed three concurrent phases: Phase I involved listening sessions with Oregon doulas (n=38); Phase II involved key informant interviews with Traditional Health Worker (THW) program stakeholders, specifically, Coordinated Care Organization (CCO) representatives and State of Oregon employees with the Oregon Health Authority (n=5); and Phase III involved online surveys with Oregon doulas (n=130) and doula employers (n=26).

In the background section of this report, we report on findings from secondary analyses of maternal and neonatal health outcomes in Oregon, characteristics of state approved THW Birth Doulas, and claims data for doula activity in the Oregon Medicaid Population. The results section constitutes the bulk of this report, where results are reported in detail for each of the three project phases. In Phase I, twelve primary themes with sub-themes emerged from the listening sessions with doulas, including: characteristics of full time doula work; demand for doulas and public understanding; the complex nature of doula work; practice relationships and employment structures; rapport between doulas and obstetrical providers; health systems challenges to doula integration; challenges to doula buy-in as THWs; challenges to serving as THW doulas; billing and reimbursement challenges and opportunities; enhancing the doula career; culturally and linguistically diverse doula care; and postpartum doula work potentials. In Phase II, two primary themes with sub-themes emerged from key informant interviews: successes in integration of doulas and challenges in integration of doulas. There were also four shared thematic results that emerged from collective analysis of key informant interviews and listening session narratives: framing doula services in policy and health systems as a health equity measure; expanding the doula role; the importance of trauma-informed care; and enhancing the role of the Oregon Doula Association. Finally, Phase III results of online surveys with doulas and employers provide a robust picture of the doula workforce in Oregon, including access and utilization barriers, opportunities, and demand. Results of the project clearly identify the emergent barriers and successes for the doula workforce in Oregon, specifically as they relate to culturally and linguistically appropriate doula care for underserved communities and utilization of the THW Birth Doula Program.

Fifteen total recommendations provide a clear roadmap for the future: 1) Educate community members about doulas; 2) Involve families in THW Birth Doula Programming; 3) Invest in community-based organizations; 4) Expand training offerings; 5) Support doulas in navigating the THW process; 6) Ensure consistency in claims paid; 7) create networking and mentorship opportunities for doulas; 8) Educate and engage health care providers on the role of doulas; 9) Invest in hospital doula programs; 10) Create doula billing hubs; 11) Increase the reimbursement rate; 12) Examine the doula role as an extension of existing roles; 13) Expand the utility of the THW birth doula registry; 14) Mandate CCO involvement in the THW Birth Doula Program; and 15) Advance efforts of the Oregon Doula Association.

## Definitions

**Doula** (as defined by the State of Oregon): A (Birth) Doula is a birth companion who provides personal, nonmedical support to women and families throughout a woman's pregnancy, childbirth, and postpartum experience. (From original version of the THW rules, 410-180-0300).

**Birth or Labor Doula** (professional definition): A birth or labor doula is a trained childbirth professional who provides emotional, educational, advocacy, and physical support to a childbearing person and their family during the prenatal, birth, and immediate postpartum periods.

**Postpartum Doula** (professional definition): A postpartum doula is a trained childbirth professional who provides parental and newborn support to families during the first three to four months postpartum.

**Full Spectrum Doula** (professional definition): A full spectrum doula is a trained professional who provides emotional, educational, advocacy, and physical support throughout an individual's reproductive lifespan, whether or not they are pregnant and through all pregnancy outcomes, including abortion, miscarriage, and adoption.

**Community-Based Doula** (professional definition): A community-based doula is trained to provide a more extensive level of doula support during pregnancy, labor/birth, and the postpartum period. Moreover, community-based doulas are members of the communities they are serving.

**Doula-Friendly:** The term "doula-friendly" for the purposes of this report means that the hospital and/or care providers are generally designated as supportive or encouraging of patients in utilizing a doula and are able to work collaboratively with doulas during patient care.

**Appropriately Utilized:** The term "appropriately utilized" for the purposes of this report means that the doula is able to engage the work they are specifically trained to do and are not asked to step outside of scope or appropriate utilization parameters.

## Introduction

A doula is a certified childbirth professional who provides personal, non-medical support to childbearing families throughout the pregnancy, labor/birth and postpartum experience. Prior to birth, doulas work with families to increase health literacy and knowledge, which leads to more informed healthcare decision making and better access to appropriate care. During labor and delivery, doulas provide continual physical comfort measures, emotional support, and informational support. After birth, doulas provide breastfeeding support as well as informational and emotional support related to postpartum and newborn care. Numerous studies have documented the benefits of doula care for improving maternal and neonatal health outcomes and experiences (Bohren et al., 2017; Everson et al., 2018; HealthConnect One, 2014; Kozhimannil, Hardeman, et al., 2016; Kozhimannil, Vogelsang, et al., 2016; Kozhimannil, Hardeman, Attanasio, Blauer-Peterson, & O'Brien, 2013; Steel, Frawley, Adams, & Diezel, 2015). In 2017, Bohren and colleagues published a Cochrane Systematic Review on the effects of continuous support for women in childbirth. Using the Cochrane Pregnancy & Childbirth Group's Trials Register, the review included all published and unpublished randomized controlled trials that compared continuous support during labor with standard care. In total, twenty-six trials involving 15,858 women were included in the review. Statistically significant main findings are as follows: increased rates of spontaneous vaginal delivery, decreased negative childbearing experiences, decreased rates of intrapartum analgesia, decreased average labor length, decrease cesarean section rates or instrumental vaginal delivery, decreased rates of regional analgesia, and decreased rates of low five-minute Apgar scores. Based on findings, the authors conclude that: "Continuous support in labour may improve a number of outcomes for both mother and baby, and no adverse outcomes have been identified. Continuous support from a person who is present solely to provide support, is not a member of the woman's own network, is experienced in providing labour support, and has at least a modest amount of training (such as a doula), appears beneficial. In comparison with having no companion during labour, support from a chosen family member or friend appears to increase women's satisfaction with their experience" (Bohren et al, 2017, p. 4). Similarly, the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SFM) put forth a joint statement in 2014, reaffirmed in 2016, stating that "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" (ACOG & SFM, 2016, p. 13)

The purpose of this project was to conduct a statewide environmental scan of the doula workforce and a needs assessment on access and utilization of doula care in Oregon. The environmental scan and needs assessment were specifically focused on doulas as Traditional Health Workers (THW), their Medicaid eligible provider status, culturally-specific and linguistically-specific care provision, and subsequent systems integration in order to serve Oregon's most underrepresented communities and redress health inequities. Three broad objectives guided this project:

O<sup>1</sup>: Conduct a statewide environmental scan to determine doula workforce demographics and composition by key sociodemographics, including, but not limited to: race, ethnicity, language, disability.

O<sup>2</sup>: Conduct a statewide needs assessment on doula care access and utilization, including barriers, challenges, and successes to participation as Medicaid-eligible providers and state registered doulas, workforce development and retention, reimbursement pathways, and culturally- and linguistically- specific service delivery.

O<sup>3</sup>: Conduct a statewide needs assessment on doula care employers, as it specifically relates systems integration and the ability of Oregon doulas to serve underrepresented communities as Medicaid-eligible providers and to receive Medicaid-enabled compensation for services

In 2017, the Oregon Legislature enacted House Bill 3261 that requires the Oregon Health Policy Board to conduct health care needs assessments of the state. The Oregon Doula Association was commissioned by the Oregon Office of Equity & Inclusion to complete this workforce needs assessment. The Oregon Doula Association (ODA) is the statewide professional association for doulas in Oregon. The Oregon Office of Equity and Inclusion (OEI) is an office within the Oregon Health Authority (OHA) that supports equity, diversity, and inclusion for all Oregonians, as it relates to the elimination of health care gaps and promotion of optimal health for all. OEI specified the target audience, scope, and deliverables for this project, which the ODA was entrusted to carry out accordingly.

## Background

In 2013, Oregon became the first state in the nation to designate birth doulas as eligible for Medicaid reimbursement. Medicaid reimbursement greatly increases the accessibility of doula care for underserved communities. Public insurance reimbursement can also create a clearer pathway for doulas to be reimbursed by other insurance and third-party payers, thus increasing doula accessibility for more families. This first-in-the-nation legislation was framed as a health equity strategy for maternal and infant well-being, where inequities by race, ethnicity, age, geographic location, language status, differential ability, immigration status, and income persist (Amnesty International, 2011; Centers for Disease Control, 2018; Creanga et al., 2012; Mathews & Driscoll, 2017; Molnar et al., 2015). Documented disparities on national and state levels, as delineated below, are unacceptable. Childbearing families, communities, and babies are suffering. Health equity strategies at community, programmatic, institutional, and policy levels must be advanced (Dau, 2016; Jackson, 2014; Serbin and Donnelly, 2016; Tyson and Wilson-Mitchell, 2016). Oregon's Traditional Health Worker program and landmark legislation is intended to help accomplish exactly that. However, barriers and gaps to reaching full implementation potential continue to exist. As commissioned by the Oregon Office of Equity and Inclusion, this workforce needs assessment project provides perspective on the main challenges and opportunities that exist to implementation and highlights recommendations for ensuring accessible, culturally appropriate doula services for childbearing families in Oregon.

### Inequities in Childbirth: National and Local Trends

*National and State Vital Records Final Birth Data were used for this portion of the report*

Nationally, racial and ethnic identities persist in childbearing and the United States continues to face a perinatal health care crisis. Key maternal and neonatal health outcomes nationally, by race/ethnicity, birth year 2016, are summarized below in Table 1.1 (Martin et al., 2018). Additionally, 42.6% of all deliveries in the United States in 2016 had Medicaid as the principal source of payment, 5% of births were to adolescents under the age of 20, and 45% of birthing people self-identified as people of color (Martin et al., 2018).

**Table 1.1: Select Maternal and Neonatal Health Outcomes, United States, by race/ethnicity**

Final Birth Data, 2016, USA (Source: NCHS, 2018)	Cesarean	Preterm	Low Birth Weight	Neonate Breastfed at Discharge
<b>TOTAL</b>	<b>31.9%</b>	<b>9.85%</b>	<b>8.17%</b>	<b>83.1%</b>
NON-HISPANIC WHITE	30.9%	9.04%	6.97%	84.4%
NON-HISPANIC BLACK	35.9%	13.77%	13.68%	70.8%
AMERICAN INDIAN/ALASKA NATIVE	28.0%	11.39%	7.77%	74.8%
ASIAN	33.3%	8.63%	8.43%	91.0%
NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER	30.5%	11.52%	7.67%	82.3%
HISPANIC	31.7%	9.45%	7.32%	87.3%

In Oregon, 45% of births in 2017 had Medicaid/OHP listed as the principal source of payment, 4% of births were to adolescents under the age of 20, and 32% of birthing people self-identified as people of color (Oregon Health Authority, 2018). As with national trends, state-level trends in childbearing demonstrate significant health inequities facing childbearing families. Table 1.2 summarizes key maternal and infant health outcomes, by race and ethnicity for Oregon, birth year 2017 (Oregon Health Authority, 2018).

**Table 1.2: Select Maternal and Neonatal Health Outcomes, Oregon, by race/ethnicity**

Final Birth Data, 2017, Oregon (Source: OHA, 2018)	Cesarean	Preterm	Low Birth Weight	Neonate Breastfed at Discharge (years 2014-2016. OHA, 2017)
<b>TOTAL</b>	<b>28.1%</b>	<b>8.3%</b>	<b>6.8%</b>	<b>83.1%</b>
WHITE	27.7%	7.9%	6.4%	92.8%
BLACK	32.9%	9.8%	8.9%	89.7%
AMERICAN INDIAN/ALASKA NATIVE	32.1%	15.0%	9.7%	85.6%
ASIAN	31.0%	7.5%	8.6%	94.5%
NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER	35.9%	12.5%	6.9%	86.9%
HISPANIC	27.3%	9.1%	7.0%	92.1%
MULTIPLE RACES	28.7%	9.7%	7.8%	92.0%

## History of the Landmark Legislation

*Excerpts for this section provided with permission from the article: Catlin, D., Everson, C., Remer, J., & Nolan, R. (2017). Integrating Doulas into the Maternity Care Team: A Health Care Transformation Measure. Midwifery Today, 124, 35-36.*

In 2011, House Bill 3311 passed through the Oregon State Legislature. HB 3311 explored the role of doulas in improving birth outcomes for marginalized communities. This initial legislation was prompted by Shafia Monroe, midwife and Founder of the International Center for Traditional Childbearing (ICTC), and colleagues. The subsequent 2012 report (entitled: *Utilizing Doulas to Improve Birth Outcomes for Underserved Women in Oregon*) recommended that Oregon incorporate doulas into Oregon's health care system as an overall strategy to improve birth outcomes for Oregon's most underrepresented communities and to redress health inequities. Specifically, the report states: "Based on research reviews, doulas are likely to be a strategy to decrease health inequities in Oregon's birth outcomes. Additionally, the committee found doulas would be an overall strategy to improve birth outcomes funded by both Medicaid and private insurance." Concurrent to this, the Oregon State legislature passed House Bill 3650 in 2011, which designated four worker types of Traditional Health Workers (THWs), namely: peer wellness specialists, peer support specialist, personal health navigators, and community health workers. Then, in 2012, Senate Bill 1580 passed, which mandated utilization of the THWs in health systems transformation. Following, a steering and rules advisory committee was formed by the State to write the rules and processes governing the state registry requirements, training curriculum, payment methods, and much more. In 2013, doulas became the fifth type of THW. Finally, House Bill 3407 passed in 2013 to establish the THW commission, who advises the Oregon Health Authority in all matters related to implementation of THWs as covered Medicaid services.

During this process, it became evident that a statewide professional doula organization was essential for adequately representing the interest of doulas during integration into the health care system. A workgroup of statewide doula professionals was thus convened. From this collaborative envisioning, the Oregon Doula Association (ODA) was formed. The initial board was elected with a focus on a culturally, racially, and regionally diverse board. The ODA established relationships with the Oregon Health Authority and the Oregon Office of Equity and Inclusion (OHA and OEI), the Division of Medicaid Assistance Programs (DMAP), and several Oregon legislators. ODA Board members hold seats on the THW Commission and subcommittees. State entities, doulas, and community organizations now look to the ODA for guidance in all matters related to doula care and systems integration.

## State Model for Birth Doula Care and Priority Populations

The state model for birth doula care includes at least two prenatal visits, intrapartum care, and at least two postpartum visits. As part of the model, doulas are required to be certified by the state and are placed on the state THW registry. The priority populations for doula service are: a woman with a racially or ethnically diverse background including, Black/African American, Asian, Pacific Islander, Native American, Latino, or multi-racial; a homeless woman; a woman who speaks limited to no English; a woman who has limited to no family support; and a woman who is under the age of 21.

## Utilization of Doulas as Traditional Health Workers: A Snapshot

*The Registry can be found at: <https://traditionalhealthworkerregistry.oregon.gov/>*

### State Registry Data: State Certified THW Birth Doulas

Doulas who would like to be designated as THW Birth Doulas, eligible for Medicaid reimbursement, must fulfill the State of Oregon’s requirements for birth doula certification, as outlined by OHA-OEI (for details, see: <https://www.oregon.gov/oha/OEI/Pages/THW%20Doula.aspx>). On September 28<sup>th</sup> 2018, a snapshot of the registry was taken for the purposes of this report. In total, since the registry became active, 60 doulas have been certified and approved. At the time of the snapshot on 9/28/2018, there were 42 active certifications; re-certification is required as part of maintaining certification eligibility. Of the 60 certifications ever approved, 20 counties of the 36 counties in Oregon had state approved doulas eligible to serve (Table 1.3). Clear gaps in service exist with regards to geographic location with forty-five percent (45%) of counties completely unserved by state approved doulas. Additionally, within the 55% of counties that do have state approved doulas, the dominance of service is occurring in the urban areas of Portland and, thus, rural areas remain underserved.

**Table 1.3: n=60 Certifications (Ever Approved), by Counties Served**

Counties Served	Number of Doulas
Benton	5
Clackamas	27
Clatsop	4
Columbia	6
Coos	1
Douglas	3
Hood River	1
Jackson	8
Jefferson	1
Josephine	5
Klamath	1
Lane	7
Lincoln	3
Linn	5
Marion	5
Multnomah	32
Polk	4
Tillamook	3
Washington County	24
Yamhill	5
Missing	5
Statewide	1

*Note: these are duplicated counts, as doulas can indicate more than one county served.*

### State Claims Data: Doula Activity in the Oregon Medicaid Population

In addition to examining the state registry, we also analyzed claims data for doulas serving the Oregon Medicaid population from January 2016 through June 2018. Aggregate data were provided by the OHA Office of Health Analytics and analyzed by the primary author. In total, in this 30-month period, 121 doula activity claims were submitted for reimbursement. Of these, 76% were paid and 24% were denied.

The breakdown of paid and denied claims, by patient age, race/ethnicity, and household language, are summarized below in Tables 1.4 to 1.6 (Doula Claims in the Oregon Medicaid Population).

**Table 1.4: Doula Claims in the Oregon Medicaid Population, by age**

By Age	Doula Claims by Year			Grand Total
	2016	2017	2018	
<b>Denied</b>				
20-29	1	10	3	14
30-39	7	7	1	15
<b>Denied Total</b>	<b>8</b>	<b>17</b>	<b>4</b>	<b>29</b>
<b>Paid</b>				
< 20			1	1
20-29	16	11	13	40
30-39	22	15	9	46
40 +	3	1	1	5
<b>Paid Total</b>	<b>41</b>	<b>27</b>	<b>24</b>	<b>92</b>
<b>Grand Total</b>	<b>49</b>	<b>44</b>	<b>28</b>	<b>121</b>

**Table 1.5: Doula Claims in the Oregon Medicaid Population, by race/ethnicity**

By Race/Ethnicity	Doula Claims by Year			Grand Total
	2016	2017	2018	
<b>Denied</b>				
Asian American			2	2
Hispanic/Latino	3	5		8
Unknown	5	6	2	13
Caucasian/White		6		6
<b>Denied Total</b>	<b>8</b>	<b>17</b>	<b>4</b>	<b>29</b>
<b>Paid</b>				
African American/Black			2	2
American Indian/Alaskan Native	3	2	1	6
Asian American	1	2	1	4
Hispanic/Latino	15	8	3	26
Other Race	1			1
Unknown	21	13	12	46
Caucasian/White		2	5	7
<b>Paid Total</b>	<b>41</b>	<b>27</b>	<b>24</b>	<b>92</b>
<b>Grand Total</b>	<b>49</b>	<b>44</b>	<b>28</b>	<b>121</b>

**Table 1.6: Doula Claims in the Oregon Medicaid Population, by household language**

By Household Language	Doula Claims by Year			Grand Total
	2016	2017	2018	
<b>Denied</b>				
English	1	10	3	14
Hmong, Mong, Mien			1	1
Spanish	7	7		14
<b>Denied Total</b>	<b>8</b>	<b>17</b>	<b>4</b>	<b>29</b>
<b>Paid</b>				
English	6	11	13	30
Korean		1		1
Spanish	35	14	10	59
Vietnamese			1	1
Cantonese, Mandarin, Other Chinese/Asian, TaoChiew		1		1
<b>Paid Total</b>	<b>41</b>	<b>27</b>	<b>24</b>	<b>92</b>
<b>Grand Total</b>	<b>49</b>	<b>44</b>	<b>28</b>	<b>121</b>

## Methods

This project utilized community-based research approaches with guiding expertise by qualified and community researchers. The Oregon Doula Association (ODA) Board of Directors and identified doula affiliates provided valuable feedback, leadership, and ongoing input regarding project design and implementation. The project utilized both direct and indirect research methods to meet outlined objectives and project purpose. Specifically, this project employed three concurrent phases, as follows: Phase I involved listening sessions, using the focus group methodology, with Oregon doulas; Phase II involved key informant interviews with THW program stakeholders, specifically, Coordinated Care Organization (CCO) representatives and State of Oregon employees with the Oregon Health Authority; and Phase III involved online surveys with Oregon doulas and doula employers.

Because this project represents the first attempt at collecting statewide doula workforce data, we used a cross-sectional approach to connect with as many key stakeholders as possible who could contribute perspectives on the doula workforce in Oregon, the integration of doulas into Oregon’s healthcare system and the Oregon Health Plan as Traditional Health Workers, and the utilization of culturally and linguistically appropriate doula services. In this cross-sectional design, the following three broad participant groups were specifically targeted: 1) doulas serving in the State of Oregon; and 2) doula employers in the State of Oregon; and 3) Key informants on doula care integration in the state. Details of the methodologies used per phase are below.

### Phase I: Listening Sessions with Doulas

The purpose of Phase I was to allow doulas across Oregon an opportunity to share their professional successes and challenges to participation in the doula workforce. Phase I employed listening sessions that followed the focus group methodology (Green and Thorogood, 2018). Questions addressed several areas of workforce barriers and opportunities, including: doula workforce development ideas and models; culturally- and linguistically- specific doula care services; and participation in the State of Oregon’s Traditional Health Worker (THW) program. Listening session scripts were created by the researchers and ODA leadership to facilitate discussion and create recommendations for increasing

access and utilization of doulas as THWs, as well as general workforce development and retention. Invitations to participate in listening sessions were distributed through local social media platforms and through personal invitation by ODA board members and doula affiliates. Listening sessions occurred in May through June of 2018. A total of seven listening sessions were conducted with n=38 participants in total: three sessions occurred in the Portland Metro area; one session occurred in Eugene; and three sessions occurred virtually through the Zoom platform for doulas who practice in the Southern and Eastern parts of Oregon. Before the listening session began, participants were informed of the purpose of the listening session, the voluntary nature of their participation, the confidentiality and anonymity precautions taken, and the use of data gathered. Participants were offered an opportunity to enter a drawing for a \$50 Visa gift card as a token of appreciation for their participation. Focus groups were audio recorded with participant permission. Narratives were transcribed and analyzed using a thematic analysis approach (Braun and Clark, 2014; Vaismoradi et al., 2013). Thematic analysis allows for the identification of emergent patterns and describes common threads that extend across datasets. Thematic analysis is particularly useful in applied research that focuses on policy and practice.

### Phase II: Key Informant Interviews with State Stakeholders

The purpose of Phase II was to elicit the perspectives of key stakeholders who currently work in Oregon's health care system and have played a role in the integration of doulas as traditional health workers. A total of n=5 representatives from Coordinated Care Organizations (CCOs) and the offices of the Oregon Health Authority participated. Semi-structured, open-ended interviews were used to guide key informant interviews. Interviews occurred between May and June of 2018. Questions specifically addressed challenges and successes to integrating culturally-specific and linguistically-specific doula care services into Oregon's health care system, as well as reimbursement challenges and successes. Key informants were invited to participate based on a snowball sampling methodology. Possible key informants were identified initially by ODA leadership and the OEI based on the informant having crucial information about the successes and challenges of doula integration into the health care system. Before the interview began, participants were informed of the purpose of the interview, the voluntary nature of their participation, the confidentiality and anonymity precautions taken, and the use of data gathered. Interviews were audio recorded with participant permission. Narratives were transcribed and analyzed using a thematic analysis approach (Braun and Clark, 2014; Vaismoradi et al., 2013). Thematic analysis allows for the identification of emergent patterns and describes common threads that extend across datasets. Thematic analysis is particularly useful in applied research that focuses on policy and practice.

### Phase III: Online Surveys with Doulas and Employers

**Doula Survey:** The purpose of the online doula survey in Phase III was to gather information about demographics and workforce composition data for doulas across the State of Oregon. Demographic questions captured measures such as age, gender, cultural and linguistic background, and education levels. Workforce composition questions captured data on geographic regions doulas serve, the diversity of doula employers, doula compensation rates, doula scope of practice, doula training, education, and work experience, and challenges and successes to sustainable doula work. A section with questions specific to the Traditional Health Worker (THW) program was also included, with questions capturing service as THWs as well as the challenges and successes to working as a THW doula in Oregon. Finally, a section with questions specific to culturally- and linguistically- specific services was included, with questions capturing service utilization as well as challenges and successes for meeting the needs of culturally and linguistically diverse clientele. A total n=130 doulas responded to the survey.

**Employer Survey:** The purpose of the online employer survey in Phase III was to gather information about the challenges and successes of doula integration from the perspective of Coordinated Care Organizations (CCOs), community-based agencies and organizations, maternity care practices, doula agencies and organizations, obstetrical providers, and families who utilized doula services. Three separate surveys were distributed as part of the employer survey package: 1) one survey to employers, identified as someone who oversees or coordinates doulas who are employees, independent contractors, collective members, interns, students or volunteers; 2) one survey to parents or consumers, identified as anyone who has hired and utilized the services of a doula for their birth or postpartum care; and 3) one survey to care providers, identified as anyone who has worked with childbearing patients who utilize doulas. Respondents were asked questions that captured information on wages or rates, scope of practice and utility, and the broadly writ value of doulas. Questions posed also captured the successes and challenges of culturally- and linguistically- specific doula care services. Finally, employers were specifically asked about Medicaid reimbursement status, interest, challenges, and successes for doulas. A total n=11 employers (representing 10 distinct employment organizations) responded to the employer survey; n=13 parents responded to the parent survey; and n=2 care providers responded to the provider survey.

**Both** sets of surveys were adapted from a template provided by the Oregon Office of Equity and Inclusion (OEI) that was used across all five Traditional Health Worker types in Oregon. Questions were modified, deleted, or added to reflect the type of work performed by doulas, specifically. The Oregon Doula Association (ODA) partnered with [doulamatch.net](http://doulamatch.net) to help create a comprehensive database of doulas in Oregon for survey distribution. Contact information from [doulamatch.net](http://doulamatch.net), personal ODA contacts, and active and inactive doulas registered as Traditional Health Workers were used to construct the database. The final list included 370 distinct doulas, of which 270 email addresses were valid and deliverable. Social media platforms where doulas are active were also used for survey distribution. The survey was distributed in August of 2018 through the database and social media. Doulas were encouraged to share the parent, employer, and care provider surveys with their professional contacts as well. The employer survey set was also distributed directly to all Coordinated Care Organizations and known doula agencies and employers. All surveys were live for two weeks. In the first page of the survey, all respondents were informed of the purpose of the survey, the types of Traditional Health Workers in Oregon, the confidentiality and anonymity precautions in place, and uses of the data gathered. All survey participants had the opportunity to enter in a drawing for a \$50 Visa gift card. The Oregon Office of Equity and Inclusion provided the Oregon Doula Association research team with the initial reports from all four surveys, including charts with percentages and frequencies as well as all open-ended responses. Some charts were imported into Excel to create bar graphs and new pie charts. Open-ended questions were analyzed and organized by themes.

## Results

In this section, we delineate results, per phase.

### Phase I: Listening Sessions with Doulas (n=38)

Twelve themes emerged from the listening sessions with doulas. These themes are discussed below. A total of 38 doulas participated across seven listening sessions. Twenty-one doulas participated from the Portland metro area, 12 served the Lane County area, one doula from Eastern Oregon, one doula from the Western area of the state, and three from the southern part of the state. None of the participating doulas came from Central Oregon. Twenty percent of listening session participants were doulas of color. The range of work experience for participating doulas included four doulas who had just completed their

certifications or were in the process of completing their certifications and six doulas who had 20 or more years of experience working as professional doulas. Five participants owned or managed a doula organization, three were employed primarily or exclusively by hospitals, and one worked in association with a birth center. Four of the participants worked as doula trainers or educators. One doula indicated her primary doula role was to serve as a bereavement doula and three doulas worked solely as postpartum doulas. Eleven doulas worked or attempt to work primarily with the priority populations identified by the Traditional Health Worker guidelines. Most participants indicated that they previously or presently worked in other fields to supplement doula income. Some doulas worked in related fields, which included the following: birth educator, nurse, nurse-midwife, marriage and family therapist, other traditional health worker role, massage therapist, public health administrator, maternal and child health case manager, and DHS case manager.

### Theme 1: Full Time Doula Work

Doulas at each listening session were asked about their ideal doula career and what it would take to get to their ideal career. All doulas shared that they chose to work as doulas due to their passion to help families and the emotional fulfillment they get from the job. Some participants shared that, at some points in their lives, part time doula work was preferable to full time work due to personal considerations such as child rearing or going to school, but there was an overall agreement that most doulas go into the career hoping to work as a doula full time. Full time work, at every listening session, was identified as taking 4 to 5 births or families a month, and two listening sessions expressed concern that taking more than 5 births or families a month frequently was too strenuous to be sustainable. One doula shared that she was a full-time doula and her only income came from doula work. Five other participants said their full-time work was either serving as a doula full time or combination of doula work and doula related work, such as doula training or administrating doula organizations. Most other doulas indicated they had interest in or were actively working towards establishing full time doula work. All doulas indicated there were substantial barriers and challenges to working as a full-time doula.

### Theme 2: Demand for Doulas: Knowledge and Understanding of Doula Care

Listening session participants said that there is still a knowledge gap among both families and obstetrical practitioners about what doulas are and what they do for families. Families who seek doula support may not fully understand the doula role or how doulas are different from obstetrical practitioners: "I actually have to explain that I'm not a midwife [to potential clients]. I kind of forget that people don't understand the differentiation between the two a lot of times." Even in the Portland metro area, which participants said has a higher concentration of doulas, people often confuse doula care with out-of-hospital births or 'natural' birth:

"I said [to a woman approaching my booth at a community baby shower] 'would you like to find out about doulas?' 'Oh, no, I am having a birth at a hospital.' 'Oh, well that's where 98% of doula births are.' 'Oh, well I don't want that. I am having an epidural.' 'Well did you know doulas can support epidurals?' 'What? No!' And so I still think there is a wild misunderstanding... I think that in certain spheres doula is a little bit more well known, but on some mainstream levels, it's still seen as some weird hippy lady, and is she a midwife? Is this safe? I think there's a lot of parent and consumer education that needs to go forward."

The knowledge gap was said to be an even bigger problem in rural areas, where obstetrical providers commonly do not understand the role of doulas: "Doula work in the culture I live is in its early baby

stages of people trusting it and believing in its value...I had to explain a lot that I am not a midwife to OBs and labor and delivery nurses.” The general understanding of a doula’s scope of practice and value is a clearly cited barrier and challenge to people receiving appropriate care.

*Theme 3: The Nature of Doula Work: Business, Burnout, and Challenges to Life as a Doula*  
Theme three grapples with all facets of doula work, including business obstacles, burnout issues, and other challenges to the doula life. As such, theme three is expressed per sub-theme to paint a holistic picture of this emergent finding.

*Sub-Theme 1: Business Side of Doula Work.* Doulas expressed the high value of doula services and that the demand for doula care is present and growing in their communities, even with misconceptions (Theme 2). However, doulas struggle with the business component of doula work, which includes marketing, pricing their services, and receiving payment. Some doulas were surprised at the amount of time and personal resources it took to build up a doula business:

Doula 1: “Yeah...Figuring out the marketing, getting your own clients, and figuring how to get paid. I feel that’s difficult for a lot of people, for a lot of doulas, at the beginning.”

Doula 2: “That has been exactly my experience. I’ve been a doula for 3 years, and it’s only been maybe a little over 7 months that I have been able to be a doula full time....And I had to be able to save up a lot of money to do that, to jump [to full time doula work]. It’s more like a steep cliff that you have to jump, onto another steep cliff. It’s really, really hard ... you are launching a business. And I also trained with Birthingways and I think their training is amazing. But I think that I personally was not trained in the business side of it...For me, it took really cutting out my old job, and I couldn’t make money with doula work before then, I just couldn’t do it... so I was going to save up for 2 months, and moved away to save up, and jumped right into it. But not everybody has the privilege to do that.”

*Sub-Theme 2: Income and Pricing.* The primary issue related to sustainable work that most doulas described as the priority is the ability to generate enough income. Two factors related to income are the ability to charge appropriate fees for services and the unstable nature of sole proprietorship. Doulas in all focus groups said that they had a difficult time being able to charge fees that would allow them to rely only on wages earned from doula work. Doulas understand that families who could benefit from doula services may not be able to pay fair doula fees, as the medical and other costs of having a baby are high. One doula, who moved to Oregon from a southern state two years prior and had been practicing as a doula for 10 years, said she “had 80-90% of my income come from doula work. So it’s possible.” But since moving to Oregon, she couldn’t establish full time work as a doula and had to find other non-related work. “This is more a hobby than a career with the money we can get right now. A lot of us do volunteer hours because people can’t afford it [doula care]. But we still do it because it’s a passion.” The other income-related issue associated with doula work sustainability is the nature of business to “comes in waves.” At times, doulas experience a lot of demand for their doula work and struggle to establish work-life balance, and at other times they “have a lull” and struggle to gain enough clients to earn a sustainable wage.

*Sub-Theme 3: Other Employment.* All listening sessions had participants that were employed at least part time outside of doula work. Many were employed full time in work unrelated to childbearing. Outside work is both the solution to the instability of doula work and a barrier that contributes to the

unsustainability and potential to experience burnout. Because most doulas are sole proprietors, the additional benefits from working for established organizations, such as paid vacation time, health insurance, and employer retirement programs, is not available to them. Many doulas maintain full time employment in nonrelated fields to maintain these related benefits, despite wanting to do doula work full time.

*Sub-Theme 4: Family and Personal Life.* Doulas who were single parents or had partners or children, in particular, expressed concern over the strain that doula work has on their relationships and caregiving responsibilities. In order for doulas to provide services to families, they need strong safety nets. For doulas with families, “your safety net has to be huge and you wind up having to rely on so many other people.” The concept of safety nets and familial obligations was directly implicated in sub-theme 5—burnout—as described below.

*Sub-Theme 5: Burnout.* Doulas in all focus groups described the problem of burnout. Doulas find it challenging to balance and weigh the value of different aspects of their careers as doulas and their personal life: charging fees that can financially sustain the doula, the desire and passion to serve families who cannot afford the doula’s normal fees, working other jobs to meet financial needs, the nature of doula work being on-call and, for birth doulas, requiring continual birth support from between 8 and upwards of 40 hours per birth. An inability to properly manage the balance of these things with personal, health, and family obligations can result in burnout. One doula describes her frustration with managing burnout while holding deep passion for doula work:

“We don’t have a shortage of people willing to do the work, we don’t have a shortage of clients that would benefit from the services. That’s not where we are lacking...It’s the balance of burnout...my concern often time comes when you have to work a full time job that’s not in the birth community so that you can volunteer to do this because this is your love, but you can’t do this because you can’t pay your bills working as a doula. So if we are able to pay our bills [with doula work] then we can do sliding scales and volunteer work and completely engage the place where our passion and heart is. But we shouldn’t have to volunteer, we are trained professionals. This [nonrelated job] is my job, this [doula work] is my passion. I would love for my passion to be my job also. But doula work doesn’t pay the bills”

*Sub-Theme 6: Postpartum Doula Work:* Another strategy to reducing burnout is to practice solely as a postpartum doula or balance taking birth clients with postpartum clients. Postpartum doulas work for an hourly rate and charge between \$20-\$30 per hour. Postpartum doula work is less demanding of a doula’s personal resources because the hours of work are generally agreed upon prior to birth. Postpartum doulas enjoy the flexibility of the work and ability to still serve clients, but the demand is not as great for postpartum doulas as it is for birth doulas. Postpartum doula work has many of the same considerations as birth or labor doula work, including the financial strain of families paying out of pocket for the service and the unstable nature of work “coming in waves.”

#### Theme 4: Practice Relationships, Employment Structures, and Professional Development

Listening session participants described six ways in which doulas form practice relationships in Oregon: independently practicing doulas, doula partnerships, doula collaboratives or collectives, volunteer agencies, doula agencies, and community-based organizations. A separate type of organization was the local doula professional associations. Professional associations serve as networking and resource sharing

opportunities, but do not necessarily have an agreement among doulas that work or business responsibilities would be shared. Most doulas who participated in listening sessions worked independently and did not share business or practice responsibilities with other doulas; most challenges expressed in Theme 3 were from the perspective of independent doulas. However, four doulas owned or administrated doula agencies or collectives and two worked in leadership positions for volunteer doula organizations. Four doulas worked as doula trainers or educators, working for doula credentialing organizations teaching doula courses. These doulas saw the benefit of collaborative doula work to overcoming cited barriers. Several sub-themes constitute Theme 4, as follows.

*Sub-Theme 1: Doula Partnerships and Collaboratives.* One of the doula educators described the way in which business structures have started to evolve in Oregon:

“I think how doulas perceive their business structure has evolved over the past 30 years... when it started, it was just ‘you’re the only doula in your town and you’re an independent practitioner... and you are lucky if you can get backup.’ Now there’s a lot independent practitioners but also backups, especially in Portland we have a wealth of support and a lot of networking. In the past 10 years there’s a rise in the doula partnership model. That can look a couple different ways but the way that a lot of people have practiced and said is very sustainable for them is having 2 doulas who both get hired by the client and both do prenatals, but as far as the birth goes, one shows up for the birth...So that partnership/shared client model is rising to be a sustainable model. There’s also a lot of other partnership models, like the collective, where there are, say, 9 doulas, and one can reach out if they have a funeral or something.”

The main benefit of working collaboratively is to increase the sustainability of a doula career by dispersing the demands of being on call. One participant who led a collective of doulas shared that the doulas in her organization have been practicing with one another “for a long time, because they don’t get burnt out.” The doula collective offered an opportunity for doulas to remain independent while relying on longstanding relationships. No matter how doulas form relationships to share clients, agency and collective owners said that sharing a call schedule and clients allows for a more flexible schedule so that doulas can take time off without losing a significant amount of revenue. Another benefit of organizing is name recognition: “it’s easier for clients to remember a business name than a personal name, too.” Another benefit of working collaboratively with a partnership or collective is that it creates a structured professional support system where doulas can turn to other peers to “talk and process [with], troubleshoot with” and offers the potential for mentorship or skill development. Local doula professional organizations are credited for helping doulas network and form or join partnerships and collaboratives. Partnerships and collaboratives also offer doulas the opportunity to remain independent from contractual relationships with hospitals or other organizations, which many doulas said was important to them. The main drawback to sharing work with doulas, and why some doulas remain independent, is sharing the compensation. Doulas have a difficult time securing paid employment at a fair rate and sharing their work responsibilities also means sharing the money earned from their work. As one doula said, “Partnership... twice the work for half the money.”

The underlying theme for successful doula relationships and organizations was establishing trust. Trust was critical for doulas to form relationships and lack of trust was a cited barrier to doulas working in partnerships or organizations: “Trust is really important when there are just two of you and I care a lot

about the quality of work and I wouldn't just pair up with anybody." The trust extends beyond the sense of reliability of the individual doula and also encompasses how the partnership's presence in the community can impact the reputation of doulas. As one participant said, "So I haven't been able to align myself with the 'doula babies' who want to practice because I feel protective of the 'brand' of doula care that appears in this community."

*Sub-Theme 2: Volunteer Doula Organizations.* Doulas from two volunteer doula organizations in Oregon participated in focus groups. While volunteer organizations offer unpaid opportunities, they also offer volunteer doulas valuable mentorship and experience. One volunteer shares, "doulas are really attracted to our organization because they want a mentorship. It's what we sell... They want to know how to work in the hospital, and our organization has a really good relationship with labor and delivery at [hospital]." Not only do volunteer organizations offer an opportunity to gain experience and leverage good relationships with hospitals or providers, they also offer a systematic way to build skills and maintain professional standards of the doula profession:

"Once the clients start showing up and once the doulas were engaged, burnout aside, over the years, new doulas were being trained and the idea that those doulas could jump into an agency that was functional and had mentors that those doulas could connect with, was a really important way to get the workforce trained... We had a 3 tier system... there was a system in place that allowed for doulas to engage with the profession in a really systematic way. Lots of mentorship... we were able to train them for what we wanted a doula to represent in the community, with the doctors...and in the culturally specific way we needed to for that population."

*Sub-Theme 3: Hospital Staffed Doulas: Opportunities and Challenges.* Some hospitals in Oregon staff doulas for their birthing families and there are also birth centers that employ doulas. Doulas were split on the benefits and challenges of employment with a hospital. The perceived benefit of hospital employment is the sustainability of doula work. Hospital work is typically shift-based, which lends to more predictable work for doulas. Hospital employment full time also means the ability to have related employment benefits, such as health insurance, 401ks, and paid time off.

The first concern with working for a hospital or other health system organization is lack of care continuity. The understanding of hospital run doula programs from Oregon doulas is that they only provide doula care to families at the time of birth, lacking the prenatal and postpartum visits that typically come with doula services. Doulas were torn between the sustainability and benefits that come with working for a hospital and the ability to form relationships before birth, establish and build trust, and better serve families:

"Ideally, I would also want medical insurance and a 401k and a salaried position. But I don't like the hospital version, the continuity of care is just not where it needs to be... you still don't know your clients and that's such a big part of the doula role, having that intimacy and people you know well supporting you"

From conversations about hospital employment came the importance of prenatal doula visits to a client's birth experience as well as the doula's experience of birth:

“I’ve thought about, ‘well what if I worked for a hospital?’ I don’t think I would like to, especially because my very favorite is prenatal. I can get so much work done in prenatal and pave the way and they’re going to have an awesome birth. Because we address their fears. Because we answered their question because we got crazy mother in law out of the room. Because of all these things. And then to watch that birth unfold is just marvelous and kind of easy.”

Notably, the association of doula care with reduced prematurity and low birth weight rates, as founded in several published research studies (Everson, 2018; Kozhimannil, Hardeman, et al., 2016) is not possible without a strong prenatal care foundation.

The other challenge presented by hospital-based employment comes from doulas’ concerns over a conflict of interest. Doulas spend considerable time and effort to gain and foster trust with their clients prior to birth; part of this trust is that the doula knows and understands the client’s wants and needs. The combination of no prenatal visits to establish and foster trust and the primary, long standing relationship being with the hospital has the potential for an ethical conflict of interest:

“The idea that someone who might tell me what I can or cannot say to clients, or even if it’s not that overt, even if I am being paid by the hospital, and I feel like I just understand their side a bit better than I understand my client, I think that would make me, inside, make me have a lot of turmoil.”

On the other hand, hospital-staffed doulas are optimistic about how their role influences the integration of doulas into the health care system. The consistent presence of doulas in hospitals, from hospital staffed doulas, hospital-based doula volunteer programs, and networking efforts of doulas with providers, has worked to help build and sustain rapport between doulas and obstetrical providers. Hospital-staffed doulas also help the nursing staff communicate with non-staff doulas who serve families on their labor and delivery floor and can assist these doulas in building rapport.

*Sub-Theme 4: Community-Based Organizations.* Doulas in two focus groups worked for community-based organizations as doulas and all focus groups acknowledged the potential of community-based organizations. Both community-based organizations represented in the listening sessions had other services and resources to offer parents and doulas, and they attributed this to their success of serving families with what they need for successful pregnancies, births, and parenting. The role of community-based organizations is further discussed in themes forthcoming as well.

#### Theme 5: Rapport between Doulas and Obstetrical Providers

The rapport between doulas and physicians was a major theme to the success of doulas working with families. Doulas described their efforts to maintain or create rapport with providers. Often, doulas had to create deliberate processes to connect with local obstetrical providers outside of the birth room to create and foster relationships. One doula described the laborious process of meeting with hospital administrators and local obstetrical providers, introducing herself, and describing her philosophy, scope of practice, and value to them. Doulas described the need for active rapport-building to both create positive experiences with obstetrical practitioners and hospitals and to correct for negative experiences that obstetrical providers may hold as a result of other doulas acting outside of their scope of practice. Doulas said that building the appropriate level of rapport takes years. One hospital-staffed doula described that the great relationship she had with some nurses and hospital staff took two years to

cultivate. Other doulas, who received referrals from providers, said it took at least two years to cultivate these relationships as well.

Doulas see a lot of benefits to building rapport with obstetrical providers and local hospitals. First, families have a better birth experience when interprofessional collaboration takes place. Second, doulas believe that the births have better outcomes. Third, doulas have a better working experience. One hospital-staffed doula described her appreciation for when hospital staff see her as a colleague and a part of the birth team. Finally, doulas see their role as allowing both nurses and obstetrical providers to practice at the top of their scope. One doula described how the trust established between doula and hospital staff allowed hospital staff to work at the top of their scope as well:

“I will say that during the birth, a lot of the times, they will come in and just periodically monitor the mom and they appreciate the fact there is a doula in the room so they can monitor the mom from outside of the room, and they do other things they need to do, can catch up on their reporting and everything, and just come in periodically and check that we are ok. And a lot of times I think the staff appreciate us when we are there from that perspective [of being integrated into the hospital]. We are engaging the mom and they don’t have to, and they are confident when there is a red flag that we will let them know. I will say that there is an improvement in that perspective, that they see us as a helping force and allow them to do what they need to do.... That’s them understanding the benefit of a doula. Really understanding the benefit of a doula.”

#### Theme 6: Health System Challenges to Doula Integration: CCOs and Doula Workforce

Themes 6 through 12 specifically concern the successes and challenges of doula participation in the Traditional Health Worker (THW) Program, underpinned in nature by the first five themes. Doulas at all listening sessions had some familiarity with Oregon’s Traditional Health Worker program and the opportunity to serve Oregonian families enrolled in the Oregon Health Plan. Six doulas were already on the Traditional Health Worker registry and seven were in the process of completing trainings or filling out the application in order to get on the Traditional Health Worker registry.

Theme 6 specifically concerns the lack of support from local coordinated care organizations (CCOs), which was discussed in-depth at two of the listening sessions. Here, both Multnomah County and Southern Oregon were described “primed and ready” to integrate doulas into Oregon Health Plan services for childbearing families, but barriers remain. One Southern Oregon agency said that if all five of their doulas served four Medicaid births a month, which would be full-time work for each doula, 75% of Oregon Health Plan births in their area would have doula services. Participants in a separate listening session said that there are doulas on the registry in their area and the doulas have reached out to the local CCO, but the doulas say that the CCO refuses to contract with doulas. In response to an inquiry about the doula workforce’s capacity to take on 10% of births in a given area, one doula responded:

“We are an active, large [doula] organization... We are all very passionate about making sure the families in our community are served here and receive [doula] care. Our local hospital has 250 births per year, the birth center has 76... We recognize that 10% of births in our area would be 25-30 births a month. We have that many doulas, if we each took one. We are in full force ready to take on the load suggested. If they can get us in doors and get [CCO] contracts with us.”

Southern Oregon doulas in two separate listening sessions shared that their CCO was willing to negotiate with a doula organization, but they did not meet an agreement that would yield a sustainable payment for services: “We have worked very hard to build a positive rapport with the clinicians and the hospital administration is willing and enthusiastic to take us on, but they are waiting for us to say that it is sustainable. And right now [at \$350 a birth] it’s not.” In two other listening sessions, the lack of a credentialed doula workforce was the primary reason that doulas were not participating as Traditional Health Workers. “They [local CCO] are ready to go, they see this as a great opportunity for their organization. Currently, it’s just me.” In other words, low availability of qualified doulas in some areas, especially rural areas, serves as a primary barrier to CCO utilization of doulas.

#### Theme 7: Challenges to Doulas Buy-In to Enrollment as Traditional Health Workers

Most doulas indicated some interest in the program and expressed hope for the THW Birth Doula Program as a key way to reach more families in their communities. Some doulas intended to submit applications in the future, and seven doulas said that they are in the process of applying and completing the required trainings and credentials. These doulas said that they are hoping to get on the registry because they are passionate about delivering doula care to families enrolled in the Oregon Health Plan, but also expressed resignation about the application process and getting on the registry: “Yes I am interested, but no I am not super motivated.” Most focus groups had doulas who would be interested in the THW Birth Doula program, but doulas refused to apply at the time of the focus group. The three primary reasons that doulas refuse to participate or are holding off on submitting their application are: 1) the low reimbursement rate for doulas; 2) the negative experiences of other doulas in applying and billing for services; and 3) the complex nature of providing doula services to families with complex needs, the additional care required for culturally and linguistically diverse families, the lack of infrastructural support to independent doulas for billing and administrative needs, and maintaining independence from the health care system. These barriers are delineated in more detail, below.

*Sub-Theme 1: Low Reimbursement Rate.* The current rate of \$350 dollars for doula care is the primary reason for lack of interest or motivation to serve as THW Birth Doulas in Oregon. At the current rate, doulas who were interested in serving on the registry could only serve one to two clients a year, leaving the doula to weigh the value of the compensation or value of contribution to families against the time and effort to pay for and attend additional trainings required to be placed on the THW registry as well as the effort to learn how to bill for services and submit claims. “I’ve been asked, Why do we only have 40 doulas on the registry and thousands of other types of THWs? The money..until the doula sees that it’s viable. You’ve got to put bait on the edge of your hook if you want anyone to bite. I think if we could demonstrate we will pay them 1,000 per birth, give [it] a year and a half and we can have enough doulas.” The lowest rate doula participants were willing to accept to serve 1 to 2 families enrolled in OHP was \$700-\$1000.

*Sub-Theme 2: Application and Billing Process.* All doulas who attended the listening sessions expressed interest and a sense of personal fulfillment in serving populations identified as priorities for health equity by Oregon. Several doulas indicated they already volunteer or offer sliding scale prices occasionally that are below the current rate paid by the Oregon Health Plan in order to care for underserved families who cannot afford doula services. However, doulas who have become Traditional Health Workers expressed that the process of applying to be a THW as well as the process of billing claims was frustrating. Doulas shared their experiences and frustrations with other doulas, which creates a landscape of laden frustration and this frustration serves as a key barrier to THW utilization:

“And the doula community talks, we talk to each other, and if there’s a problem, we know about it. And this [THW registry] is kind of known to be a hot mess, unfortunately.” Others said they would revisit the potential of applying to become a THW Birth Doula when they see that the system for applying and billing has been running efficiently and when they hear that doulas have successfully received payments: “I’m on the fence as well, paying attention, and fully support people wanting to. But I don’t want to spend a ton of time doing it and then there be nothing for the 2 years that I registered, and then having to repeat everything 2 year later for nothing. I am not going to spend the time to put my ducks in a row when their ducks aren’t in a row.”

*Sub-Theme 3: Families with Complex Needs.* Finally, a very significant challenge to doulas becoming interested in serving families who are enrolled in the Oregon Health Plan is the amount and quality of care that populations experiencing health inequities requires. Three listening sessions had participants who worked with childbearing families who were culturally or linguistically diverse populations, including Spanish speaking families, Middle Eastern families, Native American families, Black and African American families, and teen families. Other doulas shared experiences working with families experiencing mental illnesses, homeless or housing insecurity, and domestic violence. Doulas understand the benefits of providing doula care to high-risk or complex-needs populations, but these populations also require more prenatal visits to create successful outcomes. Two of the listening sessions specifically mentioned the likelihood of failure if they cannot provide more prenatal opportunities to connect with families and support them in successful births. One veteran doula who volunteered as a doula to teen families shared her concern about the adequacy of two prenatal visits (the current state model) to successful outcomes:

“We are speaking to a higher at-risk population, these are the people who they have found that would benefit the most from this service. And then they are asking for the same service we are giving to doctors and teachers and two-income middle class families, their needs are very different from a homeless family or teen family or somebody who has some domestic [violence] needs. To say that this is going to be sufficient for their needs is obviously grossly mistaken... Everything from nutrition counseling, basic infant care, body parts. Women don’t know they have placenta! They don’t know so many things that we’ve have had to sit and spend hours and hours and hours educating and supporting them for successful healthy deliveries and successful healthy postpartum, that is not going to be sufficient in 2 prenatal and 2 postpartum visits. That’s another concern, they are setting us up to not be successful”

Doulas were concerned about the consequences of two prenatal visits for the success of the THW Program as well. Doulas fear that if the standard remains two prenatal and two postpartum visits, doula care will not bear out to the full potential in being effective for improving birth outcomes and would thus be argued to no longer be a covered service: “If they are trying to make something efficacious but then they are not giving us the resources to do it fully, that set us up for failure and [they] can say ‘Oh, well, that didn’t work.’” On the other hand, one doula shared her concern of too many overlapping services: many families enrolled in OHP also utilize other services such as WIC, CaCoon, or possible DHS involvement. Adding more people into someone’s very busy schedule can “do more harm than good.” Thus, there is a balance to be achieved between the fidelity of the doula model for at-risk populations and the importance of coordinated care services for families.

*Sub-Theme 4: The Need for Community Involvement.* All doulas also agreed that the efficacy of doula services also comes from doulas who have lived experience in the specialized communities that have been identified by Oregon's THW legislation. Doulas of color, in particular, are needed to work with the communities they are a part of, but in order to be incentivized to get on the registry and make doula work as a career, they need a higher rate of reimbursement because their work requires more skill and more relationship building:

"I think initially with this whole reimbursement fee and to prioritizing certain communities... was about gaining access, so that anyone who wanted a doula could have a doula, but there should be some sort of discourse or discussion or training around what does that look like in practice. Because when you are working with prioritized groups, it's not just about access at that point. Because anyone with Medicaid could get a doula, right? I think that would change policy in why [reimbursement] should be much higher in specialized communities. But what does that look like in practice? Because it's totally different when you are working with these prioritized communities, because the depth and layer of complexity with these families and communities is much higher, and requires a higher level of skill, and it requires that you be a part of that community. You have to have that lived experience, and not that you just read a book... it shouldn't be a conversation for doulas of color, it should be a conversation for doulas."

*Sub-Theme 5: Lack of Infrastructural Support.* Doulas need significant infrastructural support to provide successful doula services to families enrolled in the Oregon Health Plan. There is a lack of administrative support for filling out and submitting claims and many doulas don't have backup support. The ability to find backup was a theme discussed in detail at every focus group; doulas were afraid they would "retraumatize a mom by not showing up or not having anyone there." Doulas would like a system where they can receive referrals from local obstetrical providers or agencies such as WIC. Doulas also want support to come from official Oregon agencies, such as the Oregon Health Authority or their local CCOs, that communicates the value and validity of doula work in hospitals: "I would need to feel more intentionally supported by the state. I need something legit that says something from the state, to show to obstetrical providers, and that I am supposed to be there and I actually have an official position deemed legitimate by the Oregon Health Authority and I am supposed to be here."

*Sub-Theme 6: Maintaining Independence from the Health Care System.* A final reason that doulas were apprehensive about applying to be on the registry was a concern around getting involved in a system that they saw as contributing to a person's trauma. Much like the tension between the hospital and a doula's commitment to the best interest of their families, doulas struggle with the tension of contractually engaging with a system that has historically contributed to trauma and helping families that they see could use and benefit the most from doula services:

"Getting the outcomes that we want, it's really important that people feel genuinely cared for, and what we know about these other groups, through overt bias or implicit bias, these people get treated poorly by the medical system often. One maybe not necessarily intended role of the doula is a sort of watchdog. Part of what we do is a witness to whatever happens, but if you have providers, even with you there, treating the patient or our client poorly, you might be the one person that's there who is not judgmental and that is being nurturing in this space, and helping to mitigate trauma that comes with that. What we are talking about are people who have a high likelihood of already having previous trauma earlier in their lives, and so they are at

high risk in their birth because they are so at being retraumatized. So the independence that doulas have, of not at being at the request of the OB or whatever and you are only there because you are allowed to by the system that traumatizes people? So that independence, I think, is really important to the outcomes that the state wants to see in those populations.”

Another doula described the independent nature of doulas and the suspicion some feel around being on a registry or requiring background checks:

“One other layer that I think that is on there is that doulas, as a bunch historically, have been rather independent, and particularly independent from institutions. Like, that’s our deal, historically, we are there to support families. And then all the sudden... this new system... is fraught with all these other things. Doulas I think are inherently suspicious... why do I need to be on the state registry, who is tracking me, what’s going on, what is the benefit, why do I have to do a background check, who has this information?”

#### Theme 8: Challenges to Becoming and Working as a Registered Traditional Health Worker

Doulas who had successfully submitted applications and became enrolled as Oregon THW doulas described in-depth the multitude of challenges they experienced. Five of the six doulas who were registered traditional health workers described their frustrations with applying to be on the registry, becoming billable providers, billing, and receiving payment. Only one doula attending listening sessions attempted to bill for services and said she only received reimbursement for one of many submitted claims. Several sub-themes thus constitute Theme 8, as delineated below.

*Sub-Theme 1: Application Process is Not Clear.* Doulas in four listening sessions said they were waiting to submit applications or waited years before submitting their applications. Doulas trying to apply to be registered THWs said that the published information about credentialing requirements was not clear and all necessary information was difficult to find:

“I think with the state registry, because we have had this conversation, or started the conversation for getting doulas on the state registry for 3 years, and I just submitted my paperwork last fall. One of the reasons I waited was there was a lot of conflicting information about the requirements. There was not a lot of clarity, I thought, so I decided to waiting until things seemed a bit more clear... If you go through Oregon Health Authority [website] there’s one sheet, and there’s all these links, and so you click on a link and it brings you to another form with five other links.... It was complicated.”

*Sub-Theme 2: Frequency of Changing Requirements.* Doulas also said that the information, requirements, the process of applying, and environmental context changed so frequently that they had a difficult time keeping up on the most recent information and some, like the agency quoted below, decided against applying until information became clearer:

“The question was I am interested in [getting on the registry], and we have interest, right? We had a point where all the doulas were this close to sending the paper work in for registration, but by the time you do everything, the website changed, the requirements changed, now maybe something else that’s going to happen. Is it 350? Maybe its not. Oh, look, FamilyCare closed. They were the ones rumored to be giving us more money, all of that. So we just said, ‘No. We’re

going to wait for it to sift out.’ Thank you for all the people who are doing the legwork on this, the vision is beautiful. Am I interested in it? Absolutely. But right now, [no].”

*Sub-Theme 3: Time.* Doulas said that it took a very long time to become OHA-approved Traditional Health Workers. The process for gathering all required credentials, submitting the application, and obtaining an NPI number took between 7 months and 2 years. Doulas said the process of applying was “frustrating” and “emotionally exhausting.”

*Sub-Theme 4: Lack of Technical Support.* Another challenge doula participants encountered when attempting to apply to be on the THW registry was the lack of direct technical support with completing and processing applications:

“There was one person who seemed to process applications at some point and they quit or retired or, maybe, I don’t know. But right now it seems like there isn’t that person...So it would just be great to have a point person there who is designated...A central location that everyone can tap into.”

Another echoed:

“They are wildly underfunded. At one point, I was on the phone with someone [discussing issues about my application] and the man said, “its just me doing this.” And I try not to get all upset and say, ‘it’s a sabotage!’ but it kinda feels that way.”

*Sub-Theme 5: Required Trainings.* All doulas attempting to complete applications and many of the THW doulas commented about the availability, quality, and value of two of the required trainings to become a state registered THW: the oral health training requirement and the cultural competency training requirement. Doulas who live outside of the Portland Metro area said they had a very difficult time obtaining the oral health training, and all doulas expressed confusion about how to implement what they learned in the oral health training into their practice as a doula: “it doesn’t make sense with the scope of practice for doulas.” Cultural competency trainings were said to be valuable, but hard to come by. One doula educator commented that the learning objectives for cultural competency trainings were never defined or clarified, which makes it hard to create new trainings or approve new cultural competency trainers. All doulas who had to complete the state-approved cultural competency training expressed concern over only having one possible source for trainings, the cost of the training being too high, and the availability of the training for doulas who live in areas (i.e., outside of Portland Metro Area) of the state where trainings are not offered. Doulas were also concerned about the relevancy of the available cultural competency trainings to current labor and delivery practices in hospitals and the doula practice experience: “someone...who has what’s going on today, because the way that birth work has evolved so quickly, you have to be 10 steps ahead of them.” While these barriers to achieving the training exist, doula participants also did express understanding the value of cultural competency training and experience for THW care with underserved communities.

## Theme 9: Billing and Reimbursement

The most frequently cited barrier for THW Birth Doulas is issues with billing and reimbursement. The first barrier within this umbrella is the the ability to create contractual relationships in order to bill with the proper parties. The second barrier is that once those contractual relationships are created, the

process of submitting claims and being reimbursed for services proves to be inconsistent and confusing. Issues and solutions for billing and reimbursement are delineated in the sub-themes below.

*Sub-Theme 1: No Ability to Bill for Doula Services.* There are two primary ways doulas can bill for services: through an obstetrical provider who also attended the birth or through directly billing for services to the family's CCO. As described in earlier themes, there are significant barriers to establishing relationships with obstetrical providers and contractual agreements with CCOs, thus creating a situation where there are many doulas who are on the registry across Oregon, but who cannot bill for services. An example can be found in this reported finding from the listening sessions: Four doulas said that obstetrical providers had referred OHP enrolled families to them because they knew the doulas were on the registry, but then these doulas had to turn away most or all of families because they have yet to be able to secure contractual relationships with CCOs, hospitals, clinics, or obstetrical providers in order to bill OHP for services.

*Sub-Theme 2: An Atmosphere of Frustration.* A common theme for doulas who became OHA-approved THWs is constant frustration at the inability to serve OHP enrolled families because of the multitude of barriers. Many have concerns that the State of Oregon will abandon the initiative to have doulas serving families who are enrolled in the Oregon Health Plan because it appears there is low utilization, but the low utilization is actually due to systemic barriers:

“How much time do we have left before someone is going to say ‘Well, this didn’t work very well, we are just not going to revisit this,’ and we haven’t even been able to serve anyone, but I got on the registry?”

Another echoed:

“I want to be out there serving my women, I want to be out there changing people for generations, I want birth to be normal and I want them to feel safe. How valuable is that for equity and inclusion? I mean its kind of contradictory that we are having this... I want to get to work and be seen as valuable because I want to change families, I want to change lives .... Instead we are tinkering around and leaving people high and dry. Its like this fantasy thing. ‘OH you are this doula, you are this community health doula but you are this untouchable doula.’ So it does leave some sort of bit of shame on my end because it leaves me unaccessible. So we need to do better.”

*Sub-Theme 3: Difficulties Submitting Bills and Receiving Payments.* Two doulas discussed their experiences with attempting to bill for doula services as THWs on behalf of themselves as individually practicing doulas. One doula describes the confusion about a doula's ability to bill as a provider, the impact of the rules and context frequently changing, and the difficulty doulas have experienced while attempting to bill for services. Another describes the difficult process of obtaining clear technical support in her attempt to create and submit bills to the CCO:

“Its so complicated. Can we bill directly as a provider? Oh we can, well how? Especially for someone who is not adept or familiar with billing medical insurance companies, but even doulas who have become preferred providers of private insurance through other [roles as] related medical professionals have a hard time billing doula work through Medicaid. Doesn't follow typical billing procedures... and the answers keep changing.”

Another echoed:

“Then comes the billing process...what they told us with billing, in their defense, they’ve never done this before.... But they just say, “oh you just have to submit a bill. Like, oh, you just go to the grocery store and buy milk.” Except that they’ve never done it, and they are talking to someone who has also never submitted a bill for anything, ‘just do it.’ I thought, ‘Cool. Um, how?’ When you think about it, who do I send it to even? Do I write on a piece of paper and make an invoice like I would give to a client for a private pay? And it’s not like that. So with [another doula] we went back and forth calling various CCOs, and we were on the OHP people’s tails all the time, and they were very annoyed with us because every time we called we would get a different answer... And finally we sussed out from all these calls that we needed to go to staples, and by a standard government form, and fill it out and then send that to the CCO. The only problem is that stuff is written in Chinese. People become medical billers to understand that, that’s like a separate course that people take and work as a profession to do that. So now we have to learn this entirely other profession just to submit a bill.”

*Sub-Theme 4: Doula Hubs.* The most recent change to policies regarding doulas as Traditional Health Workers was the ability for agencies or organizations to become billing entities and bill on behalf of doulas. These organizations are referred to as doula hubs. While doula hubs have much potential to overcoming cited barriers, doulas can also become frustrated in learning to set up this process, indicating a need for proactive support by state agencies to help doula hubs become successful. One participant doula described her experience in setting up the first doula hub and how the frustration experienced resulted in her decision to take only private paying families for now:

“You have to become a billing entity to legally bill Medicaid. And [my agency] was the first agency to become a biller for a doula... but that process wasn’t easy. I have support and so it was doable but it not something as easy as becoming a doula or getting on the traditional health worker registry....You have to become a billing agency, you have to learn how to bill, and you have to put in all that time and effort to submit this bill, and then... all of mine have been returned. So now I have to go appeal all of these things I have been denied... and it’s not worth my time for what I do professionally. It’s just not worth the time I’m spending on this, for what little I will get paid and what my doulas will get paid. It’s just easier to just say, ‘bag it, I am only taking private pay clients because it’s all I can afford to, because I have to eat.... [The problem is] nobody has ever done it. One person at the CCO was very kind and gave me this packet on how to submit a bill... but one of the steps was ‘submit the bill.’”

Hospitals and clinics will often contract with billing agencies who specialize in billing medical claims. Doula participants expressed interest in contracting with the local CCO’s billing agency in these regards. However, this model made not be feasible. For instance, the minimum number of claims one of the CCO billing agencies will process at one time is 100. When put into context, at 25 births a month for the doula hub, the minimum package is not feasible.

#### Theme 10: Enhancing the Doula Career

Doulas had suggestions for improvements that would enhance their ability to provide culturally appropriate and individualized doula care to families in Oregon. Access to trainings, increasing the rate of payment from Medicaid, and private insurance reimbursement options for doula services were the

recommendations doulas have for enhancing and developing the doula workforce. The sub-themes below represent these recommendations.

*Sub-Theme 1: Increase Access to Trainings.* Doulas across all focus groups discussed the need for access to trainings that count towards continuing education units for their certifications. Available trainings, particularly those in high demand, are expensive: “How can you get the education and be able to hone your skills if you have to pay what you earn in one birth on a training?” Doulas expressed a need to find or create trainings that focus on: successful communication between doulas and hospital staff or obstetrical providers (interprofessional collaboration); doula business structure possibilities (such as partnerships or collectives) and how to collaborate with other doulas; the business side of doula work (such as marketing, setting rates and accepting payments, and how to build a business); providing trauma-informed care to culturally and linguistically diverse families; and trainings on how to get on the registry that include the details of applying, billing, and connecting with obstetrical providers, doula hubs, or CCOs to properly bill.

Doulas also discussed the need for cultural competency trainings for all doulas and the need for a variety of trainings from a variety of trainers. Doulas discussed the value “broad” cultural competence versus more targeted culturally safe care trainings for service as doulas:

“I don’t feel we have enough cultural competency... when you talk about cultural competency... it is broad... Its still not going to prepare you to work with each group. Only when you work with a group and meet a family are you going to be able to truly get to know what they need. But what [broad] cultural competency training does is it teaches you to be sensitive to other cultures so that you can learn from that culture.”

Doulas also wanted trainings that focused on birth and family related cultural competency, specifically. For instance, they want to know methods for approaching families in learning their birthing and childrearing practices. The relationship between cultural competency and trauma-informed care was also discussed by participants. Doulas said that the type of trauma one experiences, including traumas in the context of living as people of color, impacts both the families served as well as a doula’s ability or approach in providing care:

“A big hole that I see...I work with stressed populations. Trauma informed care. Culturally specific trauma informed care. You don’t just have one trauma, you have complex trauma...Everything about a pregnancy and especially birth, once again, especially if there has been physical or psychological trauma... ‘[in birth] I am not in control of my body.’ They’re not prepared for it. What do you do as a doula, how do you handle that? For medical professionals, that’s not high on the list of their trainings. They’re very good on the science piece. It’s a very real thing and is a major contributor to outcomes.”

Doulas also described the need for cultural competency trainings from people with lived experience from these communities:

“Who is doing the training [is important]. I attended a training for culturally specific self care training...Relatability is important. And there are these two European women in a room full of brown and black people, and we are all looking at ourselves like, ‘are they...bringing on the speaker?’ but they just kept talking. I left. But it was offensive.”

Ultimately, doulas agree that the requirement for cultural competency training in order to be on the THW registry is valuable, but they want more easily accessible trainings and a larger variety of options.

*Sub-Theme 2: Increase Medicaid Rate.* Doulas in all focus groups said in order to make doula care more accessible to families enrolled in the Oregon Health Plan, increasing the rate of reimbursement would both incentivize doulas to enroll as THWs and allow doulas to take on more than one to two families enrolled in Oregon Health Plan a year. The range of acceptable Oregon Health Plan rates suggested by doulas was \$700-\$1,200 per birth. Most doulas said \$1,000 per birth was the lowest they could accept to incorporate families enrolled in the Oregon Health Plan in a sustainable way, as discussed in a previous theme.

*Sub-Theme 3: Private Insurance Coverage for Doula Care.* Doulas also expressed the need for third party payers, like private insurance companies, to cover doula services. Private insurance reimbursement for doulas would increase access to doulas for families who rely on both the Oregon Health Plan and private insurance companies. First, it would reduce the financial burden of doula services on families who utilize private insurance and will increase their access to doulas. Second, doulas could adjust their rates to more adequately compensate their work for their families utilizing private insurance to where the cost doesn't drastically impact the out-of-pocket contribution of the family, but offsets the lower Medicaid rate.

“[I told the CCO] if we could get assistance getting private insurance reimbursement, that we could potentially reduce that fee if we got a greater fee from private insurance and followed more the medical model of reimbursement, but we don't have that. Because the medical model [of reimbursement] usually follows the Medicaid model once it's in place. And it's not in place. It's there, but it doesn't function.”

## Theme 11: Culturally and Linguistically Diverse Doula Care

A stated goal of this project was to explore access to and utilization of culturally and linguistically diverse doula care for the THW priority populations. Theme 11 encapsulates this focus with several sub-themes rich in narrative regarding barriers and opportunities for culturally specific care.

*Sub-Theme 1: Improving the Sustainability of the Doula Career to Attract a Diverse Workforce.* Doulas at all sessions had suggestions on increasing access and utilization of culturally and linguistically appropriate doula services in Oregon. Doulas agree that the best strategy is to recruit, train, and support a larger number of doulas from diverse backgrounds. Doulas said that the diversity of doulas in Oregon was poor. The main barrier to a culturally and linguistically diverse doula workforce identified by doulas was the nature of the doula profession and the general employment-related struggles experienced by doulas in Oregon (Themes 1 through 3). Working as a doula already has substantial challenges for making a career of doula work and for doulas of color, the challenges are even greater:

“There are already numerous barriers for educated white middle class women to becoming a doula and having that as a sustainable career, there are even more barriers to women of color, immigrants, doulas who have been previously homeless, it is ten times more challenging to make a successful life of this. So of course they will say “That sounds great, but I am going to go back to...”

Making doula work more sustainable as a profession is necessary to attract doulas from the various cultural and linguistic backgrounds that would be required to serve the prioritized populations identified by THW guidelines. As one doula said, “It may be about the money, too. If you can’t make enough to sustain your family, why would you do it?”

One possible solution suggested is to price culturally specific or community-based doula services separately from “basic” doula services. Community-based organizations in Oregon who have doula services are an example of this suggestion. If doulas are to maintain independent work, doulas would need to be compensated differently for what they describe as specialized care requiring specialized services. Doulas see their cultural backgrounds as specialized skill sets that allow them to provide additional services that should be compensated at higher rates:

“When we talk about working in communities that have barriers. We always look at it as negative. It’s not negative. For those of us who work in this field, this is a specialty. This is added service along with being the doula, which is the basic. In any other field, when you have a specialized skillset, you are compensated differently. So looking at it from that lens, this is a special skillset you are bringing to the table. And it should be compensated differently.”

*Sub-Theme 2: Cost of Doula Credentials and Trainings.* Reducing the cost of doula trainings and certifications or offering scholarships was one way suggested at all focus groups that could reduce the barrier to entering the doula workforce. Some doulas, however, expressed concern that scholarships aren’t enough and that the scholarships available to people of color are not always utilized: “I know we have a trainer who comes and always has scholarships for women of color, so I think that’s a good starting point...however, she still struggles to find women to fill those scholarships.”

*Sub-Theme 3: Culturally and Linguistically Appropriate Trainings.* Doulas also shared their concern with the available doula certification trainings. There are no trainings available in Oregon that are taught in Spanish or other languages, and to create a workforce of Spanish speaking doulas, for instance, trainings would need to be delivered in Spanish and provided by someone from that culture. One doula trainer and a few doulas of color shared their concern at the lack of diversity of doula trainers from culturally diverse backgrounds. Moreover, some doula trainings available may be implicitly biased against some culturally valued birth practices.

“As well as the doula world legitimizing culturally specific beliefs and [practices]...that maybe [doula] standards and organizations may [deem] outside of the scope of practice...For example, rebozo use, which may be culturally specific and normal, but some organizations say that is out of [the scope of] practice for doulas.”

Because the general knowledge and understanding of doula work is poor in most of Oregon, let alone the idea that doula work could be a career path, doulas suggested that it would take very intentional and devoted efforts to identify the communities in a given area, reach out to the communities and community organizations, and collaboratively find, recruit, train, and support diverse doula workforces.

*Sub-Theme 4: Specific Concerns for Bilingual or ESL Doulas.* Specific linguistic barriers also arose during listening sessions. One Spanish speaking doula shared two issues she has experienced while providing doula care to Spanish speaking families. The first is the need to establish clear guidelines with families and hospital staff about her role as a doula and not a translator. Acting as a translator would change the

role she plays for her client. The second issue she has come across is serving undocumented families in her community and the technical assistance with billing for services. CAWEM covers prenatal and delivery services, but it is not clear who would pay for this service and she has been unsuccessful in getting answers on how to successfully bill for these services. Doulas in other focus groups also suggested that for doulas where English is their second language, the process of applying for the registry and being reimbursed may be a further challenge to their ability or interest in becoming an Oregon THW. Doulas also expressed concern that the THW registry website does not adequately track or report spoken languages of the enrolled THW Birth Doulas and this serves as another barrier to connecting families with the proper doula.

*Sub-Theme 5: Background Checks as a Barrier.* At one focus group, a doula shared that she connected with a doula who was formally a sex worker and was interested in serving families enrolled in the Oregon Health Plan, but was afraid to apply because she had a criminal background. While one small example, it serves to demonstrate that background checks without full explanation of how they will be used may serve as a structural barrier to those who have criminal background pasts and are finding new ways to engage equity and support their communities.

#### Theme 12: Postpartum Doula Work

How doulas incorporate Postpartum doula work into their workflow is discussed in Theme 3 in-depth. Here, it is important to identify the emergent theme of postpartum doulas as a key way to potentially expand THW doula reach and program impact. Specifically, doulas also want to see postpartum doula services as a covered service for families enrolled in the Oregon Health Plan. By covering postpartum visits, doulas can better serve families and ensure they have a healthy start to their new family, thus helping to address known health inequities after birth, such as maternal depression and low breastfeeding rates. THW postpartum doulas, like private practice postpartum doulas, would use postpartum care to close gaps in the continuity of care that may exist for some of their families and reduce the demand of the on-call nature of birth doula work.

#### Phase II: Key Informant Interviews with State Stakeholders (n=5)

Two primary themes, with sub-themes, emerged from key informant interviews with State of Oregon stakeholders involved in the conceptualization, implementation, and administration of the Traditional Health Worker program and associated legislation.

#### Theme 1: Successes in Integration of Doulas

Key informants could speak of successful integration of doulas into three of Oregon's CCOs. Two CCOs relied on the community-based model of doula care: one CCO created a program to work with childbearing members managing substance use treatment and the other CCO contracted with a community-based organization focused on enhancing the lives of families of color. The third CCO to successfully integrate doulas into their health system utilized the doula role as an extension of the services provided by their maternity case manager. The sub-themes below speak to best practices for integration success.

#### *Sub-Theme 1: Leadership Support*

Leadership buy-in and support for doula integration from the CCO perspective was crucial to successful incorporation of doulas. All key informants who worked directly with CCOs that successfully integrated doulas discussed holding meetings to determine feasibility, answer questions, and in some cases

introduce local doulas to clinic staff, hospital administration, or CCO personnel. Leadership who were not initially supportive were given data from their population and statistics to show how doulas could positively impact their members.

### *Sub-Theme 2: Doula Hubs*

Importantly, this sub-theme of doula hubs also came up in Phase I listening sessions with doulas, showing an area of clear convergence and opportunity. Key informants agreed that all current or potential efforts to integrate doulas into Oregon's health care system as Traditional Health Workers is through contracting with doula groups. Doula hubs, or an organization created for the specific purpose of providing billing support to doulas working as Traditional Health Workers, provided the best opportunity for doula integration in to the health care system. Participants envisioned doula hubs as contracting with maternity care clinics or CCOs. At the time of this report, the administrative rules to authorize these entities to bill and receive payment was approved. Creating and utilizing this type of organization would make it easier and more motivating for CCOs and maternity care clinics to integrate doula services. The first reason is administrative overhead, both for the CCO or clinic and for the doula hub. This participant speaks to the benefit of a doula hub as streamlined administrative processes for creating contractual agreements and negotiating the tracking of quality metrics:

“When you approach a CCO or health plan and say you want to get contracted, the likelihood of contracting with one organization that oversees 50 doulas is going to be more feasible than 50 individual doulas contracting with a CCO. One organization can also support doulas in developing professionally and contracts could include alternative payment models that could include infrastructure and admin costs, in order to bill for claims, or have quality metrics and data sharing tied to contracts. For example, timeliness of prenatal care (chart-based metric). If doulas go to first prenatal visits. Tracking initiation of breastfeeding, PCP engagement after delivery, could be built into a contract and financially incentivized.”

The second reason that key stakeholders envision doula hubs as key to the integration of doulas was the possibility for professionalization and referral points. One key informant said that professionalization is often lacking in doulas in the area: just because they qualify for the registry does not mean they have enough experience or skill to work with vulnerable populations. Key informants envisioned doula hubs as providing professional support and mentorship, while also acting as a resource for local communities and families to assist in finding qualified doulas. Key informants also envision doula hubs as culturally specific, which articulates well with doula narratives on the importance of a culturally and linguistically diverse doula workforce.

### *Sub-Theme 3: Community-Based Organizations*

This sub-theme of community-based organizations also came up in Phase I listening sessions with doulas, showing another area of clear convergence and opportunity. Community-based organizations are ideal entities to hire and partner with doulas because they are already established within communities, have relationships with community members, and have related services and resources to support families. One CCO's success in integrating doulas into their health care system relied on the fact that had spent nearly two years cultivating a relationship with a local community-based organization. Key informants emphasized culturally-specific, community-based organizations as ideal for helping to meet the needs of their population and providing genuine culturally-specific services. One key informant shared that particularly vulnerable members of their population may have been negatively impacted or

traumatized by people within the health care system and contracting with community-based organizations that focus on empowerment and enhancing cultural vibrancy has worked to help their members engage in the health care system and get the health care that they need for healthy pregnancies and births.

#### *Sub-Theme 4: Doula as a Case Management Expansion*

One CCO integrated doula services as an extension of the role of the maternal-child health case manager. This CCO's case manager saw that becoming certified as a doula and offering doula services to members was a way to customize her services. The doula skills she has are used less directly in serving as a doula and she teaches partners and support people to be the doula instead. Introducing her role as pregnancy coach and birth doula allows her to relate to families on a personal level and provide emotional support when necessary. "I don't think anyone really appreciates being 'managed,' especially in pregnancy, I think what we all need across the board is support. And especially for first time, young [parents], [parents with] lack of social support... a mentor that can walk alongside them and empower them."

#### *Theme 2: Challenges in Integration of Doulas*

One key informant spoke specifically to the challenges and barriers that resulted in a lack of doula integration in their health system. All key informants spoke of the general challenges that their organizations managed in attempting to integrate doulas. The sub-themes below illustrate the general and specific challenges of doula integration.

#### *Sub-Theme 1: Lack of Leadership Support*

Just as successful integration relied on support and buy-in from CCO leadership, the lack of integration in one CCO service area was due to a lack of top-level support from the CCO leadership. This key informant said that their CCO had significant organizational change, the organization is very big, and staff turnover meant that it was hard to determine who to speak to in receiving leadership buy-in. Nobody within the organization knows how to broach this topic with the CCO. Oregon CCOs are mandated to have THWs as a covered benefit, and one key informant shared that "the only way I know to get this conversation rolling is for OHA to go to all the CCOs who don't have THW services provided and say, 'This wasn't an ask, this was a demand.' If OHA doesn't push them along on this, I am afraid this is falling on deaf ears." This comment shows the definitive importance of OHA holding the CCOs accountable to the mandated coverage of doula service.

#### *Sub-Theme 2: Growing Pains of System Transformation*

The main challenge identified by all key stakeholders and doulas was that paying for any kind of traditional health work through medical claims was foreign to all parties involved. In 2011, when CCOs became accountable for coordinating and delivering health care for the Medicaid population in Oregon, billing Medicaid for preventative programs like the Traditional Health Worker Program wasn't "even on the radar." All THW types have been paid through other means previously: grant funding, volunteering, and private pay. Because doulas and other traditional health workers were not part of the system, and because there were no national standards on how to bill for these services at the onset of the traditional health worker program, it took extensive time for the State of Oregon to create policies and infrastructure to ensure doula and other THW services were able to be billed and claims paid. It also took time for CCOs to learn how to contract with community-based organizations and doulas.

### *Sub-Theme 3: Technical Support and Capacity for Clinics Hiring Doulas*

The State of Oregon's initial expectation of doula integration was that clinics would hire doulas directly due to the flexibility of alternative payment methods. While this is still the hope over the long-term, clinics are currently not utilizing doulas in this way and so alternative pathways for success must be achieved. One main barrier to clinic integration is the lack of technical knowledge or technical assistance in how to find, hire, manage, and fully integrate doulas into a clinic setting.

“Is there sufficient structural support for clinics in integrating doulas into their organization? We know this is a gap in service, we know the potential benefit to clients but we don't know how.”

Another echoed:

“What does doula supervision look like for someone who has never done doula work? That's just not possible. How do you, as an organization, if you have never done the work, how do you know how many births a doula can do per month a doula can do, how do you know how to do doula rotations for on-call work or handle a doula vacation, that would all be so new that it would take someone who has done the work to form it.”

Besides the details of managing doula staff, clinics in many CCOs are already at capacity and do not have the resources to take on the task of billing, managing, and paying doulas.

### *Subtheme 4: Understanding the Doula Role within the Medical System*

Lack of understanding of the scope of doula services was, and remains, a barrier to appropriately integrating doulas into the health care system. Key informants shared that doulas do not provide clinical services. Clinical services are far more easily documented and charted than the ambivalent, social support nature of doula services. As one key informant said, “How do you [doula] know if you did a good job? [Clinics and CCOs] need to be able to pay for doula services but we also need to be able to document the care doulas provide.” Because of the ambiguity and unfamiliarity of doulas to health systems, and some “complicated thinking” about which services that both had established Medicaid billing practices and most closely matched doula services, the Oregon Health Authority wrote administrative rules that would make doulas a type of case manager. However, after speaking with doula organizations, OHA became clear that the two roles are very different and different pathways for reimbursement for doulas were then created. As this sub-theme poignantly illustrates, the process of integration is far from straightforward and is ever-evolving, given the landmark nature of the legislation.

### *Sub-Theme 5: Doula Understanding of Medical Services and Medicaid*

Key informants also said that doulas are learning how the medical system works and that has added to the challenge of doula integration into the health care system. Learning to bill was said to be an initial obvious challenge, but learning the way that Medicaid works continues to be a challenge. Notably, this theme of the steep billing learning curve was also cited heavily in Phase I narratives with doulas. All key informants touched on the current Medicaid rate of compensation, \$350 per birth, as poorly received by doulas. “[CCOs] have had a difficult time encouraging doulas to submit for claims. Doula's don't want to go through the effort to get on the registry and submit for claims because of the low reimbursement rate.” One key informant pointed to the fact that Medicaid typically pays about 30% of the market rate to practitioners, and this rate is roughly on par with what doulas charge in Oregon. An obstetrical delivery with no complications is currently paid \$916 by Medicaid, so the \$350 rate is what one would

expect Medicaid to pay a doula. Key informants feel that this reaction to the rate is due to their lack of understanding or misunderstanding of how Medicaid works.

#### *Sub-Theme 6: A Slow and Complicated Process*

The final sub-theme regarding challenges to integration is the identified barrier by key informants of the slowness of the process. Obtaining Division of Medical Assistance Programs (DMAP) and National Provider Identification (NPI) numbers for individuals or groups can take some time, and the system for enrolling doulas has been inconsistent and convoluted. One key informant put it succinctly: “Nobody should be surprised it’s messy and slow. Frustrated, sure, but not surprised.”

### Phase I and II System-Level Concerns: Shared Thematic Results

There were four themes that arose from both focus groups and key informant interviews that require combining both focus group and interview data to appropriately illustrate the complexity of these thematic results. The four themes include the way doula services are framed in policy and health systems, redefining or expanding the doula role, the importance of trauma-informed care, and the role of the Oregon Doula Association in supporting the doula workforce.

#### Theme 1: Framing Doula Services in Policy and Health Systems

The first theme was the way in which doula services are conceptualized or framed in policy and health systems. The first concept within this framing is that of health equity and what it would take to fully actualize doula care as a health equity strategy, as the landmark legislation intended. Doulas agree that doula care can reduce costs associated with birth outcomes and interventions; however, some focus group participants struggled with what they described as a focus only on measurable cost reduction. Part of the health equity framing is ensuring that communities prioritized for improving birth outcomes are also described in a progressive, strength-based way that celebrates their strengths, resiliency, and, ideally, their culture:

“As a doula of color, there has to be a different lens... we are going to have a holistic approach...I think a lot of times when we have conversations about people of color its always negative, and it’s about health disparities, and we talk about here is about celebrating the strength and the culture of us as black people. Yes we are trying to reduce infant mortality rate, yes we are trying to reduce maternal mortality rate, but its about using our traditional culture... we’ve always been doulas. This is just a fancy name someone put together. We’ve always been doulas, we’ve always served our women, we’ve always taken care of each other....You can’t just address the pregnancy, you can’t just address the birth. As we are talking about culturally and linguistically appropriate care... it has to come from a progressive lens.... Culturally and linguistically appropriate is not the side item. It is *the* item, it is the thread in which we live and operate. That is our intervention that is our approach, that is our passion and why all of us are sitting here right now.”

Some doulas as well as key informants pointed out that traditionally, doulas were utilized by white middle class women and given this reputation previously associated with doula care, reframing or expanding the role of doula care to include health equity must be done strategically and thoughtfully. One participant in a rural area suggested creating a synonymous name for doula, because the term doula sounded eccentric and unapproachable and would likely meet some suspicion in her community. Another listening session participant expressed concern that continually emphasizing the connection

between doula care, prioritized populations, and birth outcomes may further perpetuate what she calls a ‘caste system of birth’:

“Even in saying that [they are] underserved puts them in a specific category that is separate...once you make us a community doula and we only serve the underserved, we become every bit as much a status symbol as the doulas who serve wealthy white women.... you don’t necessarily choose an OB or a midwife as a status symbol, it’s just kind of what you do. And that’s what I’d like doulas to be, its just what you do, and it can be a unifying factor instead of... a status symbol.”

### Theme 2: Expanding the Doula Role

Another key theme that emerged across both Phases I and II was expanding and further defining doula the role of the doula. Some participants envisioned the utilization of doulas in collaboration with other related services, such as case managers, visiting home nurses, or a part of CaCoon or WIC. Others suggested leveraging and enhancing the relationships and services that already exist and are already working within the prioritized populations. Relying on these programs to not only extend doula services, but also to recruit doulas is a potential strategy to workforce development:

“Why reinvent the wheel? These are agencies that already have beautiful relationships with the clients and the babies and it would be a natural evolution for women to work with agencies they already work with and have developed trust with.... It would make sense for these agencies to reach out to their women and say “we need you.”

Other participants suggested utilizing community members who are interested in helping provide birth support to local community members, but who are not interested in certifying or working professionally as a doula. One listening session participant described a problem in hospitals where family or friends of will attend a birth and call themselves a doula, but act in inappropriate ways. As such, this potential idea of community-recruited doulas must be approached with caution and with a focus on systems-level supports and integration.

### Theme 3: The Importance of Trauma-Informed Care

Two key informants as well as all focus group participants mentioned the critical importance of trauma-informed care training and experience for doulas. Doulas said that the vulnerable nature of birth often means people who have experienced trauma have more complex, trauma-related issues that arise during birth, and all people have the potential to experience birth as traumatic. Doulas who have experience and training related to trauma-informed care share that they are more successful with their clients and key informants said they needed to ensure that doulas working with the prioritized populations are adequately trained in trauma-informed care.

Going hand in hand with this focus is the consistent concerns over billing struggles. Key informants described the struggle to fit doula services into a system that pays through medical claims, and doulas describes the struggle to adequately describe doula services in medical terms. One doula said that doula services should be viewed from a social service model or a mental health model to better explain the kinds of services they provide and better compensate doulas for their work: “It’s more of a social services model, and the medical services isn’t comfortable with that... mental health isn’t well integrated into [medical care].” Conceptualizing doula services as a social service or adding doula care to social service agencies and community organizations was one solution to both the inadequate pay doulas

receive and to meeting the needs of complex-need populations, who require more service than what is covered in the basic state doula package.

#### Theme 4: Enhancing the Role of the Oregon Doula Association

Key informants and listening session participants discussed the current and future role of the Oregon Doula Association (ODA). A minority of focus group members said that the ODA did not have enough information available to members or facilitate enough communication about working as a Traditional Health Worker. The majority of doula were appreciation of the organization and both doulas and key informants looked to the ODA as the “point organization” to communicate what is happening with doula integration. Additionally, key stakeholders see the ODA as having the proper connections to doulas and other key community stakeholders to make THW programming successful. Participants envision the ODA as advocating at the capital for necessary changes, communicating changes in THW policies and procedures, and leading endeavors to “align all [the key players in] the state.” Participants also hope that a strategic plan for doula workforce development would be created and widely disseminated by the ODA. In every discussion of the ODA, people appreciated all of the work done on behalf of doulas and recognized that many of the successes were due to ODA advocacy. Participants also said that to achieve the future role of the Oregon Doula Association, the organization needs more resources, including funding and staffed employees. All current ODA leadership are volunteers with other full-time employment commitments. One key informant summarized this dream of a well-resourced ODA this way: “The dream being ODA staff employees who can push for a statewide agenda or plan of action.”

#### Phase III: Online Surveys with Doulas and Employers (n=156)

There were four separate surveys administered as part of Phase III. Results for each are below.

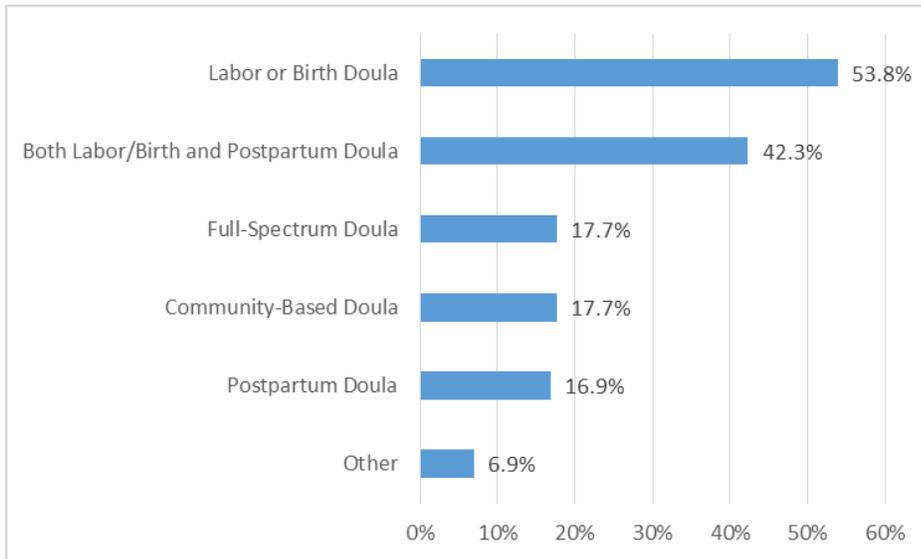
##### Doula Workforce Survey

The doula workforce survey had a total sample size of n=130. Any doula who practices in Oregon was eligible to participate in the survey. Doulas were asked a wealth of questions to ensure a full environmental scan and needs assessment of the doula workforce. Results are delineated below.

##### Doula Types, Training and Certification

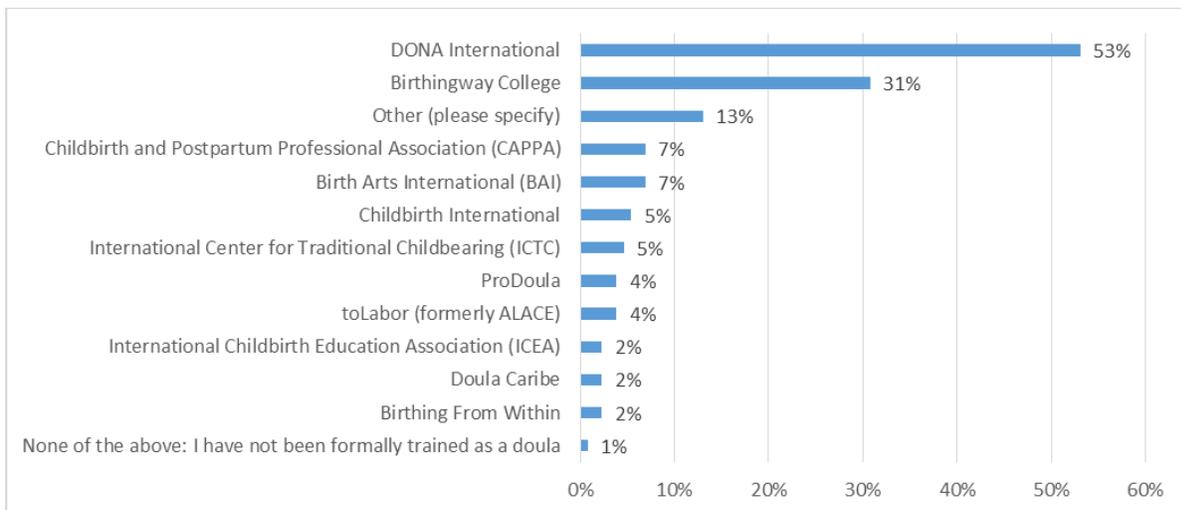
Doulas were asked questions about how they identify as a doula, their primary type of doula work, their training routes, and their certification status. Half of doulas (52.3%) identified as labor or birth doulas. The next most common doula identity was both Labor/Birth and Postpartum Doula (42.3%). There were roughly equal number of doulas who identified as postpartum doulas (16.9%), full-spectrum doulas (17.7%) and community-based doulas (17.7%).

**Figure 1.1: Doula Types**



Almost all respondents (99.2%) said they had received some sort of formal doula training. Over half (56.9%) of respondents have ever fully certified as a doula and 50% of respondents were fully certified at the time of the survey. Just over half of doulas received training from DONA International (53.1%) and nearly one third (30.8%) trained with Birthingway College. All other listed credentialing organizations were cited by less than 7% (n=9) of doula respondents.

**Figure 1.2: Doula Training and Certification Routes**

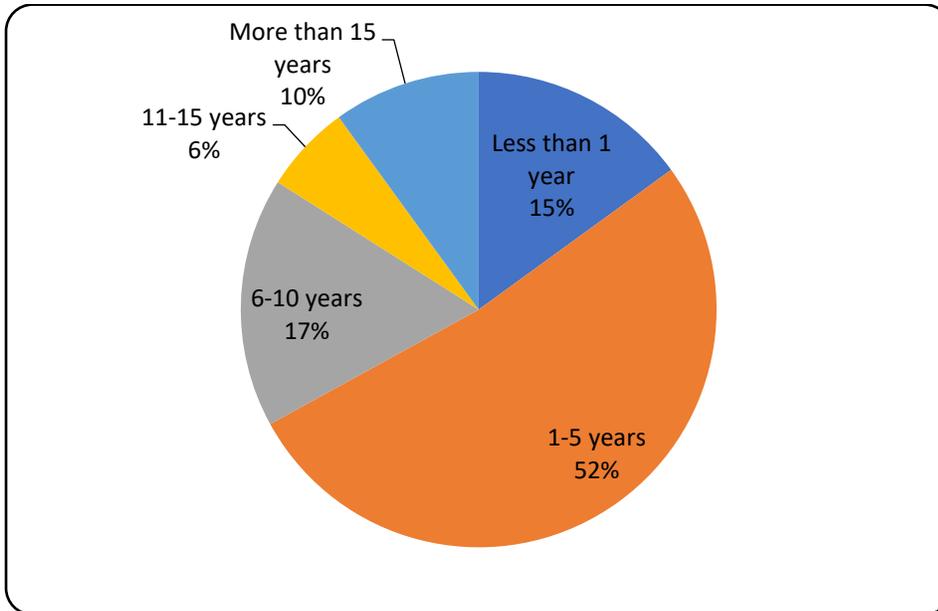


### Characteristics of Doula Employment

Doulas answered questions about characteristics of doula employment, including length in practice, doula work as a primary means of employment, and other jobs or sources of income. Most responding doulas were early in their doula career: 51.5% had been practicing for 1 to 5 years and 15.4% had been practicing for less than 1 year. A small, but important, sub-sect (16.2%) had been practicing for more than 10 years as a doula. Less than half of doulas (42.3%) consider doula work as their primary form of

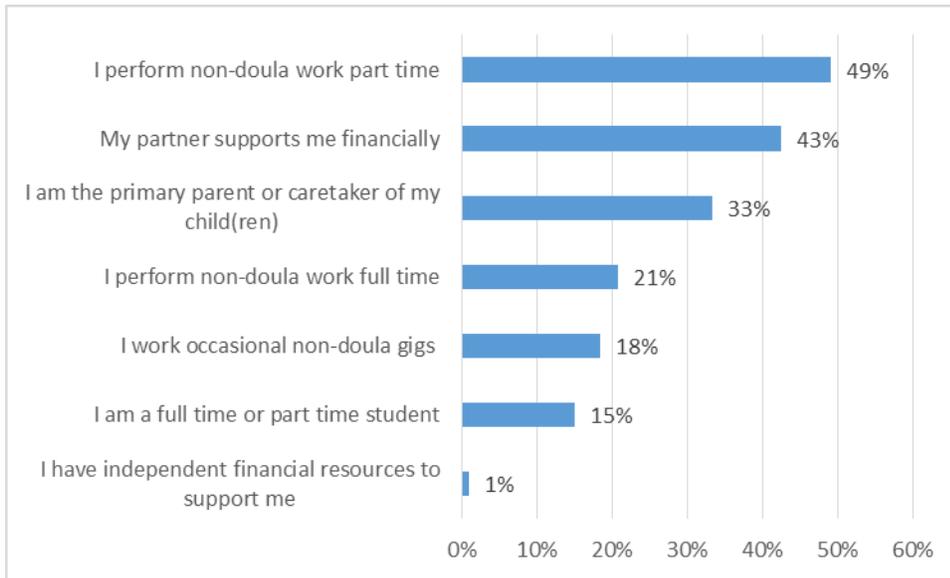
employment and only 16.2% of respondents rely on doula work as their only source of income (83.9% have additional sources of income or employment).

**Figure 1.3: Number of Years in Doula Practice**



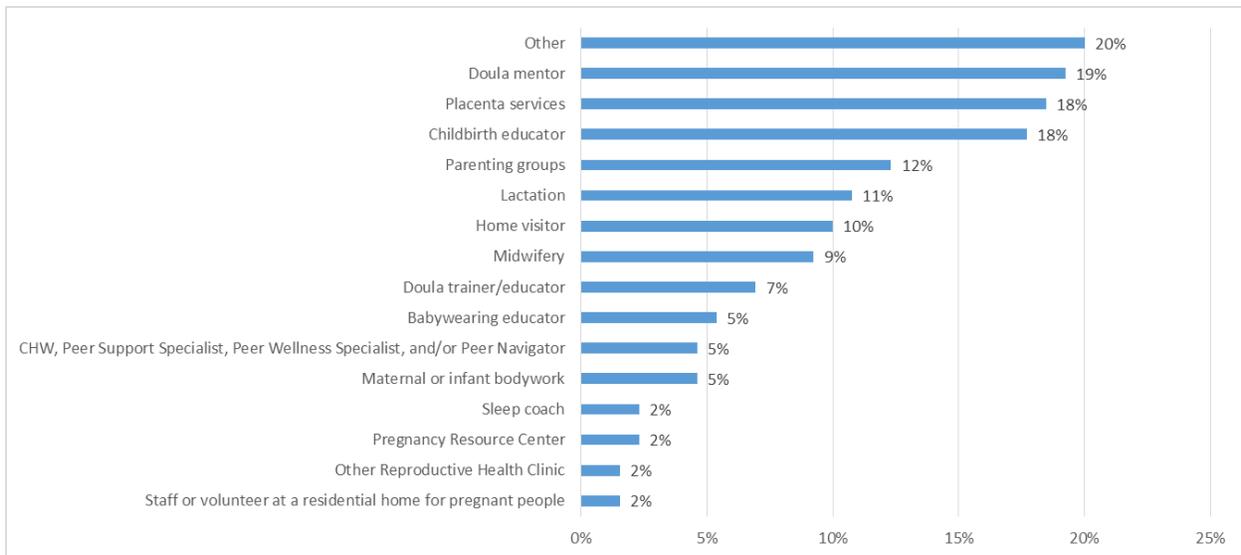
Doulas then answered questions about the amount of work and type of work done in addition to the doula role. A substantial percentage of doulas (42.5%) report that their partners support them financially. One third (33.3%) also report that they are the primary caretaker of their child or children. Nearly half (49.2%) of doulas work part-time outside of their doula roles in paying employment and one fifth (20.8%) of doulas work full-time outside of their doula work in paying employment. Doula respondents also described the kinds of work they do outside of their doula role. Most types of full-time work (48.0%), part-time work (41.4%), and gigs (40.9%) are unrelated to pregnancy, birth, postpartum or early childhood. Unrelated work includes jobs such as driving for Uber or Lyft, copywriter, business analyst, retail work, housekeeper, property manager, substitute teacher, and paralegal. Some respondents reported working full-time (32.0%), part-time (18.9%), and occasional gigs (9.0%) in health or social service related fields, such as licensed massage therapist, social worker, and acupuncture clinic manager. Doulas who also work in birth-related jobs work part-time (25.7%) or gigs (22.7%) in these positions. Only one doula (4%) worked a full-time position related to birth work as a childbirth educator. Two respondents (8%) worked in other traditional health worker roles full time, as a community health worker (and supervisor) and peer recovery counselor. Doulas who report working in caregiving roles, such as child care, elder care, or other personal support, do so less frequently full-time (8%), but more frequently as part-time work (15.5%) and as occasional gigs (27.2%). One respondent (.8%) indicated that they had independent financial means of support.

**Figure 1.4: Other Sources of Income**



Most doulas surveyed (79.2%) engaged in some sort of birth-related work outside of providing doula care. The most commonly reported forms of birth-related work include doula mentor (19.2%), Placenta services (18.5%) and childbirth educator (17.7%).

**Figure 1.5: Type of Birth Related Work**

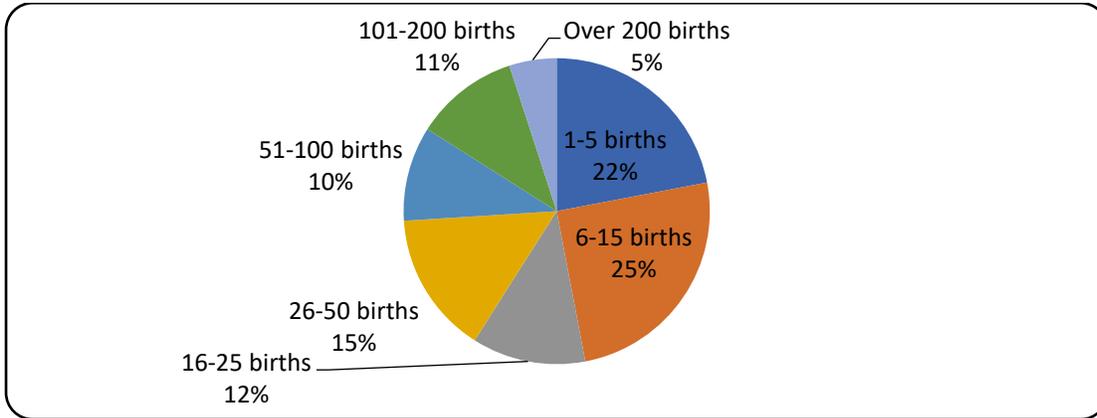


*Birth Doula Work*

Doulas who engage in birth or labor doula work reported how many births they have ever attended, their current monthly client load, and their potential work capacity. Of the currently practicing birth doulas, 40.2% had attended more than 25 births in their doula careers and 16% had attended over 100 births. One fifth of respondents (22.1%) were still early in their doula career and attended less than five births. Most doulas reported taking one client or birth per month (38%) or 2 to 3 births per month (29.8%), with 5.8% of doulas reporting they take 4 to 5 clients per month and 3.3% of doulas reporting

that they take 8 or more clients a month. In comparison, only 16.3% of doulas report that one client per month meets their capacity. Half of birth and labor doulas (51.2%) indicated that their capacity is 2 to 3 clients a month and 16.3% of doulas report that their capacity is 4 to 5 clients per month.

**Figure 1.5: Number of Births Ever Attended as a Doula**

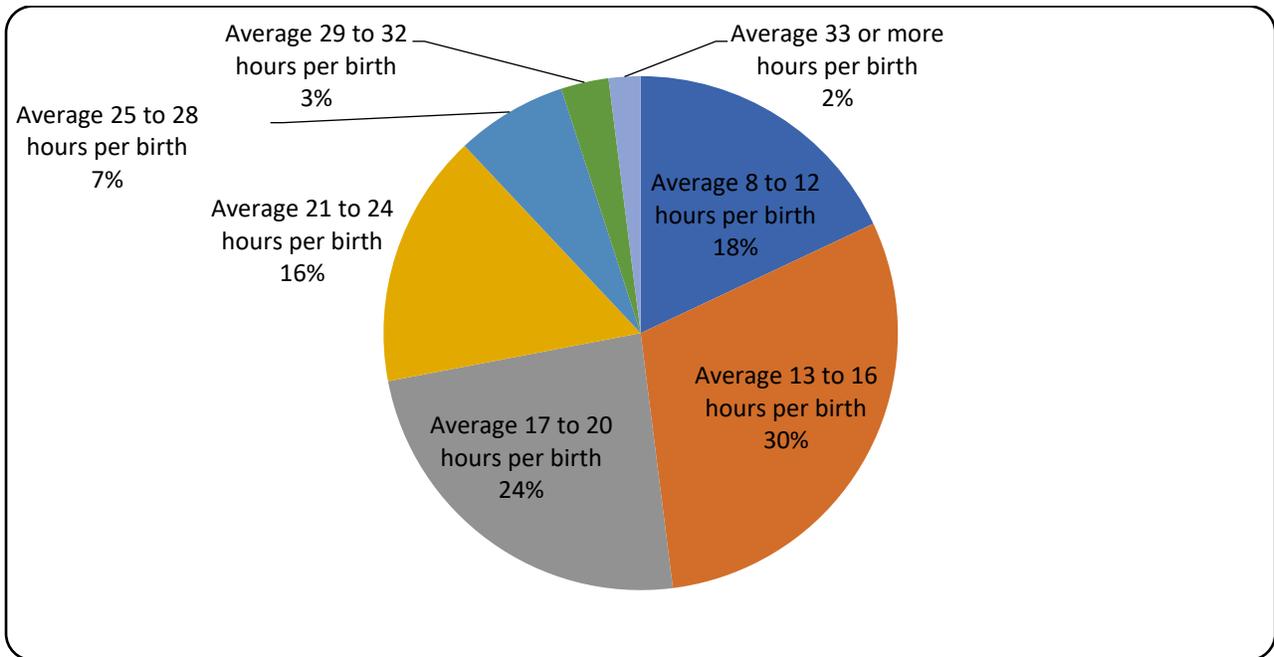


**Table 1.7: Current Birth Clients per Month and Client Capacity**

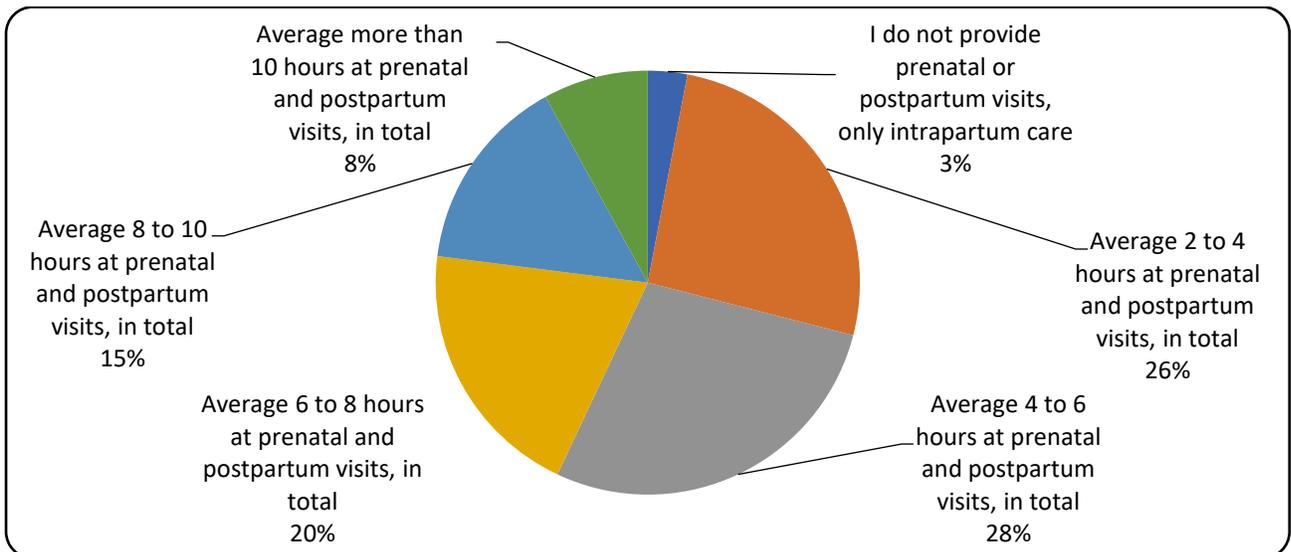
	How many clients (births) do you usually take per month?	How many clients (births) would you be willing (i.e., have the capacity) to do per month?
Value	Percent	Percent
1 birth	38.0%	16.3%
2 to 3 births	29.8%	51.2%
4 to 5 births	5.8%	16.3%
6 to 7 births	0.0%	0.8%
8 or more births	3.3%	4.1%
I am not currently practicing as a birth doula; I am not interested in taking on labor/birth clients at this time	23.1%	11.4%
Totals	121	123

Birth doulas also reported the average length of time they spend on continual care during labor and delivery with each client as well as the amount of time they spend on prenatal and postpartum care. The most frequently reported average of time spent providing labor and delivery care was between 13 to 16 hours (30.3%), followed by 17 to 20 hours (24.4%). One tenth of doulas (11%) reported that, on average, they spent 25 or more hours providing continual labor or birth support. The most frequently reported average hours spent for prenatal and postpartum care was 4 to 6 hours total (27.7%), followed by 2 to 4 hours total (26.1%), and 6 to 8 hours total (20.2%). Almost one fourth (22.7%) of birth doulas spend 8 or more hours on average with clients providing prenatal and postpartum care.

**Figure 1.6: Average Time Spent on Continuous Labor Support**

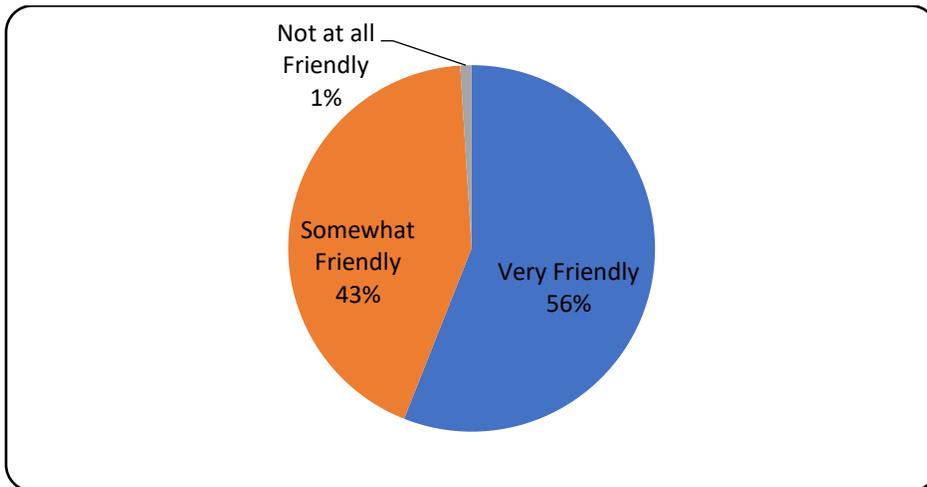


**Figure 1.7: Average Time Spent on Prenatal and Postpartum Visits**

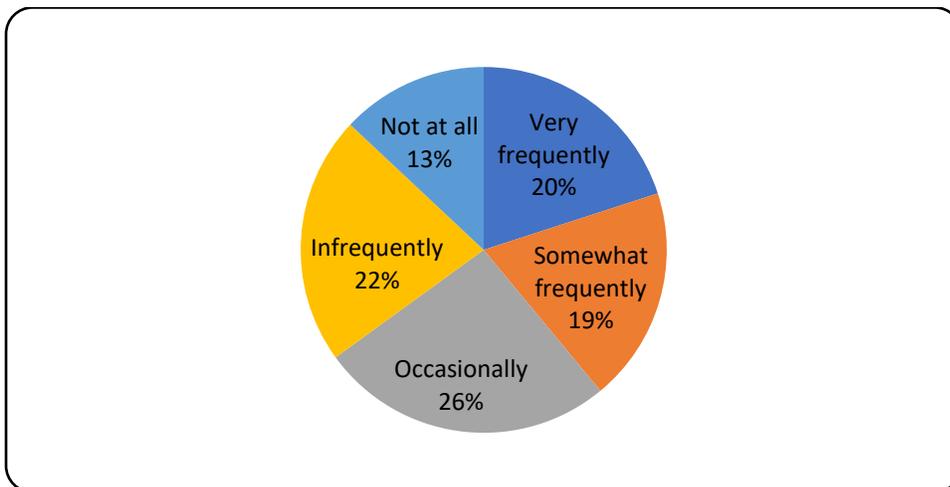


Birth doulas also reported on the doula friendly nature of hospitals and care providers as well as any exclusions from supporting clients that they had experienced by hospital or provider policies. Responses indicate that over half (56.4%) of birth or labor doulas experience hospitals and providers as “very friendly” and 42.7% stated they are “somewhat friendly”. Only one doula (0.9%) said that their local hospitals and care providers are not friendly at all. Open ended responses describe a range of experiences from a neutral level of acceptance to embracing the doula’s presence and encouraging collaboration. There were 21 responses that mentioned challenges to doula friendly hospitals were due to individual provider or hospital staff and not directly related to hospital policies or culture. Two doulas shared that the hospital-specific policies that they find challenging are policies that limit or prohibit a doulas involvement in the operating room for cesarean births. Doulas also commented on the frequency in which they were excluded from supporting clients by hospital policies or hospital staff. One quarter of doulas (24.7%) reported they are “Infrequently” (22%) or “Not at All” (12.7%) excluded from providing support to clients. Roughly equally, doulas report “Very Frequently” (20.3%) and “Somewhat Frequently” (18.6%) being excluded from providing support to clients.

**Figure 1.8: Doula Friendly Designation Status**



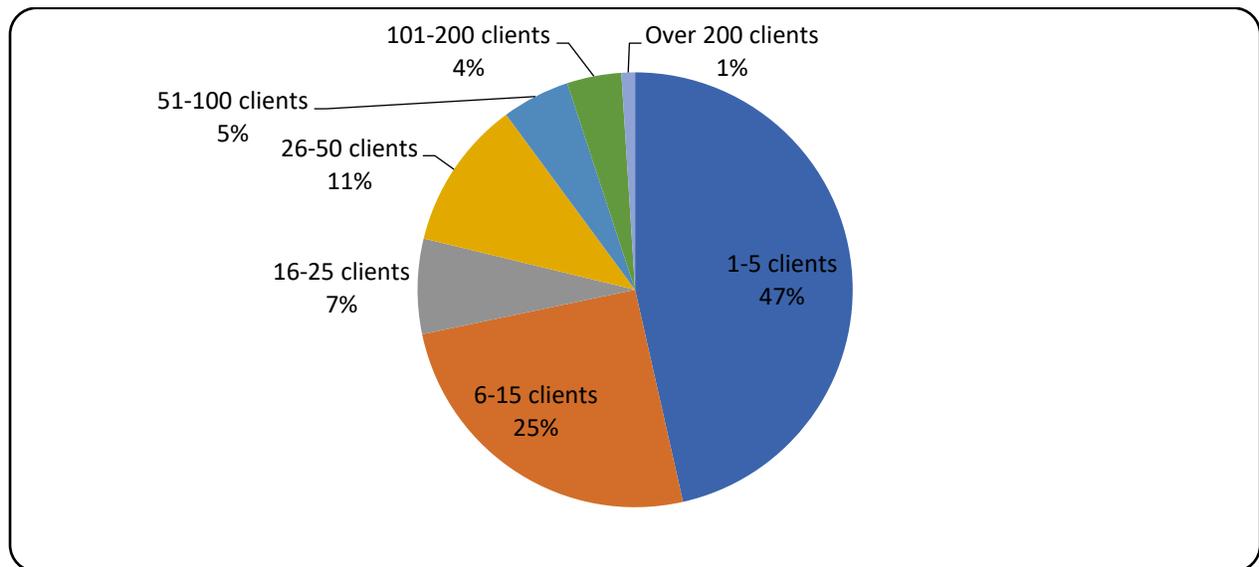
**Figure 1.9: Frequency of Exclusion to Providing Doula Support**



### Postpartum Doula Work

Doulas who engage in postpartum work reported how many total postpartum clients they had served, their current monthly client load, and their work capacity based on monthly client load. Nearly half of postpartum doulas (46.3%) reported having served five clients or less and 25.3% of doulas reported ever serving between 6 to 15 clients. One tenth (10.6%) served 26 to 50 clients ever. One third (35.6%) of postpartum doulas serve one client a month, and one quarter (24.4%) serve 2 to 3 clients per month. Few doulas serve 4 to 5 postpartum clients a month (5.6%) or 6 to 7 postpartum clients a month (2.2%). Only 13.6% of doulas indicated that their capacity is 1 client per month, and almost half of all postpartum doulas (46.2%) indicated that they have capacity to serve 2 to 3 clients per months. Some doulas (17.6%) have capacity for 4 to 5 clients per month.

**Figure 1.10: Number of Postpartum Clients Ever Served**



**Table 1.8: Current Postpartum Clients per Month and Client Capacity**

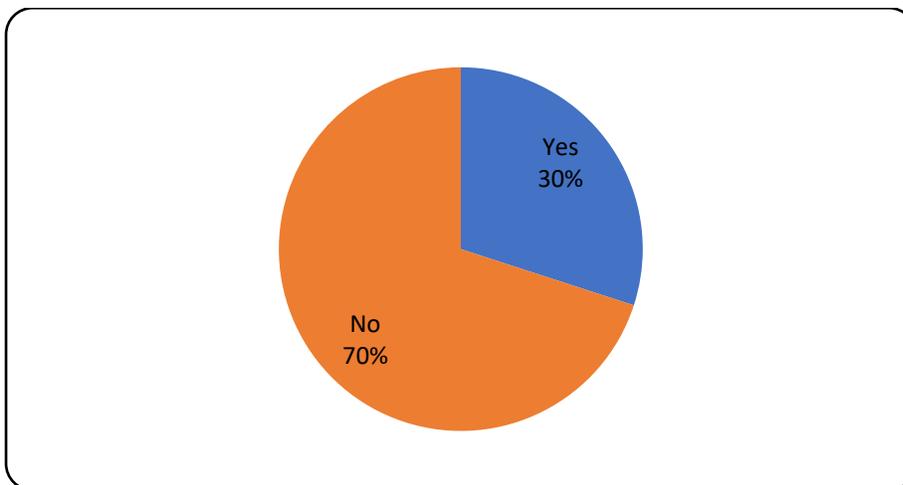
	How many clients do you usually take per month?	How many clients would you be willing (i.e., have the capacity) to do per month?
Value	Percent	Percent
1 client	35.6%	13.2%
2 to 3 clients	24.4%	46.2%
4 to 5 clients	5.6%	17.6%
6 to 7 clients	2.2%	5.5%
8 or more clients	0.0%	2.2%
I am not currently practicing as a postpartum doula/ I am not interested in taking clients right now	32.2%	15.4%
Totals	90	91

### Culturally and Linguistically-Specific Doula Services

Doula respondents then answered questions about the provision of culturally- and linguistically-specific doula services. About one third of doulas (30.5%) reported that they provided culturally- and linguistically- specific services while serving as a doula. In open-ended questions, 42 respondents provided explanations of how they provide culturally- or linguistically-specific doula services, as follows. 23.8% discussed being able to speak and provide care in non-English languages (specifically: Spanish, Russian, Hindi, Dutch, Haitian Creole, and American Sign Language); 19.0% discussed their own cultural background, including Hindi East Indian (4.8%), Black or African American (2.4%), Native American (2.4%), or being women of color (9.5%) as central to culturally-specific care services; and 52.4% discussed culturally-specific services in terms of religion (7.1%), sexual orientation or gender identification, (4.8%), or newly immigrated families (7.1%). In addition, 7.1% of doulas discussed having some sort of cultural competency training or trauma informed care training. In total, 14.3% of respondents discussed having no experience in this area, but were interested in learning to provide culturally- and linguistically- appropriate services.

Doulas also reported challenges in providing culturally competent doula services. For example, one Spanish-speaking doula said that staff will ask them to act as a medical interpreter so that they don't have to call in an interpreter. Additionally, 7.1% of respondents indicated that culturally diverse populations may not fully understanding the role of doulas or are embarrassed at the need for labor or postpartum help ("seen as weak"). One doula said there are not enough Native American doulas who are trained with the traditions and ceremony knowledge that is a big part of "who we are and [how we want] to bring our children into the world." Finally, 4.1% of respondents discussed the complex needs of serving culturally specific populations. As one participant put it: "I am a doula through a program that provides doula support to mothers of color and usually they have more indicating factors such as being labeled high risk or struggling with their socioeconomic backgrounds, so being that I am a woman of color I support them with well-known resources and lived life experiences."

**Figure 1.11: Culturally- or Linguistically- Specific Doula Care Provision**

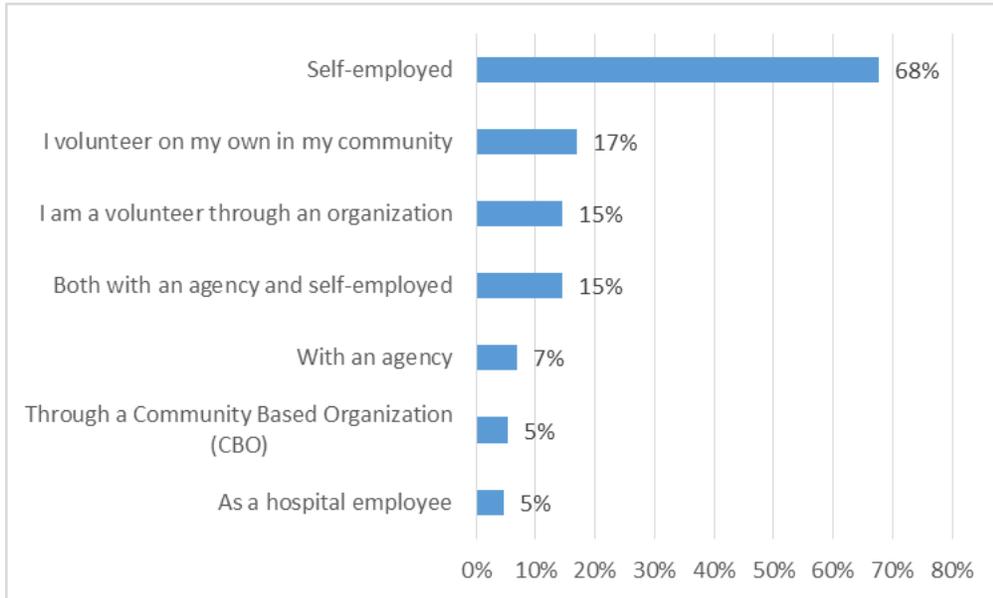


### Doula Business Models, Service Area, & Sustainability of Work

Doulas then answered questions about the ways in which they were employed, the counties they serve, their difficulty in securing doula work, and unemployment. Two-thirds of doulas (67.7%) reported that

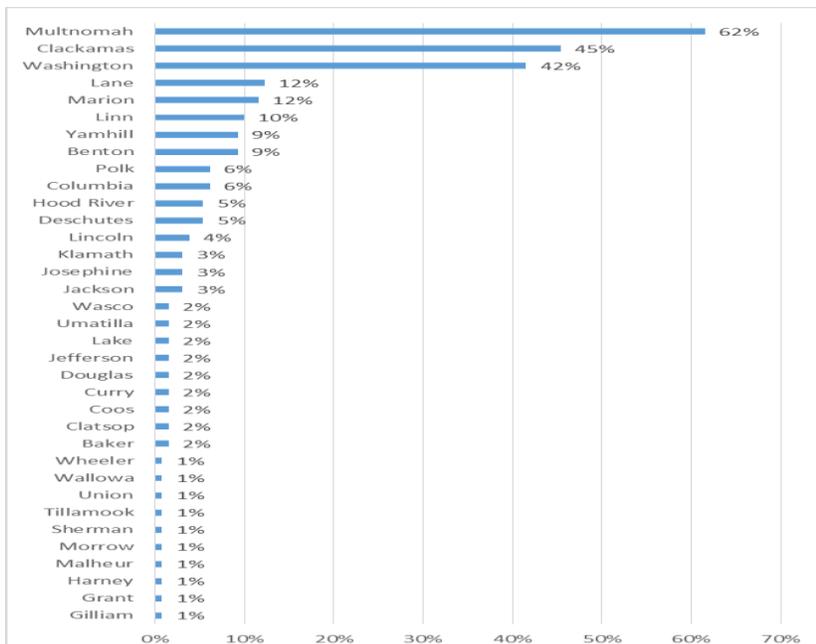
they were self-employed. The next most likely form of doula work reported was working for both an agency and self-employed (14.6%), volunteering as a doula as an individual (16.9%), and volunteering as a doula through an organization (14.6%). A small percentage of doulas reported employment through a community-based organization (5.4%) or a hospital (4.6%).

**Figure 1.12: Types of Doula Employment**



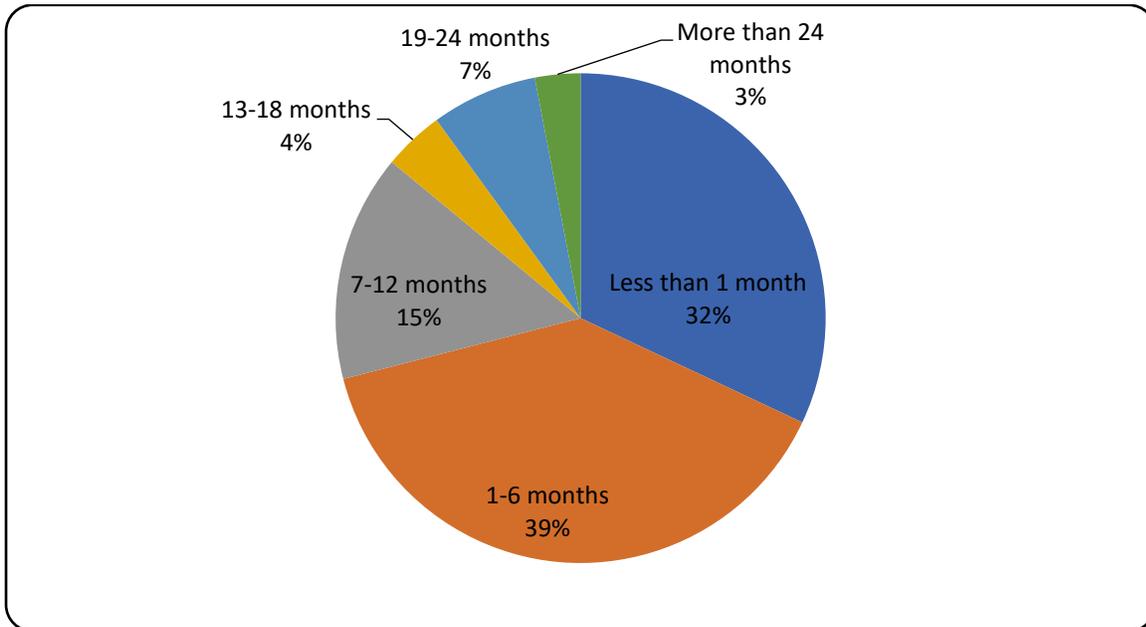
Doulas also reported their service area by county. Every county in Oregon had at least one doula who provided service to that area, as captured by this workforce survey. The counties with the most doula representation were Multnomah (61.5%), Clackamas (45.4%), and Washington (41.5%).

**Figure 1.13: Service Areas by County**



Over half of doulas (55.4%) reported experiencing difficulty finding paid doula work in the past two years. Doulas listed the reasons they found it difficult to secure paid work. Doulas most frequently report periods of unemployment from doula work between 1 to 6 months (39.2%), with about one third (31.5%) reporting less than one month of unemployment from doula work, 15.4% reporting unemployment from doula work for 7 to 12 months, and 13.9% of doulas experienced unemployment from doula work for over one year. The most frequently expressed reasons doulas experience difficulty finding paid work include a doula's inability to find clients (23%), a family's ability to pay for doula services (20%), and lack of general knowledge and understanding of doulas (12.2%). Other notable reasons include difficulties with advertising (8.1%), finding births to complete certification/recertification (5.4%), and lack of insurance coverage for doulas (5.4%)

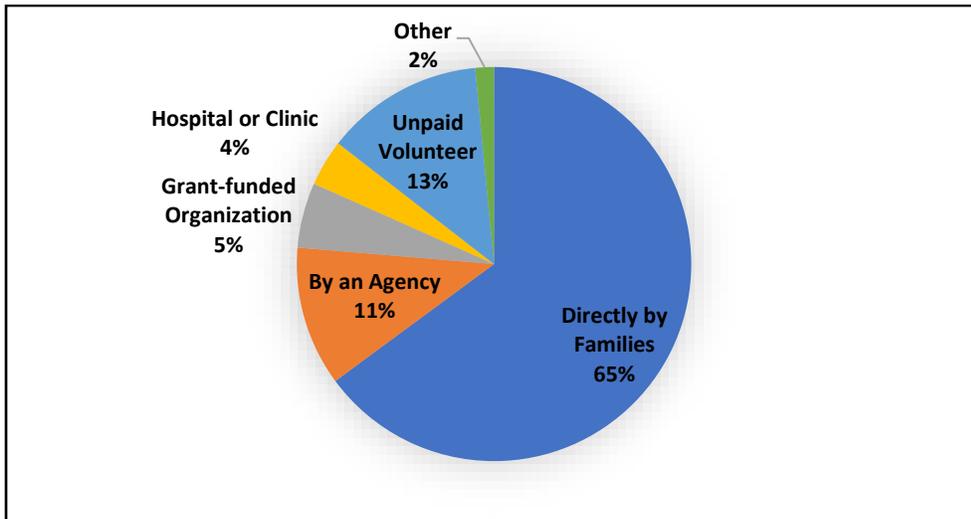
**Figure 1.14: Trends in Unemployment from Doula Work**



#### Payment Characteristics

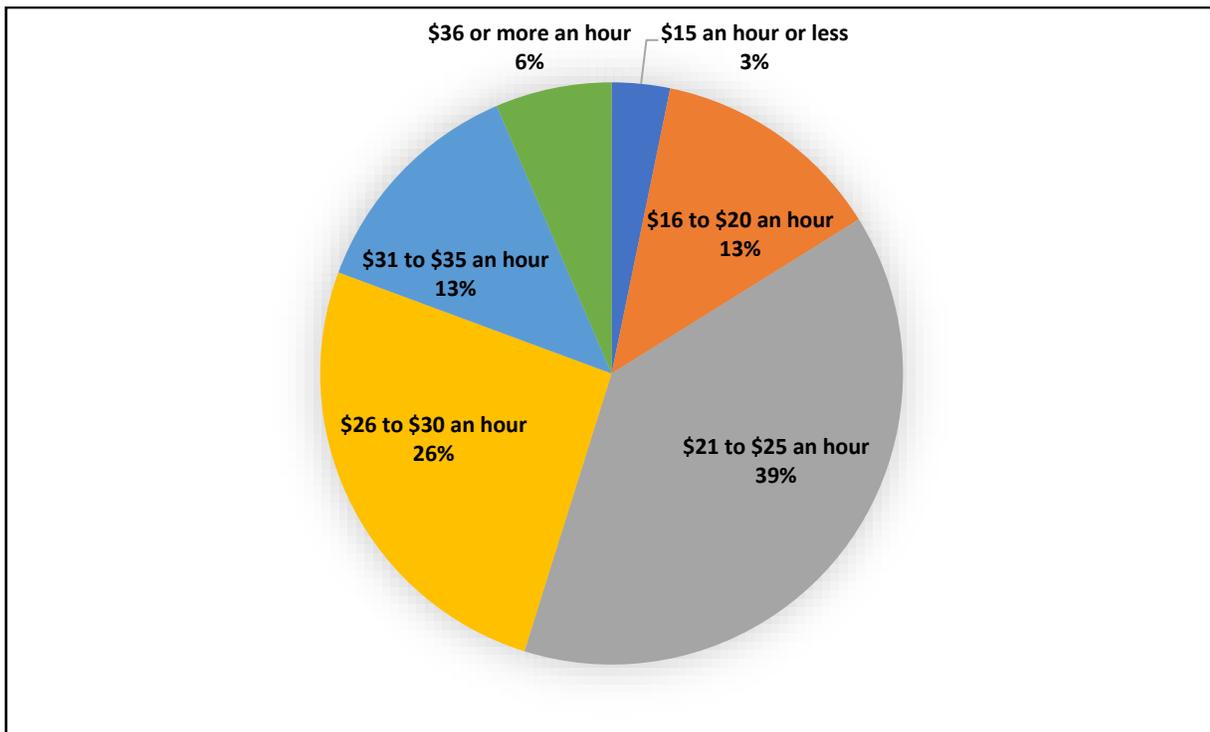
Doulas then answered questions about payment characteristics for doula services, including how they are paid, how much they charge or earn for services, how often they offer sliding scale fees, and how frequently they offer pro bono (without charge) work. Almost two-thirds of doulas (64.7%) reported receiving payment directly from families, following by 13.1% reporting unpaid volunteerism, 11.5% reporting employment by an agency, 5.4% reporting employment by a grant-funded organization, and 3.9% reporting employment by a hospital or clinic.

**Figure 1.15: Principal Payment for Doula Work**

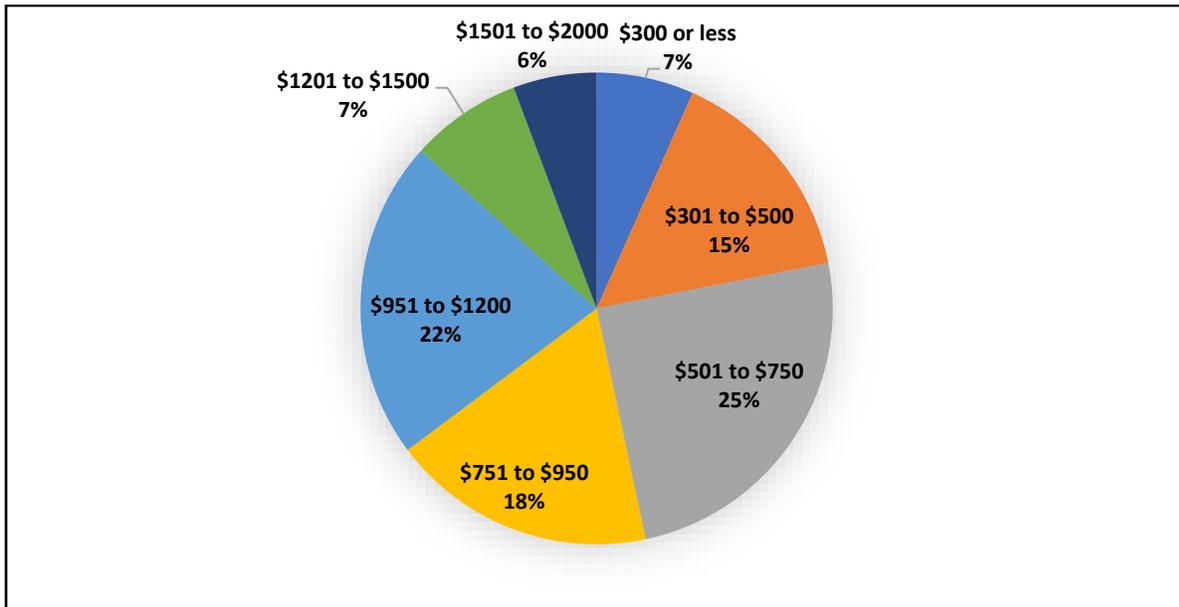


Doulas also reported their hourly or package rates. Most postpartum doulas charge for services by the hour while birth doulas charge a global package fee that includes prenatal and postpartum visits in addition to birth support. The most frequently reported range for hourly postpartum doula fees was \$21 to \$25 an hour (38.7%), followed by \$26 to \$30 an hour (25.8%). For package or global birth doula fee rates, 39.9% of respondents indicated a range of \$751 to \$1200, followed by 24.7% reporting their normal rate as \$501 to \$750 per birth and 21.9% reporting their average rate of \$500 dollars per birth. A minority of doulas (13.3%) reported earning between \$1201 and \$2000 per birth.

**Figure 1.16: Hourly Wages of Doulas per Hour (Postpartum Doula Focus)**

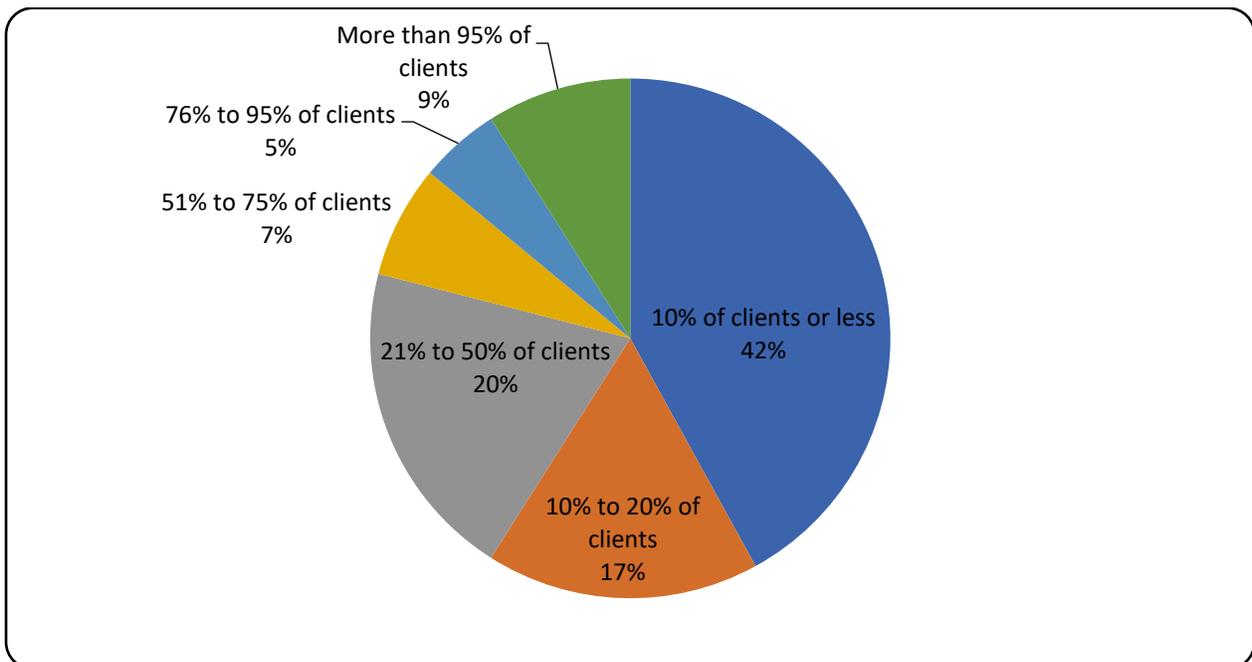


**Figure 1.17: Global Package Doula Fees (Birth Doula Focus)**

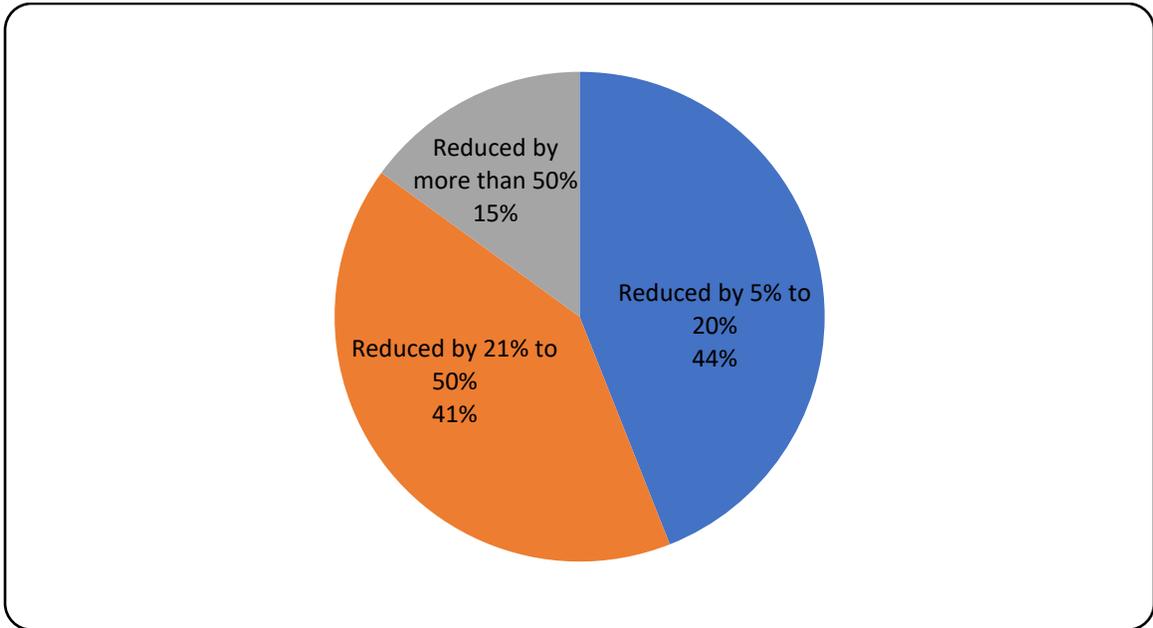


In addition, over half of doulas (60.8%) said they engaged in a sliding scale fee structure for clients who could not otherwise afford a doula's regular fee. Doulas most frequently reported reducing their fee for 10% of their clients or less (42%). For doulas who engage in sliding scale fee structures, respondents were roughly equal in reporting that they reduce their rate by 5% to 20% (43.8%) or 21% to 50% (41.3%); 15% of doulas reported reducing their rate by more than 50%.

**Figure 1.18: Percentage of Doula's Clients Who Receive a Sliding Scale Fee Structure from Doulas**

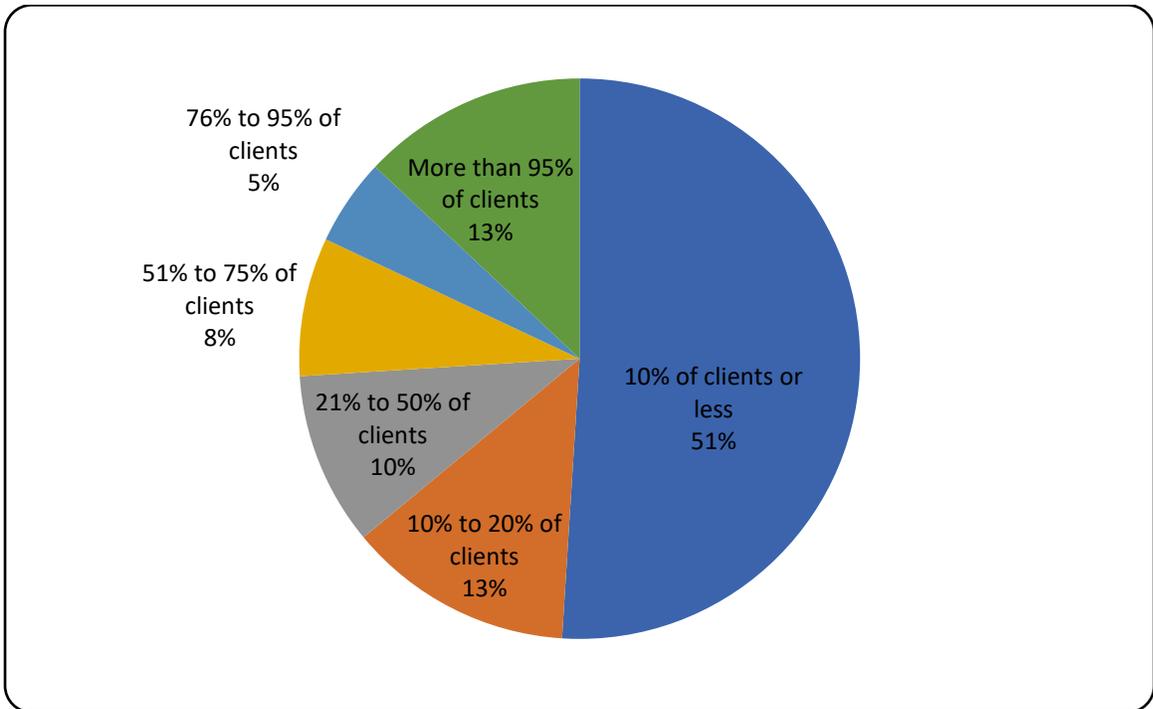


**Figure 1.19: Percent of Normal Fee Reduction**



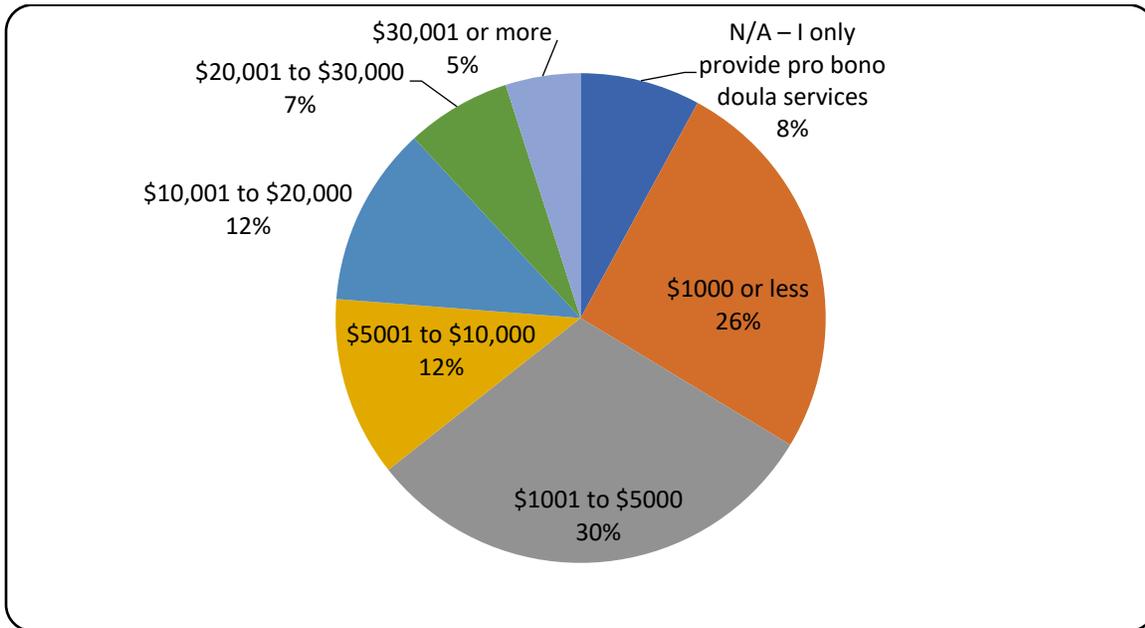
Regarding pro bono services, over half of doulas (57.7%) said they engage in pro bono doula services for clients who could not otherwise afford doula services. Half of doulas (50.7%) provide pro bono services to 10% or less of their clients.

**Figure 1.20: Percentage of Doula Clients Receiving Pro Bono Doula Services**



Doulas also reported their annual gross income. Over half of doulas (57.0%) earn less than \$5,000 annually and 7.7% of doulas only provide pro bono doula services. Doulas were roughly equally distributed across the following income categories: \$5,001 to \$10,000 (12.3%), \$10,001 to \$20,000 (11.5%), and over \$20,000 (11.3%). Six doulas (4.6%) indicated that they made \$30,001 or more annually from doula work.

**Figure 1.21: Annual Gross Income from Doula Work**



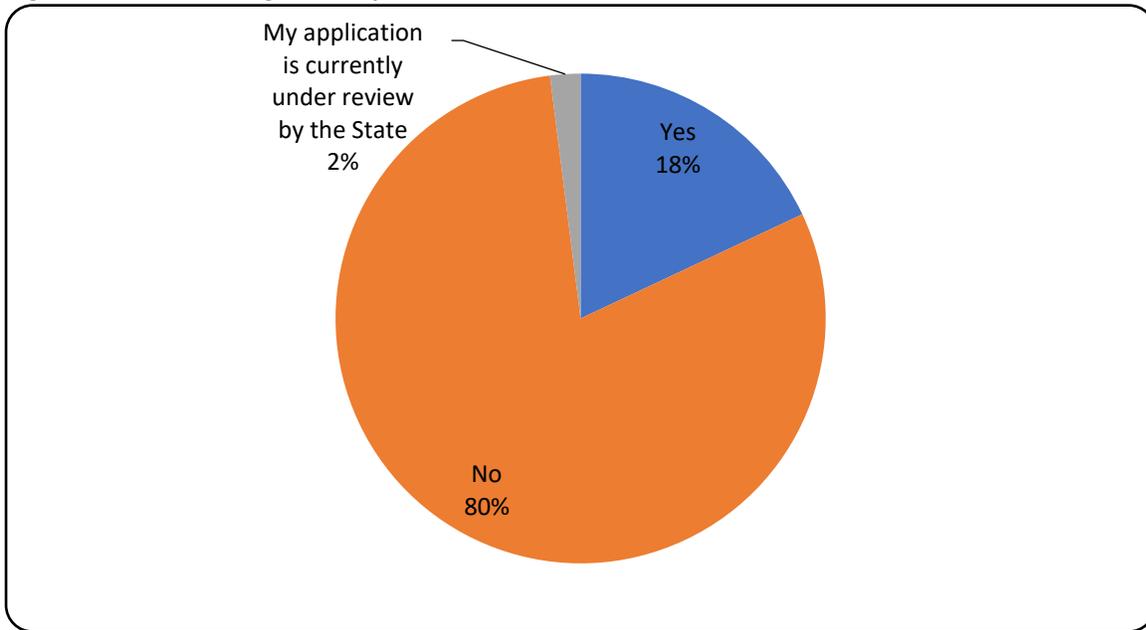
### Doula Skills and Training Adequacy

Doulas were then asked questions about the appropriate utilization of their skills and their opinions about the adequacy of the training and skills they possess. Most doulas (88.5%) report that their doula skills and scope have been appropriately utilized. Almost all doulas believe they hold sufficient knowledge and skills to provide support as a doula (98.5%) and have adequate training and continuing education opportunities available to develop doula knowledge and skills (91.5%). However, doulas were only responding with regards to doula-specific basic training and skills. Wraparound skills and trainings, such as in becoming THW Birth Doulas, remained a gap, as is reported in the next section.

### Doulas as Traditional Health Workers in Oregon

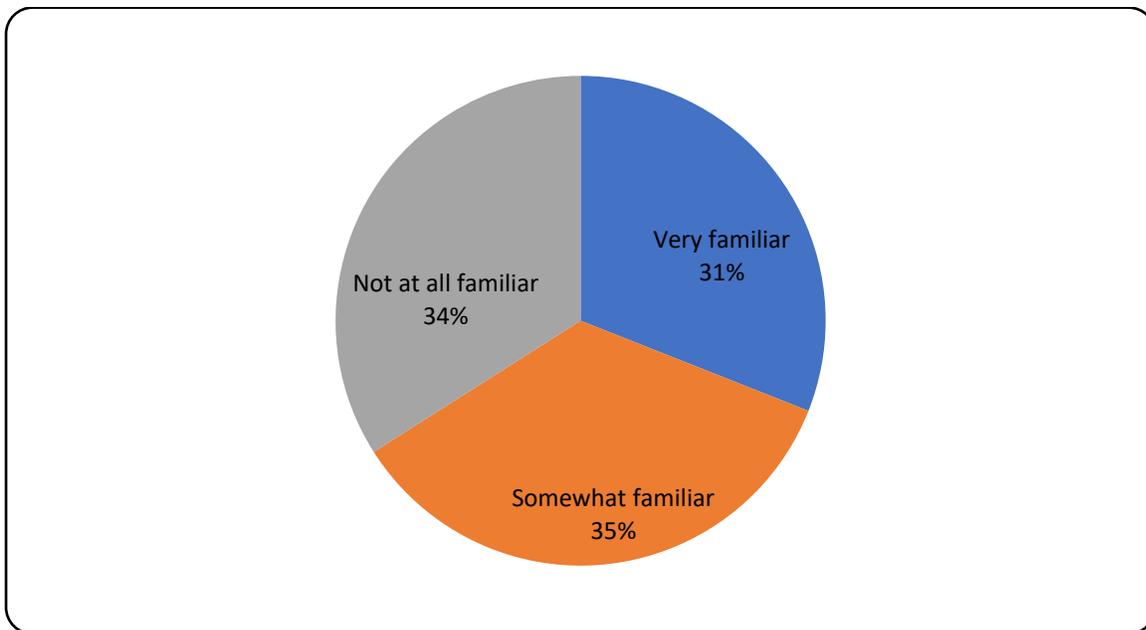
Doulas then answered questions about their knowledge of, interest in, and participation in Oregon’s Traditional Health Worker (THW) program. Over half of doulas (50.8%) were familiar with the general THW program, while 27.7% had some familiarity with the program and 21.5% of doulas reported no familiarity. One fifth of respondents reported that they were currently Oregon Health Authority (OHA) approved THW Birth Doulas (18.5%) or that their applications were under review at the time of the survey (1.5%), equating to a total of 20% respondents who were functionally THW Birth Doulas.

**Figure 1.22: Percentage of Respondents that are THW Birth Doulas**



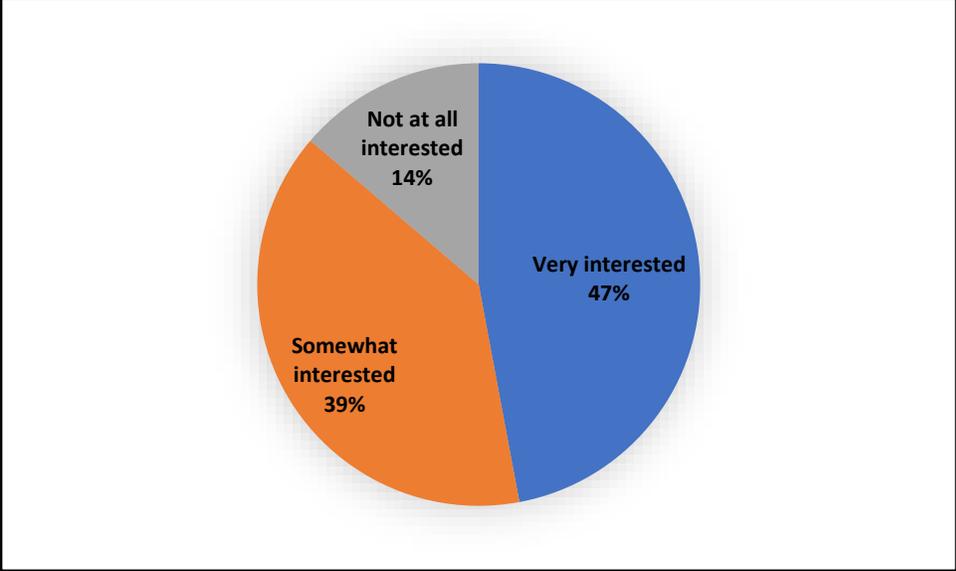
Familiarity with the process to apply to be an OHA-approved THW Birth Doula was roughly equally divided between those very familiar with the process (30.8%), somewhat familiar with the process (35.4%), and those not at all familiar with the process (33.9%). One tenth of doulas surveyed (10.8%) were not at all interested in becoming a THW Birth Doula, while 6.9% of doulas cannot apply because they do not provide birth support. Most doulas (78.8%) that were not on the state registry said they were interested in learning more about the resources, processes, and benefits of becoming approved as a THW Birth Doula.

**Figure 1.23: Familiar with the Process to Become a THW Birth Doula**

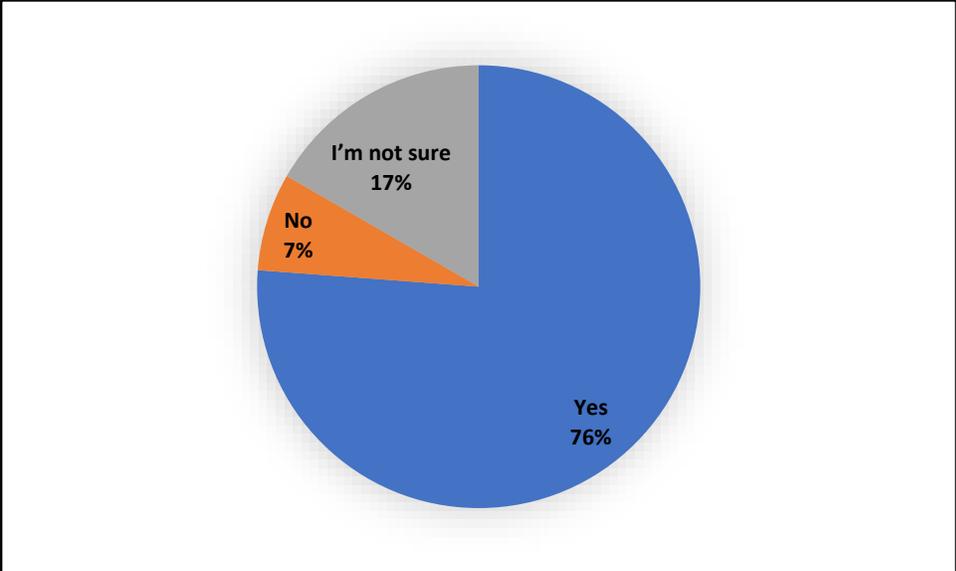


Nearly half of respondents who provide birth or labor support (47.1%) indicated that they were very interested and 39.1% were somewhat interested. Doulas were also asked if they would be interested in becoming a THW Postpartum Doula, if that became an option in the future. Three quarters of responding postpartum doulas (76.2%) said they would be interested in becoming a THW Postpartum Doula, and almost one quarter said they weren't sure (21.9%); 7.1% said they would not be interested in becoming a THW Postpartum Doula.

**Figure 1.24: Interest in Becoming a THW Birth Doula**



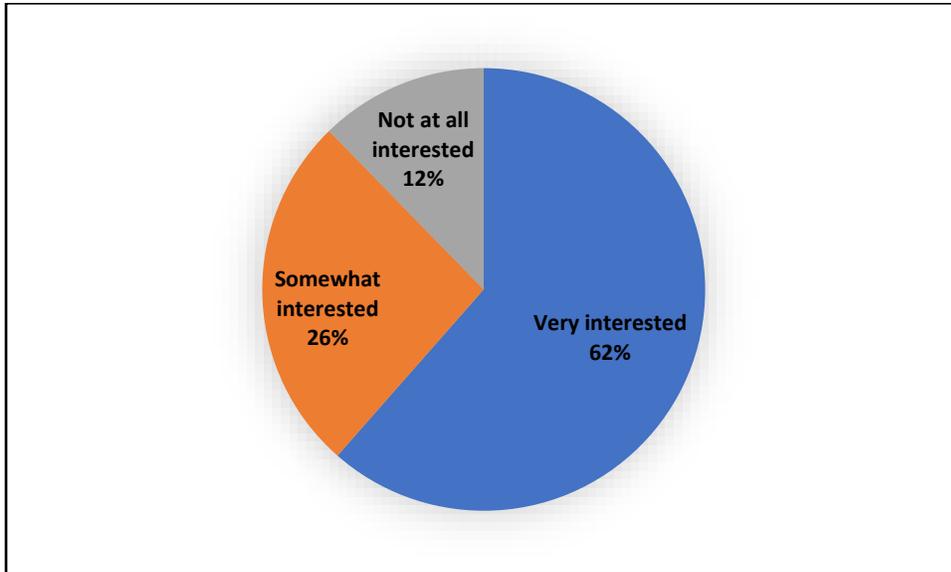
**Figure 1.25: Interest in Becoming a THW Postpartum Doula (if option becomes available)**



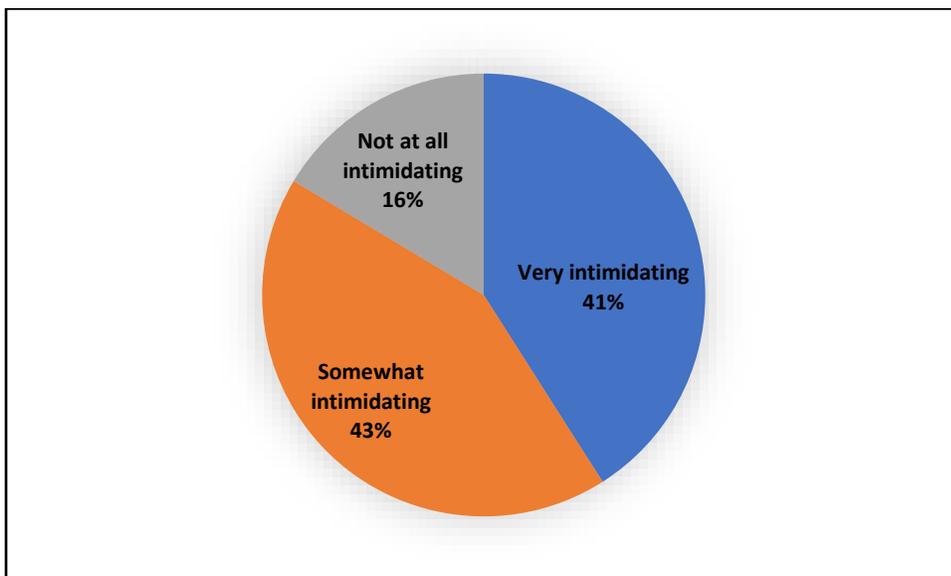
### Billing Processes and Understanding

Doulas then answered questions about their interest in learning how to bill insurance companies or Medicaid, their comfort level with billing insurance, and the experiences of currently certified THW doulas in billing Medicaid for doula services. Most doulas who provide birth services were either very interested (61.5%) or somewhat interested (26.1%) in learning how to bill insurance or Medicaid for birth doula services. The majority also reported that they were very intimidated (41.0%) or somewhat intimidated (42.6%) by the process of billing insurance or Medicaid.

**Figure 1.26: Interest in Learning How to Bill Insurance**



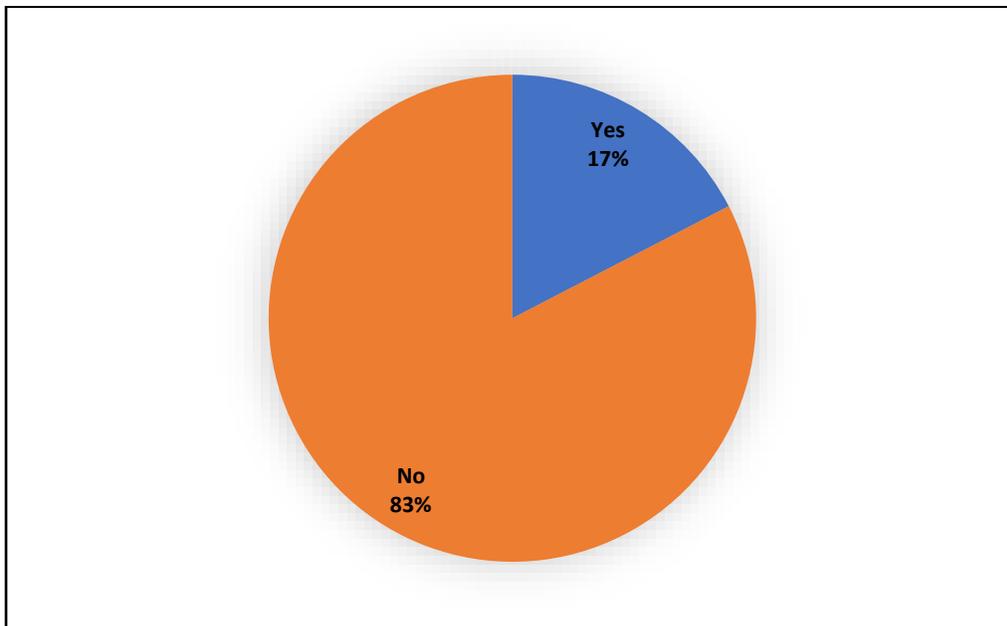
**Figure 1.27: Level of Intimidation Experienced by Doulas Regarding Billing Processes**



Only 17.4% of the currently OHA-approved THW Birth Doula respondents had successfully billed and were reimbursed by Medicaid. Barriers to billing reported include not having a billing number and not getting follow up assistance to obtaining the billing number (25%); not understanding how to bill for a prenatal visit when the doula did not attend the birth (25%); in one service area with more than one CCO, the CCOs have different requirements making the process unclear (25); and waiting on payments to come through for submitted claims (255). One doula who successfully billed shared their success story this way in the survey:

“It took time and lots of follow up, but I have submitted claims to the two primary CCOs in Jackson county, and have been reimbursed for all of them either the first time or after resubmitting the claim. There was a steep learning curve, but the process is well documented and should be easier for Doulas to follow.”

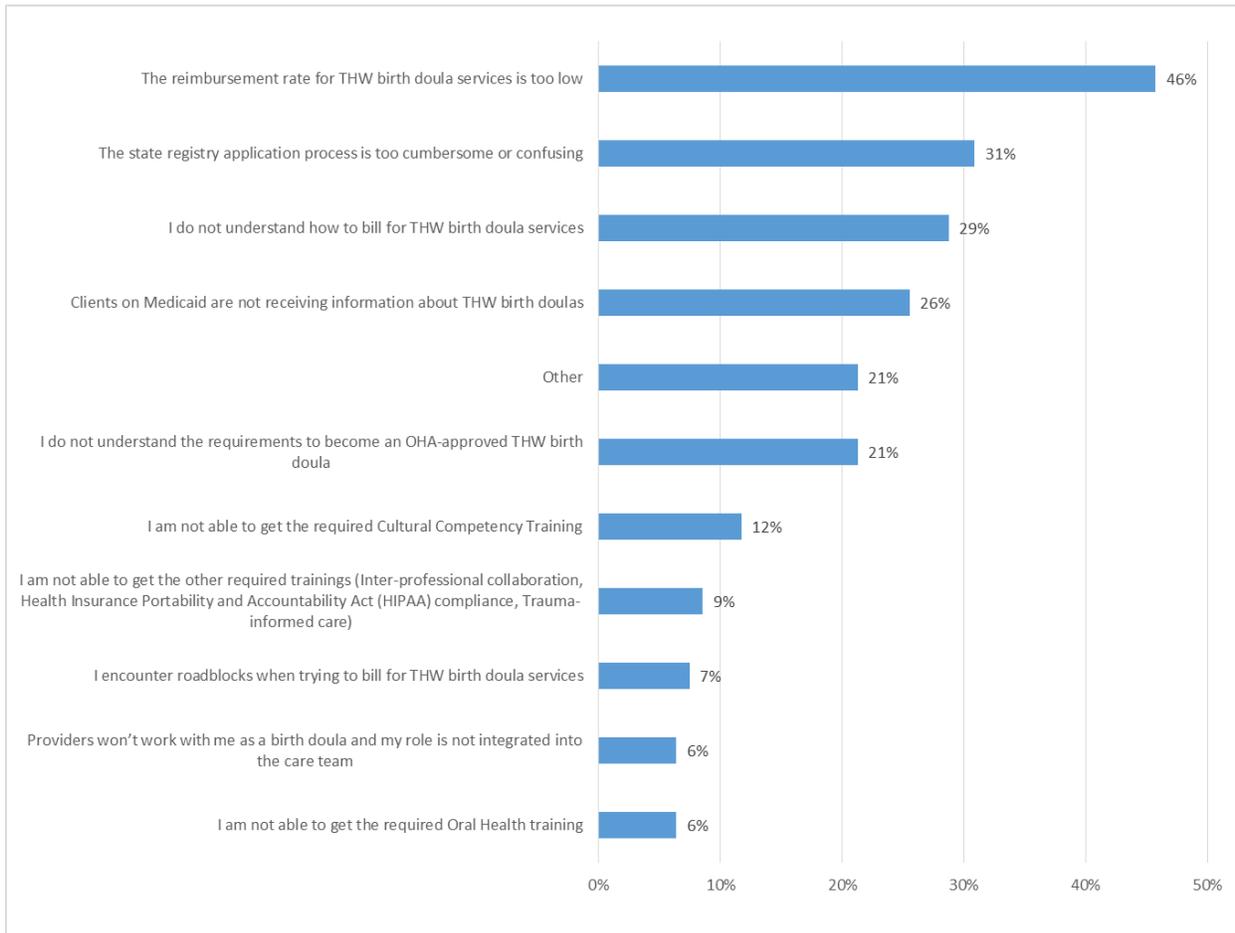
**Figure 1.28: OHA Doulas Who Successfully Billed and Received Reimbursement by Medicaid**



#### Barriers and Challenges to Becoming THW Birth Doulas

Respondents were then asked to describe the barriers and challenges they experienced in trying to become OHA-approved THW Birth Doulas in Oregon. The most frequently reported barrier by nearly half of respondents (45%) is the reimbursement rate for THW birth doula services is set too low, followed by the application process being too cumbersome or confusing (30.8%), not understanding how to bill for THW birth doula services (28.7%), and that families enrolled in Medicaid are not receiving information about THW birth doulas (25.5%). Other notable barriers specified in open-ended comments included not having the time or resources to complete the application or trainings, the difficulty of navigating the OHA website to find information for applying, outdated information on the OHA website, lack of technical support from the OHA in applying to be on the registry, the trainings required are not accessible nor affordable, and the lack of support for OHA birth doulas by CCOs and providers.

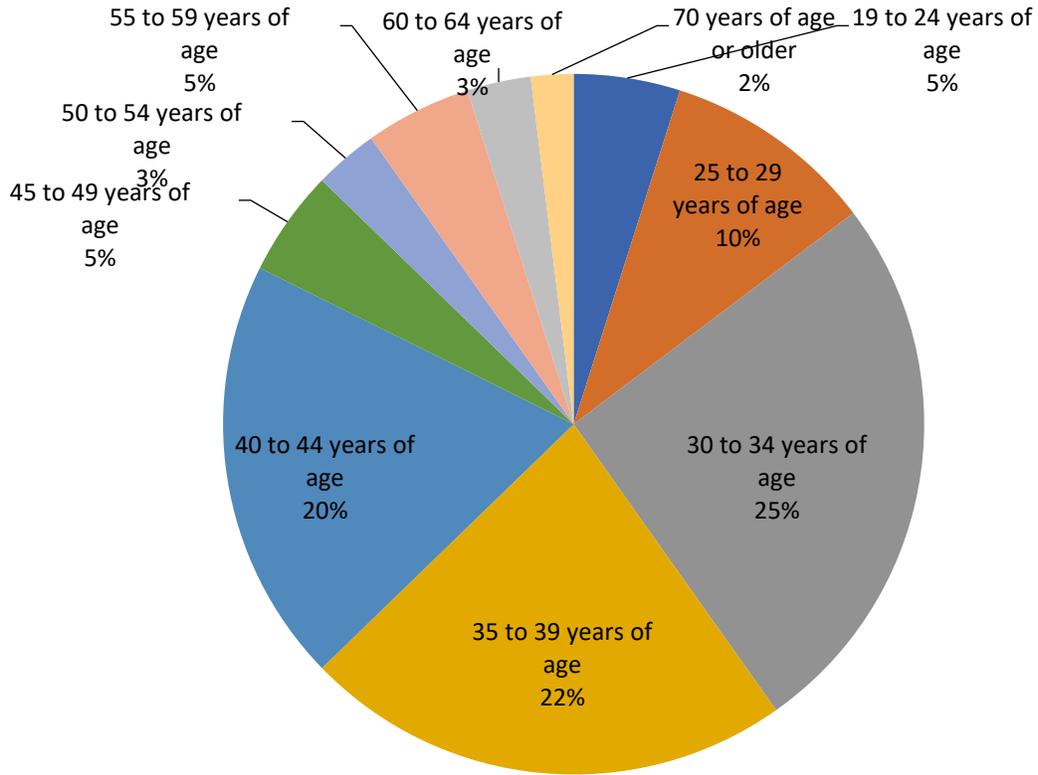
**Figure 1.29: Primary Barriers or Challenges to becoming a THW Birth Doula**



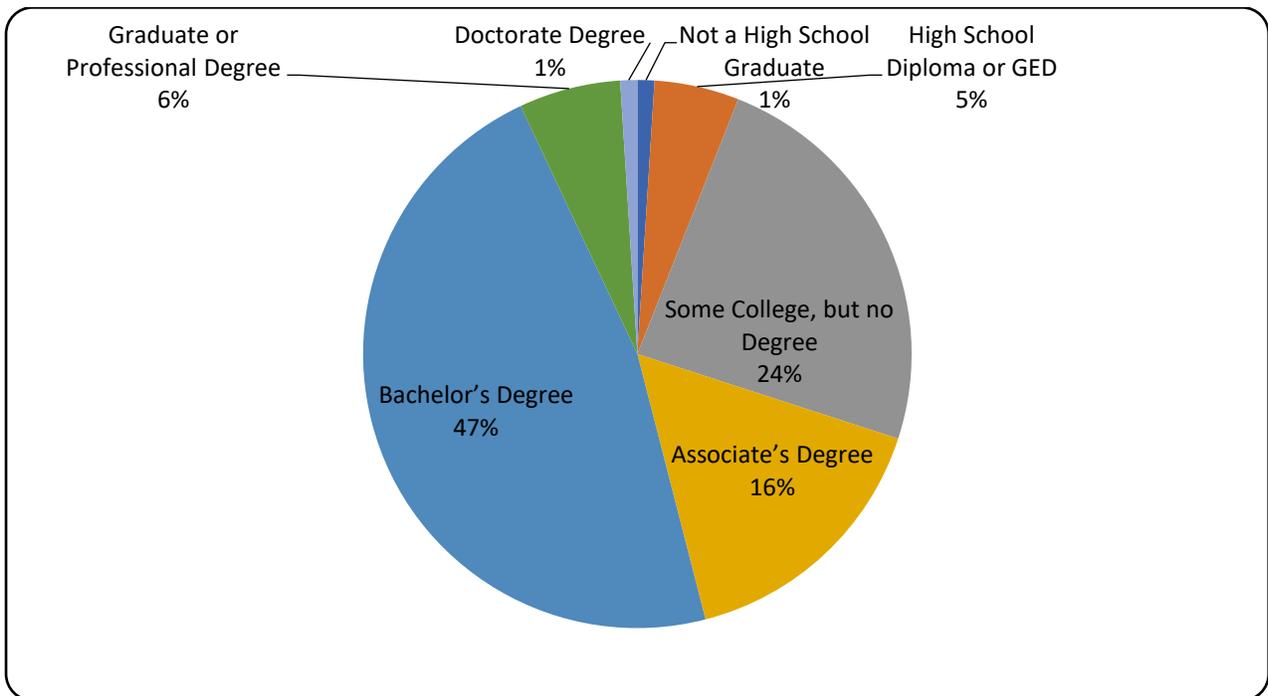
### Demographics of Doula Respondents

Doula respondents ended the survey by answering questions about basic sociodemographics, such as age, education, gender identity, sexual orientation/affection, and racial, ethnic, tribal, and ancestral backgrounds. Doulas also answered questions about the languages they speak. This information is vital to both characterizing survey responses as well as to understanding the diversity of the doula workforce in Oregon. Two-thirds of respondents (68%) reported that they were between 30 and 44 years of age; 14.9% were between 19 to 29 years of age and 17.2% were 45 or older. Roughly half of participants (46.9%) had a bachelor's degree and 68.5% of participants had a degree beyond a high school diploma. Over three quarters of respondents (81.4%) identified as cisgender female while 2.7% of respondents identified as gender fluid or gender non-binary. Over two-thirds of respondents identified as straight or heterosexual (71.2%) while 21.6% identified as a member of the LGBTQI++ community. In an open-ended question, participants were asked to express their race, ethnicity, tribal affiliation, country of origin or ancestry in their own words. Most respondents (n=74; 69.8%) indicated primarily identifying as white or Caucasian. Eight participants (7.5%) had multiracial, multiethnic, or multicultural self-descriptions. Two participants (1.9%) primarily identified as Native American, six (5.7%) identified as Hispanic or Latino/a, six (5.7%) identified as Black or African, or African American, and one (0.9%) identified as Asian Indian.

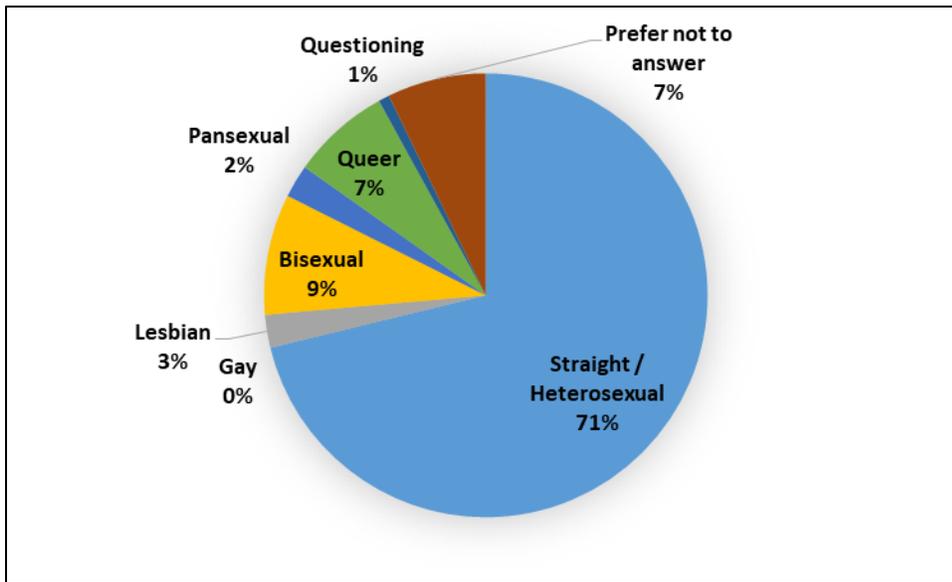
**Figure 1.30: Age of Doula Respondents**



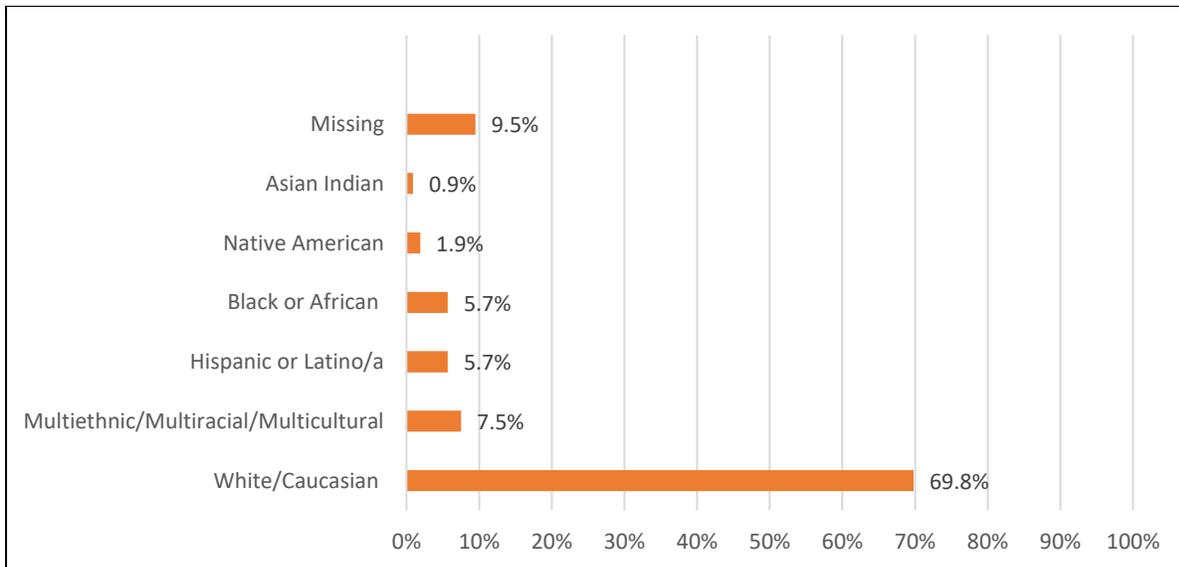
**Figure 1.31: Highest Level of Education Completed by Doula Respondents**



**Figure 1.32: Sexual Orientation or Affection of Doula Respondents**



**Figure 1.33: Race and Ethnicity of Doula Respondents**



Almost all respondents indicated that they spoke English outside of the home when speaking of important matters (97.7%) or when receiving written communications (99.2%). Almost all respondents said that they spoke English Very well (99.2%) and the remaining (0.8%) spoke English well. Five respondents (3.9%) indicated that they need a sign language interpreter for others to communicate with them and two respondents (1.6%) indicated that they needed spoken language interpreters to communicate with others. Almost all respondents indicated that they did not have a hearing impairment (93.6%). Four respondents (3.2%) indicated that they had mild hearing loss and one participant (0.8%) indicated they had moderate hearing loss. There were no recorded responses indicating blindness or difficulty seeing. Roughly one tenth of doulas (10.4%) said that a physical, mental, or emotional condition limited their activities.

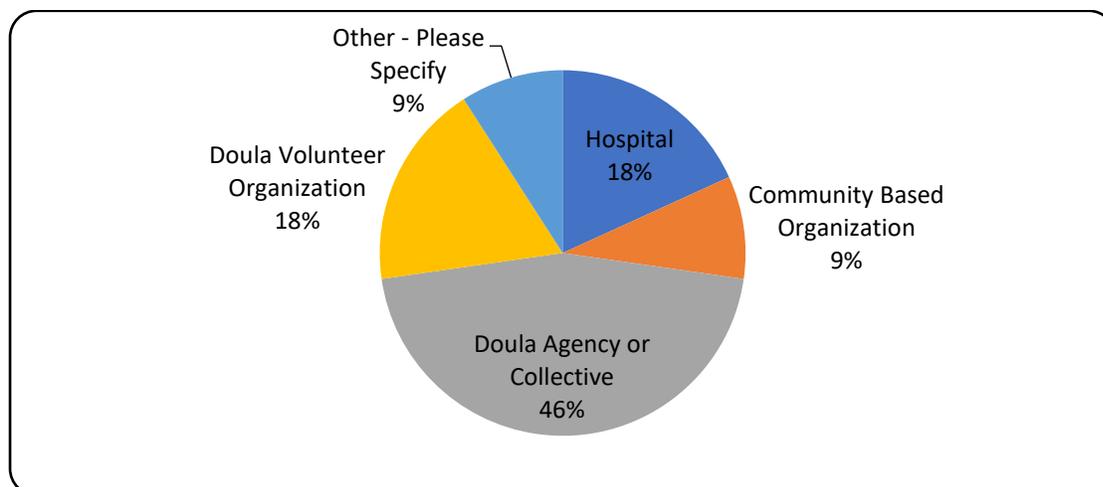
## Employer Survey

Doula employers were defined as anyone who oversees or coordinates doulas who are employees, independent contractors, collective members, interns, students or volunteers. The following information was gathered using the doula employer survey. The total sample size for the employer survey was n=11 employers representing 10 distinct employment organizations.

## Employer Characteristics

Eleven doula employers working with 10 distinct organizations across the state participated in the survey. Because of the low response rate, frequencies will be the primary way results of this section are presented. Respondents represented Birthing Stone Doula, Birthingway College, Brave Birth Doula Care, Gateway Doula Project, Itsabelly, North Star Doula Service, PDX Doulas (2), Providence Women’s Clinic, and Rogue Valley Doulas. The 11 employment responses represented five different doula employer organizations types. The types of organizations that respondents worked with were primarily a doula agency or collective (5, 45.5%), followed by doula volunteer organizations (2; 18.2%), hospitals (2; 18.2%), community-based organizations (1; 9.1%); and educational or training organizations (1; 9.1%). There were no clinics, freestanding birth centers, or doula hubs participating in the survey.

**Figure 1.34: Type of Doula Employment Organization**



Doula employers reported serving fifteen counties across Oregon (note: doula employers could indicate service in more than one county). The largest service areas covered were Multnomah (8; 80%), Clackamas (4; 40%), Washington (3; 30%), and Yamhill (3; 30%). Other counties covered included Clatsop (2; 20%), Columbia (2; 20%), Deschutes (1; 10%), Hood River (1; 10%), Jackson (1; 10%), Josephine (1; 10%), Lane (1; 10%), Lincoln (1; 10%), Linn (1; 10%), Marion (1; 10%), and Polk (1; 10%).

## Hiring and Staffing

Respondents were asked about the types of doulas they staffed as well as doula education and training requirements. Most employers staffed labor or birth doulas (8; 72.7%) or doulas that worked as both labor and postpartum doulas (7; 63.6%). Half of employers (5; 45.5%) staffed postpartum doulas, roughly half (5; 45.5%) staffed community-based doulas, and one third (4; 36.4%) staffed full spectrum doulas. Some employers also indicated the number of each doula type they staffed; these results are presented below in Table 1.10.

**Table 1.9: Types of Doulas Staffed** (note: employers can staff more than one type of doula)

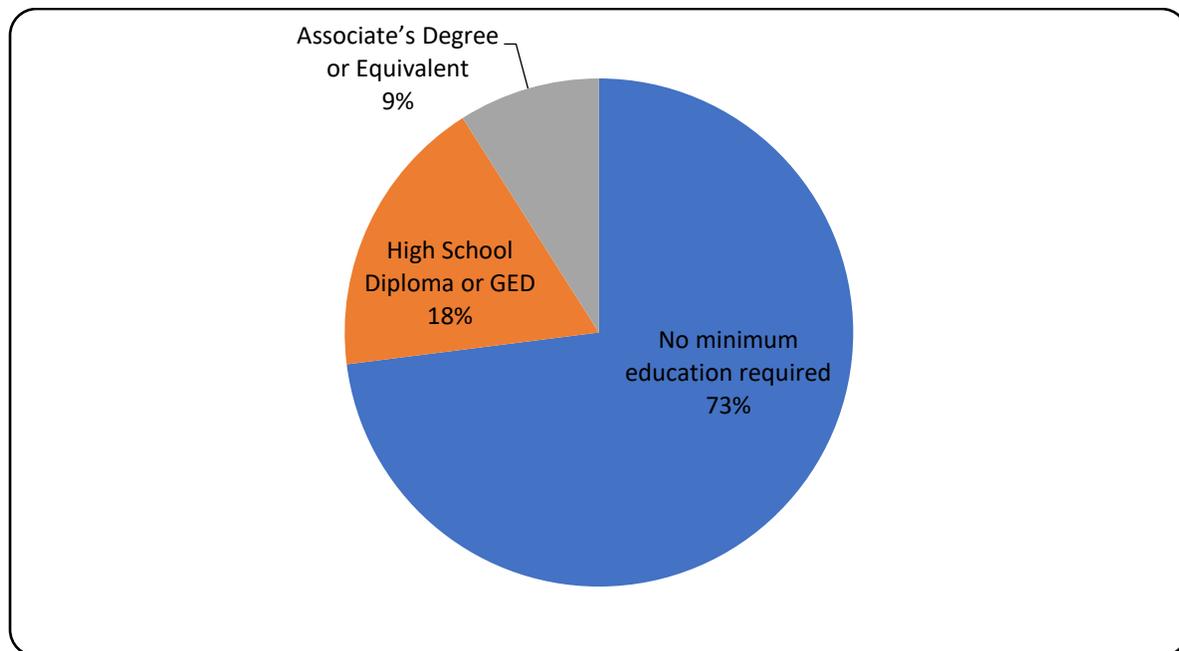
Doula Type	Frequency Staff
Labor or Birth Doula	72.7%
Postpartum Doula	45.5%
Both Labor/Birth and Postpartum Doula	63.6%
Full-Spectrum Doula	36.4%
Community-Based Doula	45.5%
Total Respondents	11

**Table 1.10: Number of Doulas Staffed, per Doula Type**

Birth Doulas Staffed	Frequency Staffed
3	11.1%
4	11.1%
5	11.1%
6	11.1%
12 (or 12ish)	22.2%
12-30 at any given time	11.1%
17	11.1%
30	11.1%
Total Respondents	9
Postpartum Doulas Staffed	Count
1	16.7%
2	33.3%
4	16.7%
5-20 at any given time	16.7%
6	16.7%
Total Respondents	6
Both Labor and Postpartum Doulas	Count
1	20.0%
2	20.0%
3	20.0%
5-15 at any given time	20.0%

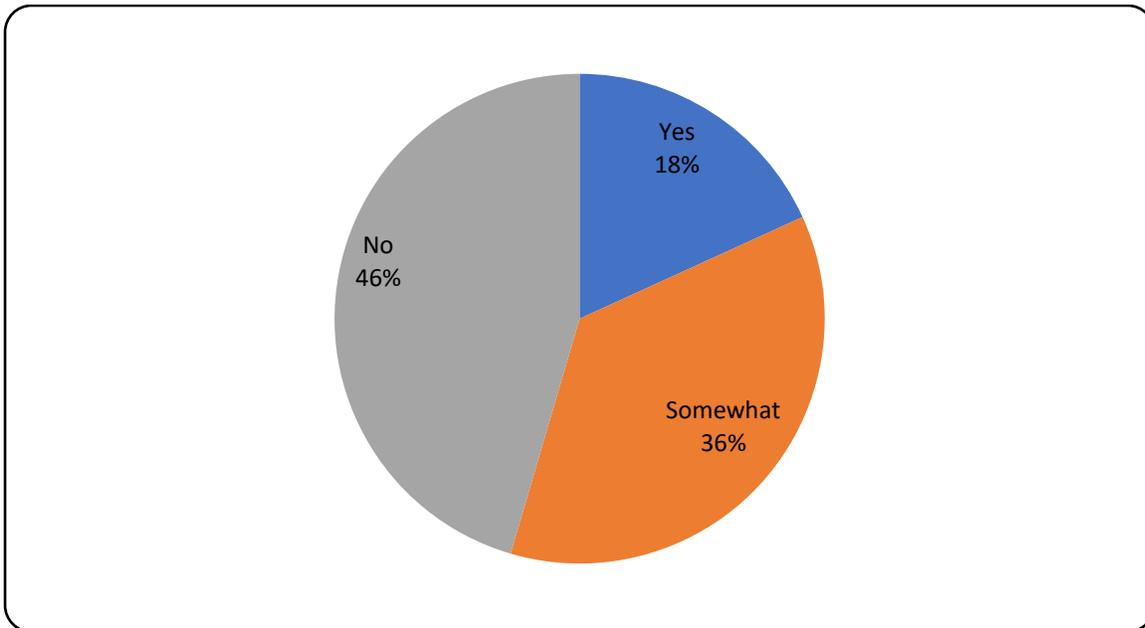
Most doula employers (8; 72.7%) required no minimum basic education level, but two (18.2%) require a High School Diploma or GED and one (9.1%) requires an associates or equivalent degree. Ten of the 11 doula employers (90.9%) require that staffed doulas have doula training, but only two (18.2%) require that doulas have a doula certification. Employers also listed other, additional required trainings or credentials with responses as follows: being an OHA-approved Traditional Health Worker (1; 9.1%), cultural competency training (19.1%), and additional health training such as NPR and vital signs (19.1%). About half (5; 45.5%) of employers require a collaborative practice training or other onboarding training, mentorship, or supervision. One organization (9.1%) said they encourage, but do not require DONA trainings and enrollment in the Oregon THW Program, and another organization (9.1%) said their doulas need extra training in breastfeeding, multiples specific education, and postpartum depression. Finally, one organization (9.1%) said doulas are required to have 12 hours of continuing education per year, CPR training, and a food handler’s permit.

**Figure 1.35: Minimum Level of General Education Required**



About half of organizations (5; 45.5%) said they do not experience difficulty finding qualified doulas to hire, while four organizations (36.4%) said they somewhat experience difficulty and two (18.2%) said they experience difficulty finding qualified doulas to hire. Ten organizations also described their challenges or successes in hiring qualified doulas. Common challenges or barriers included finding people with personal characteristics such as commitment or follow through (4; 40%), doulas lacking experience or comfort with the business side of doula work (4; 40%), finding culturally diverse doulas to meet culturally-specific population demand (2; 40%), inability to find paying clients (1, 10%), and low reimbursement rate from OHP with a large OHP-enrolled client base (1; 10%). Three organizations (30%) described their successes in finding qualified doulas: one organization (10%) said they had extra layers of qualifications, including references, orientation, and mentorship prior to connecting doulas to families, while two organizations (20%) said that their business structures attract qualified doulas.

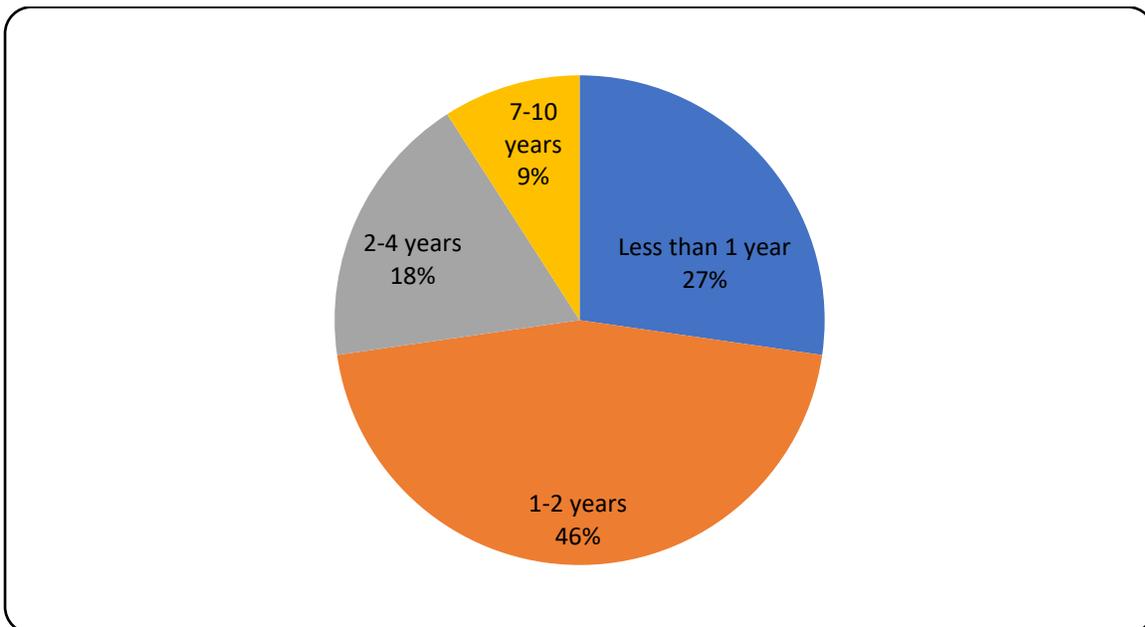
**Figure 1.36: Reported Difficulty of Employers with Finding Qualified Doulas**



**Doula Work Settings, Job Responsibilities, and Skills**

Respondents also answered questions about the average length of time doulas have worked for the organization and how frequently they work in various settings. Roughly half (5; 45.5%) of organizations reported that their currently employed doulas have been with the organization for 1-2 years.

**Figure 1.37: Length of Time at Employer for Currently Employed Doulas**



Employers were asked how frequently their doulas work in a client’s home, community-based organization, hospital, birth center, clinic, educational setting, and/or governmental agency. While doulas can work in a variety of settings, they most often practice in hospitals and the client’s home.

**Table 1.11: Doula Work Settings and Frequency of Work**

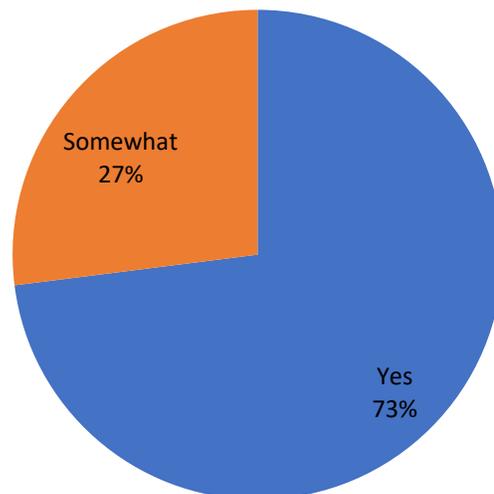
	Always	Frequently	Sometimes	Never	Not Sure	Responses
Client's/family's home	11.1 %	55.6 %	11.1 %	22.2 %	0.0 %	9
Community Based Organization	0.0 %	11.1 %	55.6 %	22.2 %	11.1 %	9
Hospital	63.6 %	36.4 %	0.0 %	0.0 %	0.0 %	11
Birth Center	0.0 %	11.1 %	55.6 %	33.3 %	0.0 %	9
Clinic	0.0 %	0.0 %	60.0 %	40.0 %	0.0 %	10
Educational setting	0.0 %	11.1 %	66.7 %	11.1 %	11.1 %	9
Governmental agency (e.g., WIC)	0.0 %	0.0 %	22.2 %	55.6 %	22.2 %	9

Respondents then answered questions about the appropriate utilization of doula skills and other primary roles doulas fill other than providing doula services. All 11 employers said that their organizations always appropriately utilize doulas skillset. Two thirds of respondents (7; 63.6%) also hired or staffed doulas primarily to do work other than doula support. Respondents reported the following roles or responsibilities doulas were asked to engage outside of doula service: administrative roles (4; 57.1%), educators or mentors (3; 42.9%), group facilitation (1; 14.3%) and lactation support (1; 14.3%). One respondent (14.3%) said they were a volunteer organization and most doulas thus have full-time employment outside of their organization.

Employers also answered questions about the knowledge, skills, and training of their doulas and if they provide training opportunities to their doulas. Nine of the 11 organizations (81.8%) said that their doulas have sufficient knowledge and skills while two organizations (18.2%) said they somewhat believe their doulas have sufficient knowledge and skills. Nine respondents elaborated on their doulas' skills and experiences in an open-ended response, which included responses such as: the employer attracting people who recently certified and are attempting to gain experience and mentorship; the employer noting that most doulas that have a DONA certification have sufficient knowledge and skills; employers indicating said they have in house training and apprenticeship programs that adequately train and educate doulas; employers indicating they require a substantial amount of experience to be considered as an employee; and an employer explaining that the skills they find excellent are professionalism, collaborative practices, skill set on floor as experienced doula, immediate postpartum breastfeeding support, high risk client care, and cultural competency care.

Respondents then answered questions about training opportunities for their doulas. Eight of the eleven respondents (72.7%) offer continuing education or training opportunities and three respondents said they somewhat offer continuing education or training. Ten respondents (90.1%) explained how trainings were offered in an open-end question with responses including: providing Continuing Medical Education dollars for yearly training and education; providing scholarships when available for doula continuing education; holding doula trainings, including full trainings and Skills Night onboarding sessions; sharing information about local trainings; and offering informal continuing education at staff meetings. Respondents also indicated the types of trainings they provided or supported with responses including: trauma informed care, client case study/peer review circles, pelvic floor health, essential oils, administrative guidance, customer service training, business, advanced labor and postpartum skills, professionalism, emergency doula skills, supporting loss, advanced breastfeeding knowledge and skills, pregnancy and infant loss training, and, in collaboration with a community based organization, a local drug needle exchange training, and a collaborative practice training for new collaborative members.

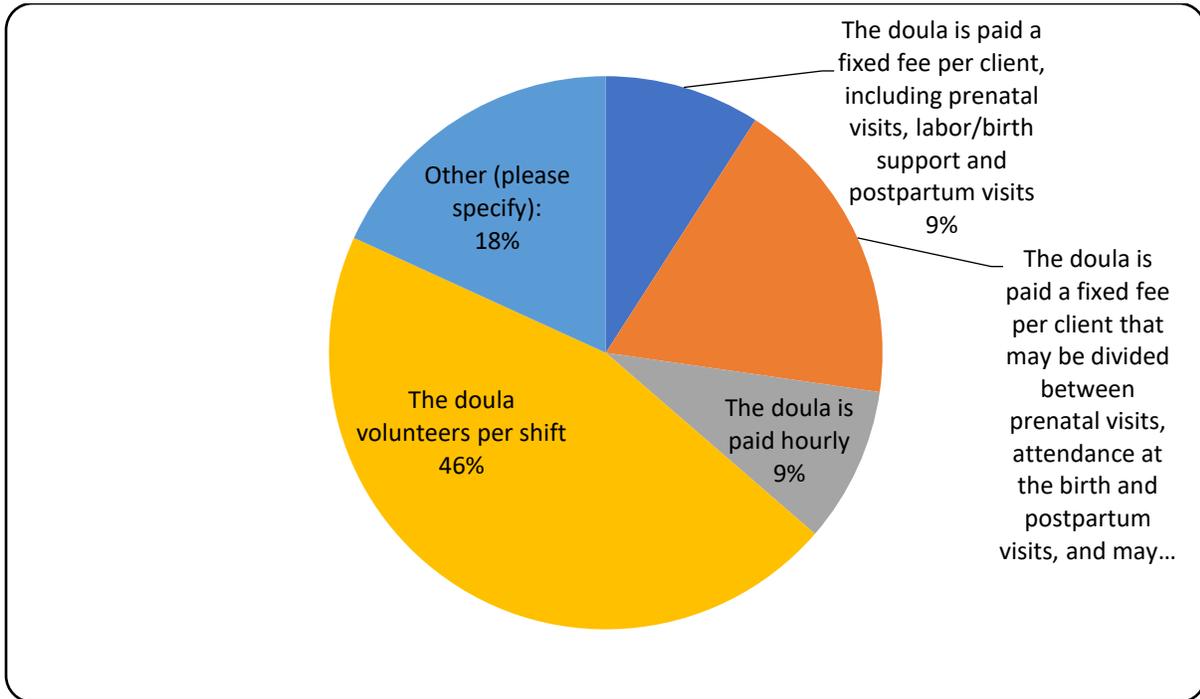
**Figure 1.38: Employer Provision of Training or Continuing Education Opportunities for Doulas**



### Payment and Income Characteristics

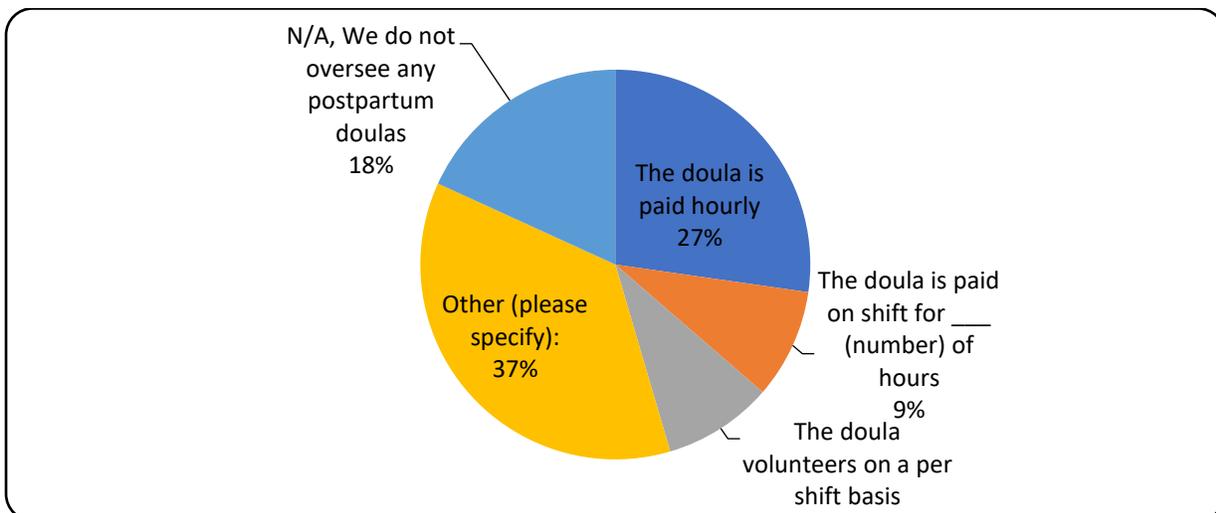
The employer survey also collected payment and income characteristics. Roughly half of respondents (5; 45.5%) have doulas who worked per shift. The next most popular payment structure is paying a fixed fee per client (4, 36.4%), followed by one respondent (9.1%) who said that their doulas are affiliated with the organization, but receive payment directly from the client.

**Figure 1.39: Payment Structure of Birth Doula Work**



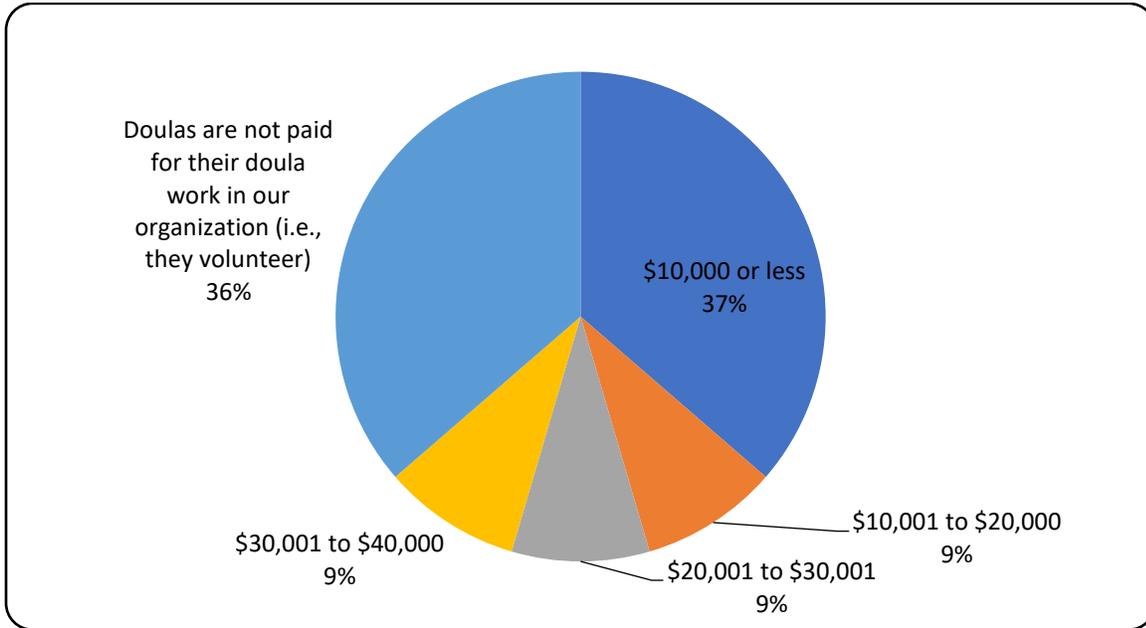
Organizations were also asked to describe how they structure their postpartum work and payment. Two organizations (18.2%) do not oversee postpartum doulas. For those who do employ postpartum doulas, their responses on fee structure are represented in Figure 1.40, below.

**Figure 1.40: Payment Structure for Postpartum Doula Work**



Respondents reported the average annual income that doulas earn from doula work. Four of the seven organizations (57.1%) who staff doulas said they earn less than \$10,000 annually. The following income categories were also reported: \$10,001 to \$20,000 annually (1; 14.3%), \$20,001 to \$30,001 annually (1; 14.3%), \$30,000 to \$40,000 annually (1; 14.3%).

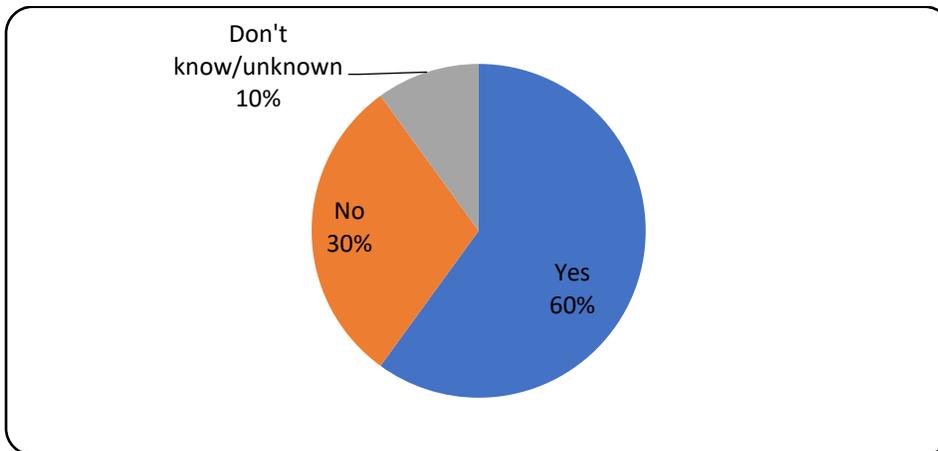
**Figure 1.41: Average Annual Doula Income**



#### Culturally-Specific and Linguistically-Specific Doula Services

As one of the key objectives of this workforce needs assessment, respondents were asked if their doulas provide culturally- or linguistically-specific doula services. Ten respondents (90.1%) replied to the question. Of these, six (60.0%) said they provide culturally- and linguistically- specific services, three (30.0%) said they did not provide culturally- and linguistically- specific services, and one (10.0%) said they didn't know if their doulas provide culturally- and linguistically- specific services.

**Figure 1.42: Employer Provision of Culturally-Specific and Linguistically Specific Doula Services**

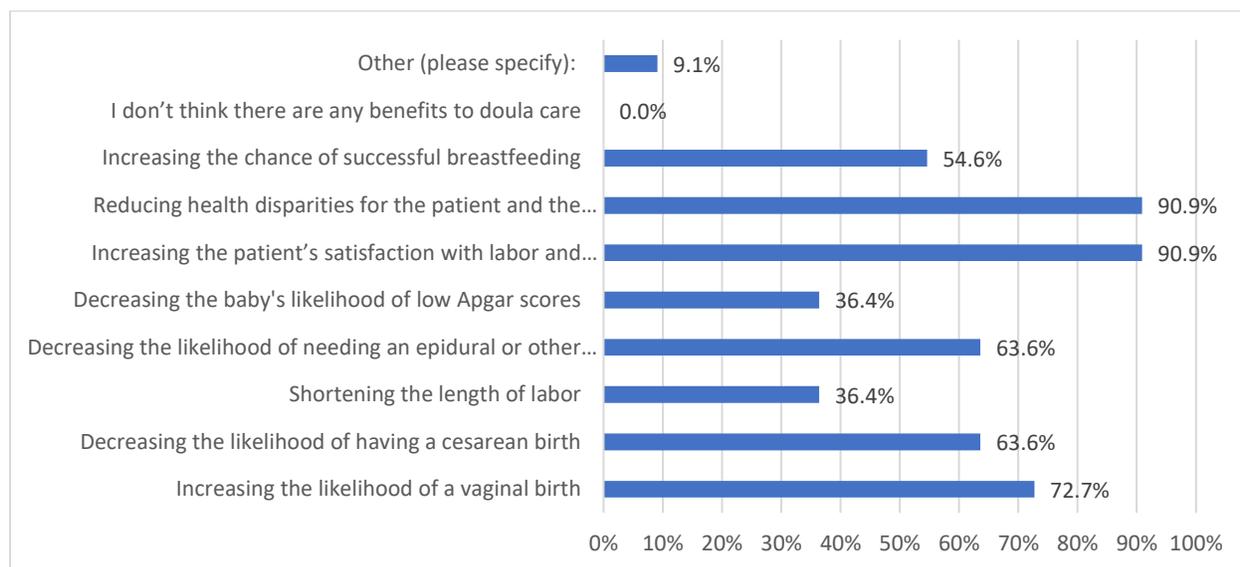


Ten respondents also explained the challenges, successes, and barriers to providing culturally- and linguistically- specific services. Two organization (20%) said that they have a diverse group of doulas from multiple cultural backgrounds and who speak different languages, but doulas work in shifts and the laboring family gets whoever is on call that day. Another organization (10%) partners with a local community-based organization to train black and African American doulas and they offer scholarships for bilingual doulas in the Latinx, Russian, Chinese, and Southeast Asian Communities. This organization also incorporates other types of related professionals, such as personal support service workers and social workers who have experience with addictions recovery and behavioral or homeless communities, youth, immigrant, domestic violence or intimate partner violence, and sex worker communities. Three organizations (30%) mentioned that they had Spanish speaking doulas and one organization stressed that there was only one Spanish speaking doula in the organization’s service area and there is no backup Spanish speaking doula. One organization (10%) said that they had an African American and Muslim doula so can connect with that particular patient population, but otherwise has no other diversity in their employment base. Three organizations (30%) said that they struggle to staff culturally diverse doulas and this is an identified need for their organization. The barriers mentioned to staffing include lack of instructors that teach quality classes on providing culturally specific services, difficulty for doulas working with non-English speaking clients and fostering trust, and lack of funding to pay doulas.

### Benefits of Doula Care

Respondents then answered a question asking what they think are the most important benefits of doula support. Almost all (10 of 11; 90.9%) respondents said that reducing health disparities and increasing the patient’s satisfaction with labor and delivery experience were the most important benefits. Main cited benefits of doula care by employers are delineated below in Figure 1.43.

**Figure 1.43: Benefits of Doula Care as Perceived by Employers**



### Concerns about Employing Doulas

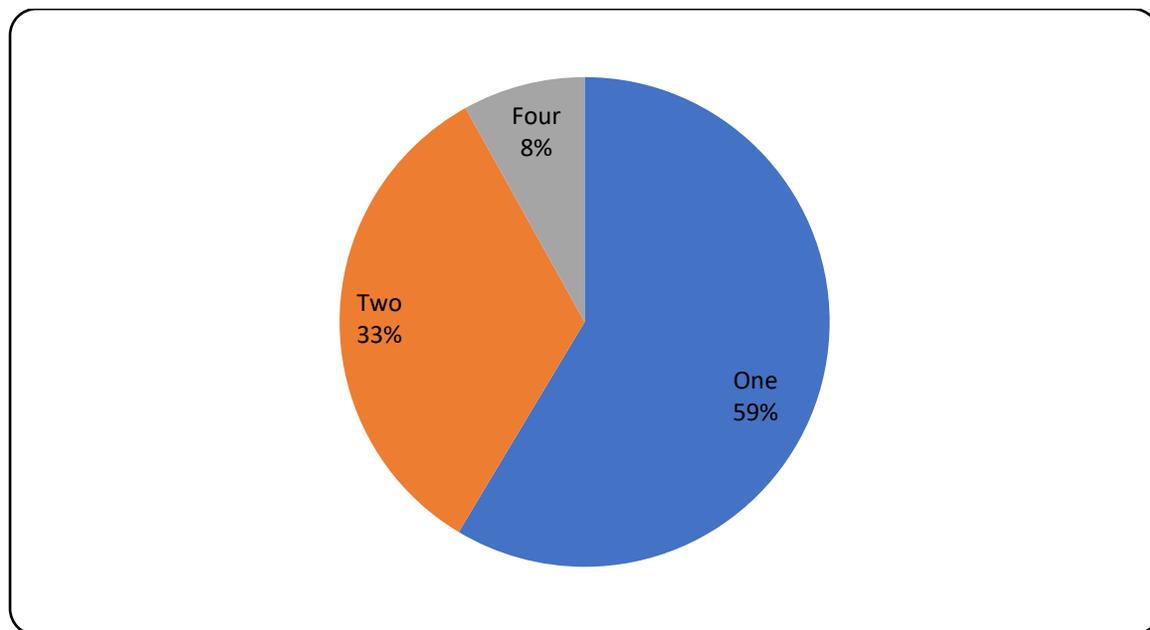
Finally, respondents were asked to explain their primary concerns or barriers to employing doulas. Ten respondents provided open-ended responses to this question. Seven organizations (70%) mentioned the inability to find funding, pay doulas, or charge insurance/Medicaid fees that provide a sustainable wage.

One respondent (10%) said that community expectations of reasonable doula fees was created by the requirement for student doulas to offer free support. Three of the seven organizations (42.9%) that said funding was a barrier specifically mentioned insurance: one (14.3%) said that the health system’s unwillingness to pay for doulas is a barrier, another (14.3%) said that the “paper trail for getting doulas reimbursed by the state” was their main barrier, and a third (14.3%) said the Medicaid reimbursement was too low for an on-call doula structure. The organization who suggested the Medicaid reimbursement rate was too low also suggested shift work for labor-only work if the current rate is sustained. Four respondents (40%) specifically mentioned the sustainability of doula work both financially and physically on a long-term basis. As one respondent bluntly said, “the burnout rate is high.” One organization (10%) said that sustainable doula work is harder still in rural areas while another (10%) said that their organization is volunteer-based and would like to move to a community-based model because without funds to hire doulas, they have issues attracting doulas. The volunteer nature of their organization also means the process to apply for grants is slow and a further barrier to attracting and employing doulas.

### Parent Survey

Parents are key employers of doulas in the private sector. The following information was gathered using the parent survey. The total sample size for the parent survey was n=13 parents who have utilized doulas in the past for one or more childbearing experience. All but one participant (12; 92.3%) used a birth doula during their labor and birth. Breakdown of number of doula experiences by birth is reported in Figure 1.43. Just over half of participants (7; 53.9%) had utilized a postpartum doula during their first three months postpartum.

**Figure 1.44: Number of Births a Doula was Utilized for**



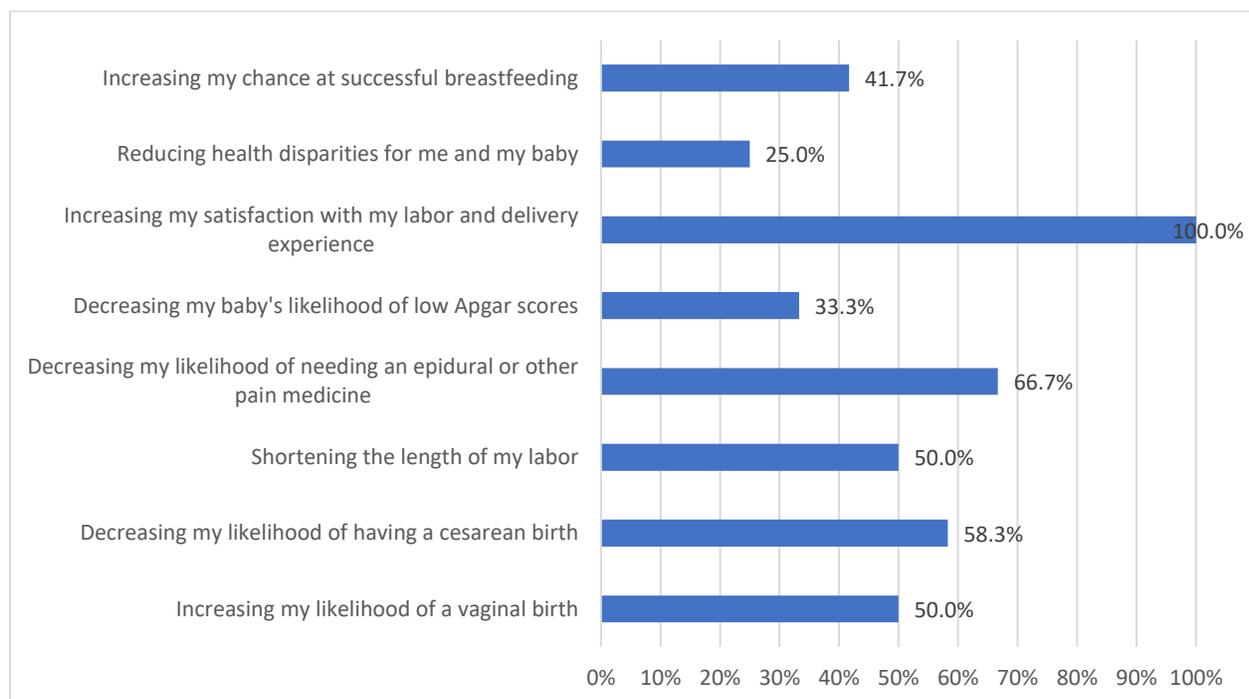
### Birth Doula Care Experiences

Parents were asked the reasons they sought doula care, the benefits of doula care they thought were most important, the ways in which doulas were valuable in their own personal experiences, and the

level of training of doulas hired. Twelve parents reported their main reasons for hiring a doula. All twelve (100%) said that they engaged with doula services to have continuous support from someone who they would know beforehand. The next most frequently reported reason was to support the parent emotionally and provide reassurance (11; 91.7%), followed by to support the parent physically and provide pain relief (10; 83.3%). About half of respondents engaged with doula care mainly for advocacy for childbirth goals and values (7; 58.3%), to support their partner (7; 58.3%), to provide the parent with information and resources for their questions and needs (6; 50%), and to give the parent a better chance at a desired outcome such as vaginal birth or less painful birth (6; 50%). Three parents (25%) said they were encouraged to find a doula by a professional or care provider.

Parents also identified 8 benefits of doula care that were important to them. All respondents (12; 100%) said increasing their satisfaction with their labor and delivery experience were important benefits to doula care. Main benefits cited are delineated below in Figure 1.44.

**Figure 1.45: Benefits of Birth Doula Care as Perceived by Parents**



Parents also described the most valuable things about doula care in their own words. Their open-ended responses largely fall in line with benefits reported in multiple choice survey responses. A sampling of their narrative responses is below:

“She was there no matter what I was going through. Her presence was peaceful and she seemed to fade into the background when I didn't need her and was there when I did”

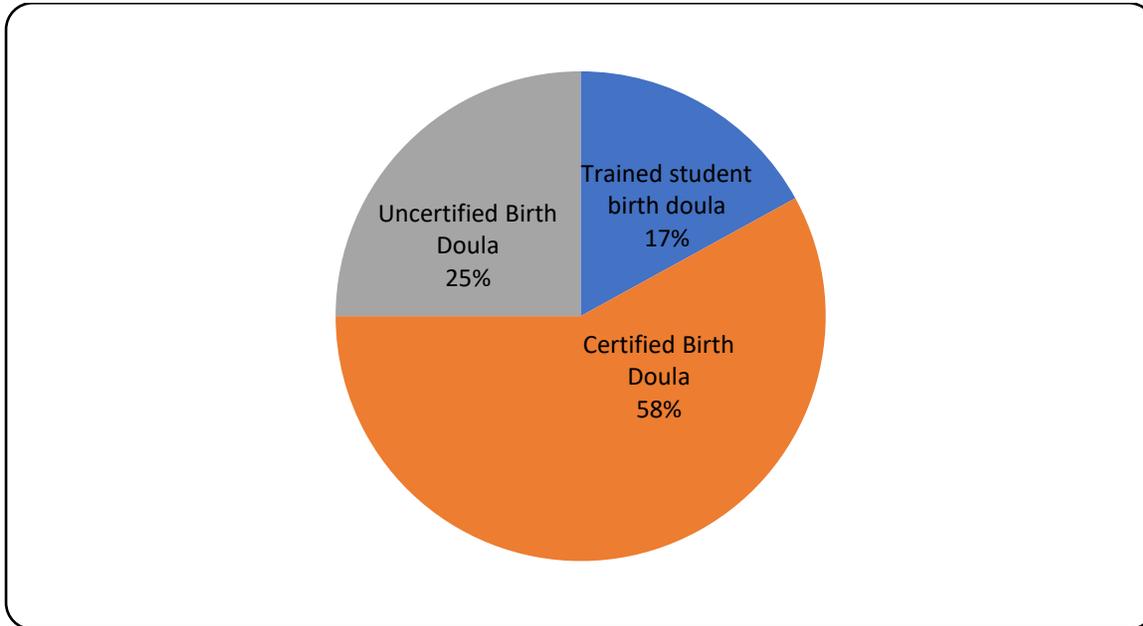
“Her reassurance of things being "normal" allowed me to relax into the process.” “

“Helped suggest positions that helped with pain,”

“All the information prior to birth also helped prepare me and reduced my fear of pain and anxiety.”

Parents also reported their doula's level of training and experience. Over half of parents (7; 58.3%) reported that they had a certified birth doula, three parents (25%) said they had an uncertified birth doula, and two parents (16.7%) said they had a trained student birth doula.

**Figure 1.46: Training Level of Birth Doulas Employed by Parents**



#### Postpartum Doula Care Experiences

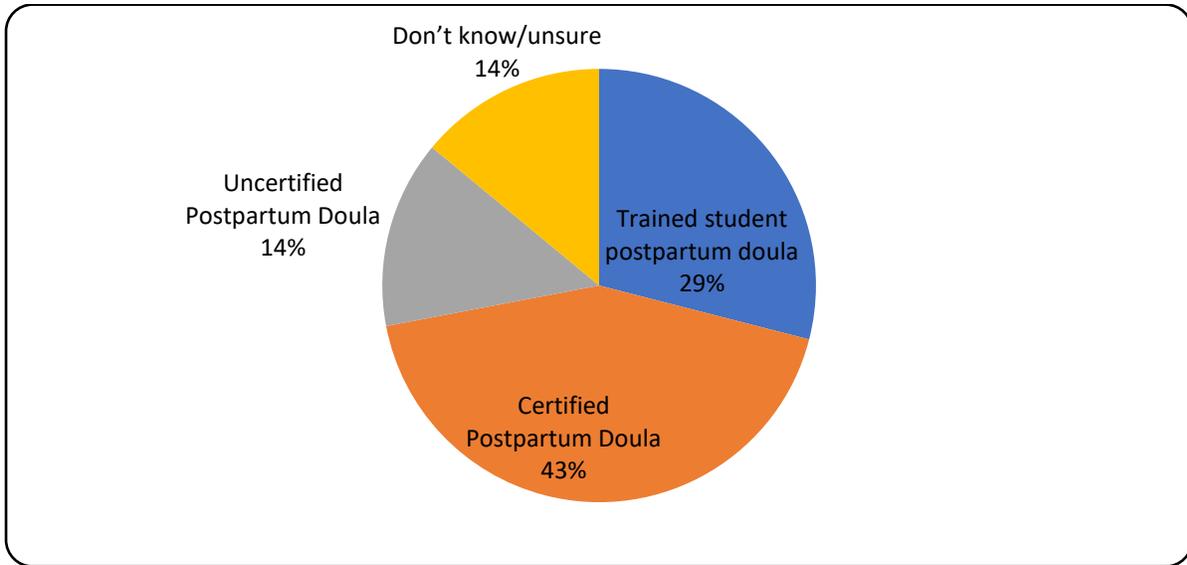
As applicable, parents answered questions about the reasons they sought postpartum doulas, when postpartum doulas provided support, and the most valuable pieces of their postpartum doula experience. Just over half of participants (7; 53.9%) had utilized a postpartum doula during their first three months postpartum. Participants reported 13 primary reasons they sought postpartum doula care. The most frequently reported reason was to support the parent emotionally and provide reassurance (5; 71.4%), followed by supporting the parent informationally and providing resources for their questions and needs (4; 57.1%), and to help with postpartum mental health and wellbeing (4; 57.1%). Other reasons less frequently chosen include breastfeeding support and advice (3; 42.9%), infant care and advice (3; 42.9%), providing physical support as the parent recovered (2; 28.6%), help the parent get sleep (2; 28.6%), lack of local support (28.6%), to support cesarean recovery (1; 14.3%), sibling support (1; 14.3%), partner support (1; 14.3%), and the encouragement by a professional (1; 14.3%). One participant (14.3%) indicated that their labor and birth doula included postpartum care. All respondents (7) said that their postpartum care occurred during the daytime.

When asked what the most valuable aspects postpartum doula care, seven respondents described six different benefits. The most frequently reported benefit was answering questions or providing resources (5; 71.4%), caring for the infant (4; 57.1%), emotional support (3; 42.9%), referrals to health care professionals (2; 28.6%), household chores (2; 28.6%), and caring for older children (1; 14.3%).

Respondents reported their level of training and experience their postpartum doula possessed. Three participants (42.9%) reported that they had certified postpartum doulas, two participants (28.6%) reported that they had trained student postpartum doulas, one participant (14.3%) reported that they

had an uncertified postpartum doula, and one participant (14.3%) said they were unsure of their doula’s training or experience.

**Figure 1.47: Training Level of Postpartum Doulas Employed by Parents**



#### Doula Availability and Skills Possessed

Parents then answered questions about doula availability for hire and if the doula held sufficient skills. Most parents (10; 76.9%) indicated that they did not have a difficult time finding a qualified doula or a doula that they could afford (8; 61.5%).

**Table 1.12: Parental Difficulty Hiring a Doula**

	Did you experience any difficulty finding a qualified doula to hire?	Did you experience any difficulty finding a doula that you could afford?
Answer	Percent	Percent
Yes	15.4%	15.4%
Somewhat	7.7%	23.1%
No	76.9%	61.5%
Total Respondents	13	13

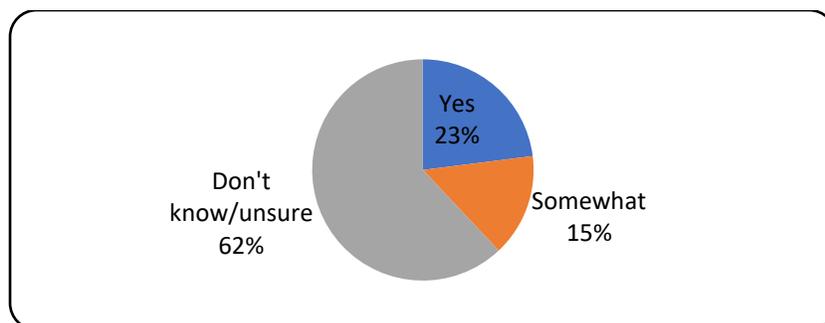
Eleven parents provided explanations to their experiences of finding qualified doulas. Most parents experienced no difficulty finding a doula. 7 parents (63.6%) said they had already known a doula or the doula that served their family prior to hire. Two parents (18.2%) said their prenatal yoga teacher was a doula and they either hired the teacher or the teacher acted as a resource to find a doula. One parent (9.1%) searched on care.com to find their doula and one parent (9.1%) was connected with a doula through Daisy CHAIN (non-profit organization). One parent (9.1%) said they utilized AllCare health insurance and there was only one doula contracted with them. This doula was not available for the parent’s birth and it took a lot of time and effort to get another doula contracted with AllCare. Another parent said they were looking for a professional doula who supports all types of birth, and finding one was difficult. Eight respondents provided explanations for to their experience finding qualified doulas they could afford. Three parents (37.5%) said they did not pay for doula services. One parent (12.5%) got postpartum doula care through a local nonprofit, one parent (12.5%) had doula care covered by health insurance, and one parent (12.5%) used a hospital-employed doula service. Another parent (12.5%) said their doula care cost half of what they expected. Four parents (50.0%) expressed their personal value for doula services despite what they thought to be a generally high cost for the service: “The cost is high. It should be high for what is offered, but it's a lot to pay out of pocket for.”

Nearly all respondents (12; 92.3%) said their doula had sufficient skills and knowledge to provide appropriate support, while one respondent (7.7%) said their doula somewhat had sufficient skills and knowledge. Nine respondents provided additional comments on the areas where their doulas were lacking or excellent. Most participants (8; 88.9%) who commented about skills said they felt their doulas were knowledgeable and informative, and they were confident in their training and experience. One parent (11.1%) listed other qualities they found to be important in their doula: licensed massage technician credentials and being a mother. Two participants (22.2%) shared that specific skills that were helpful were picking up on or understanding a client’s needs “even before I did.” One parent (11.1%) said that their doula’s ability to emotionally support them was lacking: “My doula was very good at physically supporting me. Emotionally I wish she would have asked me more direct questions as I was very much struggling.”

#### Culturally-Specific and Linguistically-Specific Doula Care for Parents

Parents were then asked questions about whether they received culturally- or linguistically- specific doula services. Three parents (23.1%) said they received culturally-specific or linguistically-specific doula services and two parents (15.4%) said they received somewhat culturally-specific or linguistically-specific doula services. Over half of parents (8; 61.5%) were unsure.

**Figure 1.48: Provision of Culturally-Specific and Linguistically-Specific Doula Services to Parents**

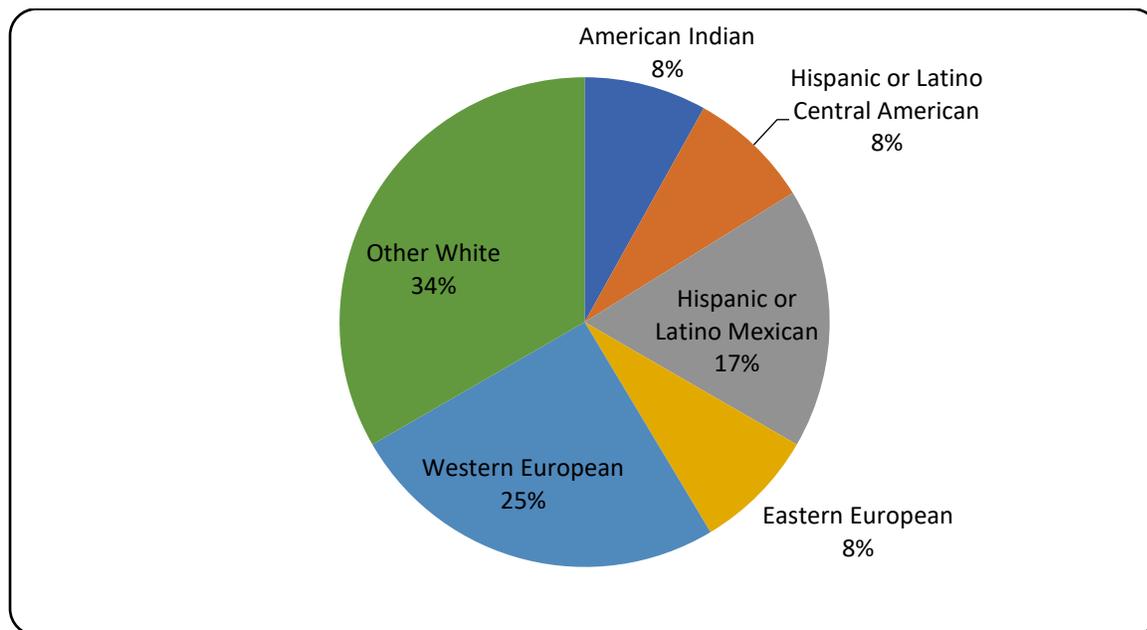


Nine parents (69.2%) wished to share additional information about their experience with doula care. Respondents expressed the doula’s important role in the contribution to the well-being of their partners and children and themselves (3; 33.3%) and their belief that all families should be able to use doula care (4; 44.4%). One respondent (11.1%) expressed their surprise that doulas aren’t yet integrated into the healthcare system, stating “that we haven’t done it large scale yet.” Another respondent (11.1%) said more awareness and resources are needed: “I believe doula care needs to be more talked about and advertised and also easier to contact and get ahold of.”

### Demographics of Parent Respondents

Parent respondents ended the survey by answering questions about basic sociodemographics. This information is vital to both characterizing survey responses as well as to understanding populations served by the Oregon doula workforce. Twelve of the thirteen respondents shared their racial or ethnic identities. The majority of respondents (66.7%) indicated that they primarily identified as white or European. Full racial and ethnic identities of parental respondents are delineated below in Figure 1.49.

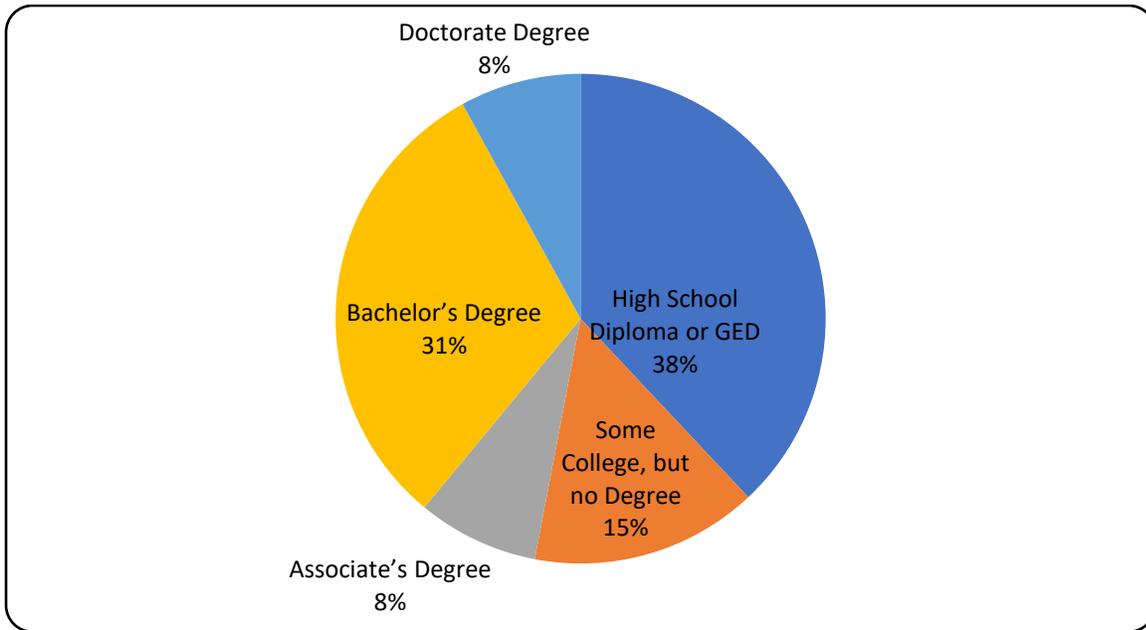
**Figure 1.49: Race and Ethnicity of Parent Respondents**



All respondents (13) indicated that English is the primary language spoken at home and they speak English very well (13). None of the respondents reported being blind or deaf, having serious difficulty hearing or seeing, or require a sign language or other interpreter. One (8.3%) respondent indicated that they had a physical, mental or emotional condition that limits their activities.

All thirteen respondents reported their age, education level, gender, and sexual orientation/affection. Half of respondents (7; 53.9%) were between 25 to 34 years of age, two respondents (15.4%) were 19 to 24 years of age, two respondents (15.4%) were 40 to 44 years of age, one respondent (7.7%) was between 35 and 39 years of age, and one respondent (7.7%) was between 45 to 49 years of age. All participants (13) achieved at least a high school diploma and over half (6; 45.4%) had a college degree. Nearly all respondents reported their sexual orientation/affection as straight or heterosexual (92.9%) while one participant (7.1%) reported their sexual orientation/affection as bisexual.

**Figure 1.50: Educational Level of Parent Respondents**



### Care Provider Survey

Two care providers filled out the care provider survey. Only one indicated the kind of care provider they were, which was a certified nurse-midwife (CNM). Both providers indicated the types of settings they provided care in, which included hospital labor and delivery (1), hospital postpartum/lactation (1), Hospital other (1), clinic (2), freestanding birth center (1), and out-of-hospital/home (1). Both providers serve Clackamas and Multnomah County, and one provider indicated that they served Columbia, Tillamook, and Washington counties as well. Both providers said patients utilize doulas at all births they attend and both have experience with birth doulas. One provider said they work with birth doulas and postpartum doulas roughly equally. Both providers worked with certified birth doulas, but one provider had experience working with uncertified doulas as well.

Providers were asked about their patient's experience with finding doulas who were qualified and that their patients could afford. One care provider said that their patients did not experience difficulty finding qualified doulas and the other was unsure if their patients experienced difficulties finding qualified doulas. Similarly, one care provider said that their patients did not experience difficulty finding doulas they could afford while the other said they were unsure about affordability.

Care providers were also asked their opinions about the skills and knowledge of the doulas they have worked with, their scope of practice, and their experience working with doulas who provide culturally-specific or linguistically-specific doula support. Both providers said that the trained doulas they worked with have sufficient doula skills and knowledge and these trained doulas also work within their scope of practice. One provider shared that their organization employs doulas and that the doulas are highly trained and of very high quality, and they occasionally work with private doulas as well. The provider was "generally impressed" with the private doula's level of knowledge, training and professionalism. The provider said they only had one negative private doula interaction in the time they worked for their organization. When asked about working with doulas who provide culturally-specific or linguistically-

specific care, one provider said they had experience with such care and another provider said they sometimes experience such care.

Both providers reported on what they believe are the most important benefits to doula care. Seven primary benefits were reported with the two main ones shared by both providers being increasing patient's satisfaction with labor and delivery and reducing health disparities for patient and baby. Other cited benefits include: increasing the likelihood of vaginal birth, decreasing the likelihood of having a cesarean birth, shortening the length of labor, decreasing the likelihood of needing an epidural or other pain medicine, and increasing the patient's chance at successful breastfeeding. Both care providers said they refer patients to doulas very frequently. One provider elaborated to say that they have doulas at their practice and they encourage patients to meet them prior to labor; almost all patients at their practice utilize doulas subsequently.

## Discussion

Oregon stands as a leader in healthcare innovation and striving towards the Triple Aim of improving the experience of care, improving the health of populations, and reducing the per capita cost of care (Institute for Healthcare Improvement, 2018). Landmark legislation passed in the formative years of 2011, 2012, and 2013 made Oregon the first state to take a systems approach to the integration of Traditional Health Workers, including doulas, into the medical system for the care of underserved communities. Furthermore, while there have been some attempts to initiate doula integration into other health care systems, such as in Minnesota and most recently New York, and older surveys of doula workforce characteristics (Lantz et al., 2005) exist, this report represents the first attempt in the nation to complete a workforce needs assessment for doulas across an entire state. This report highlights the successes and challenges to work as a doula in Oregon and, specifically, the successes and challenges to integrating doulas into Oregon's health care system.

Key informants and doulas who worked with community-based organizations were able to describe the most exemplary successes of doula integration. Doula integration requires top-level support from Coordinated Care Organization (CCO) leadership and relationship-building between organizations, doulas, providers, CCOs, and patient members served. Results from this project also illustrate novel directions in the utilization of doulas as a health equity measure. For instance, some CCOs have supported the creation of a population-specific program (example: culturally-specific doula care for African American and Black families) or through extension of the case manager role to include doula care. Despite documented successes, many areas in Oregon are encountering roadblocks to doula integration and several communities remain underserved. The two most noted and significant barriers found in this project were the low Medicaid reimbursement rates for doula services, which are simply not sustainable, and significant issues with the billing process, both in terms of difficulty understanding the billing process as well as inconsistency in when doula activity claims are paid by the State. Additional primary roadblocks include lack of CCO support for doulas, limited doula workforce capacity in less densely populated areas (e.g., rural areas where fewer doulas serve), limited access to state certification requirements (e.g., trainings), and difficulties with successfully navigating the THW Birth Doula application process. Because of the focus of the THW program as a health equity measure and the importance of culturally-specific and linguistically-specific care, a foundational barrier underscoring these primary barriers is limited access to culturally and linguistically diverse THW Birth Doulas who have lived experiences with the prioritized communities. As delineated in this report, doula work in

Oregon has significant challenges to sustainability for all doulas, and the challenges and barriers are far greater to doulas of color who do not have significant resources available to them and who face systemic oppression in the healthcare system at-large. Collectively, the barriers have resulted in two iterative situations: 1) the inability of doulas to serve with full potential OHP-enrolled families; and 2) potential THW Birth Doulas withholding applications and engagement with the THW program until they see evidence that they will be adequately and consistently paid for their services by the CCOs.

It is critical that these barriers are addressed timely and thoroughly. Oregon is at a delicate place in the historical timeline for this landmark legislation. States across the United States are looking to Oregon to see how well the state leads out on this health care transformation measure. Policymakers and programmatic leaders both within and outside of Oregon are watching and waiting to see if Oregon is truly able to make a difference in health inequities for childbearing people. Oregon childbearing families are relying on the state to ensure successful implementation of this legislation to support their well-being and health outcomes. Perhaps most notably, results of this workforce needs assessment demonstrate that Oregon doulas are absolutely interested, willing, and able to serve as THW doulas and help make this innovation a reality. However, the barriers and challenges encountered over the past several years into the present by Oregon doulas has created a landscape of overwhelming frustration. Simply put, the state risks losing the workforce that can make the THW Birth Doula program a success. If these frustrations are not adequately and timely addressed, this frustration will become the greatest barrier the THW Birth Doula program faces, as trust will be broken and doulas will no longer be willing to support this health care transformation measure.

Alternatively, if barriers can be overcome and exemplary successes capitalized on, the doula workforce is currently ripe for cultivation and integration into the healthcare system. Many doulas indicated that they already care for low-income and underserved families—including those priority populations targeted in the landmark legislation—by offering sliding scale or pro bono services to families who would not otherwise be able to afford doula services. Across surveys and listening sessions, it is clear that Oregon doulas have an overwhelming interest in serving as THW doulas. Below, we summarize the emergent areas of the survey that were then given depth and power via listening sessions, as described above in this discussion and in the results section.

### The Doula Workforce in Oregon

While it is difficult to estimate the number of doulas in Oregon, the Oregon Doula Association was able to obtain 270 active doula email addresses and had 130 responses, which is a 48.1% response rate. Doulas serving every county in Oregon participated in the survey, with higher concentrations in the metropolitan areas surrounding Portland and Eugene, which likely reflects general doula distribution. Employers and care providers also centered on the Portland metropolitan area. As such, the challenges and successes of doula work described herein may be more generalizable to the metropolitan areas of the state. Future research should focus on issues by service area, with a focus on rural areas.

Most doulas were birth doulas (53.8%) or worked as both birth and postpartum doulas (42.3%) and most work done by doulas was birth work (63.1%) with far less being reported as an equal division between birth doula work and postpartum doula work (13.1%). Both birth and postpartum doulas who completed the survey were early in their career. Two thirds of birth doulas (66.9%) indicated that they had been practicing five years or less and attended 25 births or less (59.8%). Similarly, most postpartum doulas had 15 postpartum clients or less in their doula career to-date (71.6%). Both doulas and

employers noted the high degree of burnout there is in the doula profession due to both financial and physical sustainability issues, which means doulas who trained/certified more than five years ago may have moved on to other types of work. The trend of early career doulas could also reflect doula care as a growing profession in Oregon. Future research into long-term career doulas (i.e., doulas working for more than five years) is necessary to further understand possible differences in struggles of establishing a doula career versus struggles in sustaining a doula career. Trends in career length from this project indicate the importance of mentorship as part of professionalization and sustainability in service.

Half of doulas (54.7%), on average, spent between 13 and 20 hours with each client, which is consistent with the literature on the duration of labor (Alberts, 1999; Trueba et al., 2000). For time spent in prenatal and postpartum visits, over half of respondents indicated 2 to 6 hours of prenatal and postpartum, with 26.1% providing 2 to 4 hours of non-intrapartum care (26.1%) and 27.2% providing 4 to 6 hours of non-intrapartum care. Hours in this survey captured only direct care giving. More information about the kinds of tasks doulas do outside of direct caregiving, such as marketing, administrative tasks, traveling to clients, and maintaining certifications, is necessary to accurately measure doula time expenditure per client.

Regarding place of service, doulas indicated that, overall, they work with hospitals and care providers that were considered doula-friendly or somewhat doula-friendly, and many expressed a sense of warmth and value from collaborating care providers. Experiences, however, varied greatly based on location. In reciprocity, care providers who participated in the survey found value in the doulas they worked with and felt that the doulas worked within scope of practice. Both care provider respondents said they referred patients to doulas while 25% of parents said that they sought doula services based on the recommendation of a care provider or other professional. In contrast, some doula respondents also indicated that at times they were excluded from supporting clients by hospital or provider policies. Future research with care providers and doulas about circumstances of doula exclusion will help add to the narrative about doula scope of practice and appropriate utilization.

Regarding training and certification, nearly all doula respondents (99.2%) received some form of official doula training. However, only 50% of respondents were fully certified at the time of survey. To better develop Oregon's doula workforce, barriers to completing doula trainings and certification requirements must be addressed, especially the unique barriers faced by doulas of colors. Primary barriers to doula training and certification include the cost of training, the difficulty finding births to attend for their certification process, and the lack of doula mentorship.

The identified benefits of doula care were fairly consistent across employer, parent, and caregiver surveys. All parents (100%) and caregivers (100%), and nearly all doula employers (90.9%), stated that increasing patient satisfaction with labor and delivery was an important benefit of doula care. The next most important benefit to doula care seen by doula employers (90.9%) and care providers (100%) was reducing health disparities for pregnant persons and their babies, but only 25% of parents felt this was an important benefit. The next most important benefit to parents was decreasing the likelihood of needing an epidural (66.7%) and decreasing the likelihood of having a cesarean birth (58.3%); both benefits were also important to employers (63.6%) and care providers (63.6%), respectively.

## Sustainability of Doula Work

There are significant gaps in the doula career with respect to work capacity, ability to find work, income, and fees associated with doula work. Over half of doulas (55.4%) reported experiencing difficulty finding work, which is reflected in the average work per month and capacity for work per month. Simply put, most doulas are not working to their capacity. The average births per month served by Oregon doulas is 1.65, but the average capacity of births per month is 2.56. The average number of clients postpartum doulas serve per month is 1.36, but the average postpartum doula capacity is 2.61 clients per month. Further, 42.3% consider doula work their primary form of employment, but 83.9% of doulas must rely on other sources of income outside of doula work, often time in fields unrelated to birth work or related medical services. Given that 76.9% of doulas earn \$10,000 or less per year from doula work and the federal poverty rate for one person in 2018 is \$12,140 (Oregon Center for Public Policy, 2018), doulas are forced to find other work or means to support themselves to avoid poverty. To fill in these sources, nearly half of doulas (42.5%) rely on their partners to contribute to family income, half of doulas work part time (49.2%), and one-fifth of doulas work full time (20.8%) in other professions.

Doula reimbursement rates must also be set at such a rate as to ensure livable wages. The most frequently reported rate of payment for global birth doula fees was \$751 to \$1,200 (39.9%), and an additional 46.6% of doulas charge less than \$750 per birth. Three birth clients a month (the capacity of 51.2% of doulas surveyed), at \$750 per birth, would yield an annual income of \$27,000 annually and three birth clients a month at \$1,200 would yield an annual income of \$43,000. Four birth clients per month would yield annual incomes of \$36,000 to \$57,600 at \$750 and \$1200 global fees, respectively. Moreover, doulas commonly engage in pro bono work as part of their service to the community. Sixty percent (60.8%) of doulas reported engaging in sliding scale fees and 57.7% of doulas reported offering pro bono services at times. Ensuring sustainable wages and clear pathways for prospective clients to secure doulas are critical components of increasing the utilization of doulas in Oregon.

Given that only 11 employers responded to surveys and the unknown total number of doula employers in Oregon, it is unclear if annual income reported by employers is generalizable across Oregon or similar employer types. Nevertheless, annual incomes reported by employers align with reported income ranges from all doula types. Doulas in listening sessions also described the ways in which working in collaboration with other doulas, such as agencies or collectives, or being hired onto a hospital, may increase the long-term sustainability of doula work; however, there is limited evidence that being employed through an organization as a doula increases the annual income from doula work.

The survey also touched on the demand for doula services. Overall, parents (76.9%) and doula employers (45.5%) reported that it is not difficult to find qualified doulas to hire, which may reflect geographic clustering of doulas, as nearly two thirds of doulas who responded to the doula survey (61.5%) work in Multnomah County. Care providers, employers, and parents all expressed the personal value they found in doulas to support them physically and emotionally and many parents, in open ended responses, expressed that the value for the services was worth what they paid. Doulas in the survey indicated that parental lack of knowledge of THW Birth Doulas may be a barrier to access and utilization, especially for underrepresented communities. Because so few parents (6%) statistically across the United States have utilized doula services (Declercq, et al., 2013), future research with parents will give a more robust idea of the barriers and challenges to parental access and utilization of doula services.

## Traditional Health Worker Program

One fifth (20%) of survey respondents were Traditional Health Worker (THW) Birth Doulas. Given the issues of fiscally sustainable doula work discussed above, it is not surprising that the most frequently cited barrier (45.7%) to doulas who have become or are trying to become OHA-approved Traditional Health Workers (THW) is that the reimbursement rate is set too low. Additionally, one third (33.9%) of doulas surveyed were not even aware of Oregon's THW Birth Doula Program. Most doulas who were not on the state registry (78.8%) were interested in learning about the program and 47.1% were very interested in becoming THW Birth Doulas.

Most physicians (82.6%) take Medicaid patients and their Medicaid patient share varies between 11.9% and 34.7% (Gillis, 2017). If THW doulas took similar Medicaid patient shares, a doula who has a capacity of three clients per month would serve 4.32 to 12.49 OHP-enrolled families per year and a doula who has capacity for 4 clients a month would serve 9.6 to 16.66 clients per year. Being able to serve more Oregon Health Plan (OHP)-enrolled families in birth would also help to bridge the gap of doulas feeling called to serve at sliding scale or pro bono rates for clients who could otherwise not afford doula services. To help increase the number of OHP-clients served, not only do more doulas need to be state approved, but doulas will also need considerable help in billing for services. Most doulas (83.6%) had some interest in learning how to bill insurance for birth doula services and an equal amount (83.6%) said they were intimidated by the prospect of billing insurance. Only 17.4% of THW Birth Doula respondents have successfully billed OHP for doula services provisioned.

Survey results indicate that doulas also need the capacity to bill third party, private health insurance for their services. By distributing some of the cost of doula care with all forms of insurance to reduce the burden of the entire global fee, doulas can charge a more sustainable rate to stay in business for the long term, families can more easily engage with doula services because the out of pocket cost will be lower for them, and doulas can also make room in their schedules to allow for a Medicaid patient share that compares with physicians.

Apart from the reimbursement rate being too low for doulas to sustainably participate in Oregon's THW Program, many of the other cited barriers to participation in the program are easily overcome with additional technical and administrative support from the Oregon Health Authority (OHA). Doulas reported having problems with the application process (30.8%), understanding the requirements and how to fulfill them (21.3%), and obtaining the required trainings (11.7% for cultural competency and 8.5% for other trainings). Updated and streamlined application processes, greater availability of trainings, and increased FTE for OHA support staff to help with the processing of applications are key mechanisms to overcoming identified barriers. Understanding how to bill for services (28.7%) is another barrier that is easily overcome through the provision of technical assistance to individual doulas or to the process of creating doula hubs (concentrated billing service entities that act on behalf of doula). Finally, clients receiving information about THW Birth Doula services is another barrier that can be addressed through transparent and accountable communication by CCOs to their patient members.

## Culturally Specific Doula Services

Results from this survey indicate that the doula workforce is comprised of 21.7% doulas of color, which is on par with that found in the general Oregon population at 22.9% (source: 2010 census); 20% of listening session doula participants self-identified as doulas of color as well. In addition, 30.5% of doula respondents indicate that they are providing culturally-specific and/or linguistically-specific doula

services. In open-ended questions, 42 respondents provided explanations of how they provide culturally or linguistically-specific doula services. Of these, 23.1% indicated being able to speak and provide care in the non-English languages of their clients; 19% indicated their own cultural or racial background as relevant to providing culturally-specific doula services; 52.4% indicated having served culturally-specific populations based on religion, sexual orientation, or newly immigrated familial status; and 7.1% indicated having some sort of cultural competency training. Additionally, 14.3% of respondents indicated having no experience in these regards, but the respondents were interested in learning to provide culturally and linguistically appropriate services.

Doulas also reported specific challenges in providing culturally and linguistically appropriate doula services. For instance, one Spanish-speaking doula said that staff will ask them to act as a medical interpreter so that they don't have to call in an interpreter. Three people mentioned culturally diverse populations not understanding the role of doula or embarrassed at the desire for labor or postpartum help ("seen as weak"). Another doula said there are not enough Native American doulas who are trained with the traditions and ceremony knowledge that is a big part of "who we are and [how we want] to bring our children into the world." Another doula echoed: "I am a doula through a program that provides doula support to mothers of color and usually they have more indicating factors such as being labeled high risk or struggling with their socioeconomic backgrounds, so being that I am a woman of color I support them with well-known resources and lived life experiences."

Parents (38.5%), employers (60.0%), and care providers (50%) reported witnessing some level of culturally- and linguistically- specific doula care. None of the parents surveyed indicated that culturally- and linguistically- specific services were the reason they hired their doula. Some doulas who serve culturally diverse populations said that the doula role may not be well understood. While global education for all families in Oregon would increase utilization of doula care, culturally responsive targeted education for culturally diverse populations by community members is critical both for access to care and for growing a diverse doula workforce.

### Expanding Doula Reach: The Role of Postpartum Doulas

Findings also indicate that postpartum doula work, incorporated alongside birth doula work, can provide an opportunity for long-term career sustainability as well as help foster emotional mental health and social well-being for new parents. Emotional support was a major benefit of postpartum doula care, as cited by 42.9% of participants, and referrals to appropriate health care providers, including for the treatment of postpartum depression, was a cited benefit by 28.6% of parents. Profoundly, one respondent specifically credits the appropriate treatment of their postpartum depression to their doula's postpartum care. Given how frequently maternal depression goes unrecognized and untreated, and given the impact maternal depression can have on health outcomes for parents and children (Sontag-Padilla et al., 2013), the Oregon Health Authority should look at adding a THW Postpartum Doula designation to the THW Program, both for advancing health equity and for improving the sustainability of doulas as THW providers. Results of the doula workforce survey clearly indicate that postpartum doulas have the capacity for and desire to serve OHP-enrolled families. Half of postpartum doulas (46.2%) say they have the capacity to take 2 to 3 clients a month and they typically charge \$21 to \$30 an hour (64.5%). Three-quarters of postpartum doulas (76.2%) said they would be interested in becoming a THW Postpartum Doula if the option became available.

## Recommendations

Collectively, results from this three-phased workforce needs assessment demonstrate the promise of doulas as traditional health workers (THW) for advancing health equity in childbirth for Oregon families. Findings also indicate several areas for improvement that must be addressed timely and comprehensively if the full potential of the THW doula program is to be realized. To this end, we make several recommendations for cultivating a thriving and representative doula workforce that can meet the needs of culturally and linguistically diverse childbearing families. Our recommendations target multiple stakeholders involved in this legislation and the THW programming, including: the Oregon Health Authority, DMAP, the Oregon Office of Equity and Inclusion, state legislators, doulas, health care providers, Coordinated Care Organizations, families, community-based organizations, and professional associations. Recommendations provide a roadmap forward for the changes that must be accomplished for access and equity to ultimately prevail. There are 15 recommendations in total.

**Recommendation #1: Educate Community Members about Doulas.** Doulas report that education on the role and values of doulas within their communities is insufficient. This lack of knowledge about the doula role reduces access to doula services as well as decreases the chances of recruiting doulas to serve their communities. This knowledge gap was greater in rural areas. Community members should be educated about the services and benefits of doula care and, most importantly, that these services are covered under the Oregon Health Plan. Doulas and key informants recommend that public education efforts focus on a strengths-based, community and family-enriching perspective of doulas and emphasizes the importance of birth experience to all families. A public outreach campaign about doulas and the THW program, at-large is necessary, and a collaboration between the Oregon Doula Association, the State of Oregon, and other community-based partners would prove fruitful in these regards.

**Recommendation #2: Involve Families in THW Birth Doula Programming.** While this report did capture the voices of parents, their involvement was limited to sharing their experiences of doula care, given the project objectives. Families who desire doula care or who have used doula care, especially families from underserved communities, also have much to contribute to idea generation around solutions to barriers for families. Engaging families in state-level working groups and THW programming is recommended to ensure that Oregon families stay centered during innovation.

**Recommendation #3: Invest in Community-Based Organizations.** The exemplary successes of doula integration have primarily come from community-based efforts. Successful partnerships between CCOs and community-based organizations takes time, including heavy relationship-building and interprofessional education on the role of doulas. Results from this project demonstrate that community-based organizations provide the best leverage for connecting with childbearing families in Oregon and often have the best network of related wraparound services, thus offering the best opportunity to fill necessary gaps in the lives of families and to avoid duplicative services. Moreover, community-based organizations are commonly involved in providing culturally-specific and linguistically-specific care services for targeted populations. As such, investment in community-based organizations that work with the THW prioritized populations is a clear pathway forward for increasing access to and utilization of culturally and linguistically diverse doulas.

**Recommendation #4: Expand Training Offerings.** The lack of accessible trainings was a key barrier found in this project. Doula respondents consistently expressed the need for more accessibility around trainings for the THW Birth Doula certification requirements as well as to continually develop their knowledge and skills—something employers also desire. Accessible trainings are defined here as trainings that are regularly available, available in both in-person and on-line formats, taught by multiple qualified trainers, that can be accessed in several parts of the state (i.e., not just Multnomah County), that are well advertised, and that are affordable on a doula salary. Regarding topics for inclusion, trainings need to address a breadth and depth of issues, including: doula sustainability issues (e.g., successful business practices, community-organizing for doulas, doula partnerships and agency development); a THW Program “know how” series (e.g., THW certification requirements, application process, billing process); and specific professional development offerings necessary to ensure doulas are fully equipped to provide comprehensive care to the prioritized populations, including cultural competency and trauma-informed care. Notably, doula respondents expressed experiencing significant barriers in completing their applications because of a lack of oral health and cultural competency available trainings. Doulas also expressed concern over the lacking number of trainers who offer cultural competency trainings. The Office of Equity and Inclusion should consider hiring more trainers and more diverse trainers to offer cultural competency trainings. In addition, the topic of trauma-informed care was profoundly cited by both doulas and key informants, where they highly recommended that trauma-informed care trainings be made readily available and widely disseminated due to the frequency in which doulas encounter families who manage trauma.

**Recommendation #5: Support Doulas in Navigating the THW Process.** As one participant in a focus group said, while the frustration with applying for the THW program and billing for services is understandable, becoming an OHA-approved THW Birth Doula is becoming an act of “advocacy outside the birth room.” Doulas need to be educated about the process and benefits of becoming a THW Birth Doula and provided support in obtaining necessary trainings and applying to be on the registry. Technical support for navigating the application process and ensuring that materials on the THW website are accurate, up-to-date, and reflect components of knowledge translation and health literacy is central, as doulas found the materials provided confusing, inconsistent, not streamlined, outdated, and not readily useable. Doulas requested that the Office of Equity and Inclusion assemble information in one place on the Office of Equity and Inclusion’s Traditional Health Worker website as well as offer technical assistance to doulas in filling out applications. Doulas also suggested that the Office of Equity and Inclusion may not have enough resources to fully support the process of processing applications and supporting applicants and recommended that more FTE and resources be devoted to these tasks. Most notably, doulas need technical assistance and ongoing support in billing OHP for medical services. One of the strengths of the doula workforce in Oregon is the level of connectedness and networking and the intentions of doulas to develop and train their skills. Creating trainings or workshops on how to apply, how to bill, and how to get paid, while also providing all of the paperwork necessary and required trainings, will likely result in more THW Birth Doulas in Oregon.

#### **Recommendation #6: Ensure Consistency in Claims Paid**

One of the most interesting finds from this report is the analysis of actual claims data against doula workforce perception of claims data. For the 20% of doula respondents that are THW Birth Doulas and who are eligible to bill for Medicaid reimbursement, there is an overwhelming sense that claims are rarely, if ever, paid, even when the doula does “everything they [the State] tell me to.” Actual claims

data for doula activity between January 2016 to June 2018 indicates that there is some reality to this perception, with only 76% of claims being approved in this 30-month period and 24% being denied. The perception in the doula workforce, however, is much graver, with doulas believing that rarely are claims paid and that the trend is for more claims to be denied at a greater rate in more recent months. The Oregon Health Authority should investigate the reasons behind denied claims and identify patterns that needed addressing. If claims are not consistently paid and doulas are not supported in this process, then the THW Birth Doula Program risks continued under-utilization, as the expense of childbearing families.

**Recommendation #7: Create Networking and Mentorship Opportunities.** Doulas and key informants discussed the benefits of and need for mentorship programs for doulas. This is particularly needed (and difficult to do) in rural areas (i.e., Central and Eastern Oregon) of the state and for doulas of color. Key stakeholders need to work together to find solutions to the networking and mentorships issues noted in this report.

**Recommendation #8: Educate and Engage Health Care Providers.** Both key informants and doulas described the necessity of professional rapport between obstetrical providers and doulas. Efforts to continue building rapport and educating providers on the role and scope of doulas need to be continued and fostered by stakeholder organizations, such as the Office of Equity and Inclusion and the Oregon Doula Association. Providers serve as “gatekeepers” to doula care in many ways, being able to either support a client in accessing a doula or blocking patient engagement with doulas. Investing in interprofessional collaborations and education between providers and doulas is central to THW Birth Doula Program success and to ensuring families receive the team-based, compassionate, and professional care they deserve.

**Recommendation #9: Invest in Hospital Doula Programs.** Results from this report indicate a small, but promising trend in doulas that are employed by hospital-based systems or birth centers. Integration of doulas into already existing clinical settings is a clear pathway forward to increase access to THW Birth Doulas and to improve their overall utilization. However, hospitals and other clinical settings may be unfamiliar with the doula role and will need technical assistance in the staffing and management of doulas within a clinical setting. Investing in hospital doula programs with support, best practices, and case study successes is a key way to address several of the barriers noted in this report.

**Recommendation #10: Create Doula Billing Hubs.** A primary way to overcome several of the barriers noted in this report is to consolidate administrative efforts required through the creation of doula hubs. Doula hubs are a model wherein one central doula organization, agency, or like entity takes on billing responsibilities of navigating the THW system on behalf of hub members, including billing responsibilities. Doulas overwhelmingly supported this idea. Key informants also saw the potential of doula hubs, noting their ability to offer professional development, mentorship and training as well as administrative support. Doulas need significant technical support and resources for the initial creation of doula hubs, and the Oregon Health Authority, the Oregon Doula Association, and other key stakeholders should partner together to envision the doula hub model on a systems-wide scale.

**Recommendation #11: Increase the Reimbursement Rate.** On a systems-level, the primary suggestion from doula respondents to reduce barriers and increase access was to revisit the compensation rate. Increasing the rate will attract more doulas to the THW Birth Doula program and ensure the program is sustainable. The Oregon Health Authority should consider the fact that the

Traditional Health Worker program can act as an extension of the values of equity by increasing the rate to a sustainable wage, thereby increasing access to a sustainable career and access to a service known to improve birth outcomes. Moreover, the need for a sustainable and appropriate reimbursement rate is central to the focus of the THW program on culturally and linguistically appropriate services, as ensuring communities of color and other non-dominant cultures are appropriately compensated for services provided is a foundational equity value. In a recent study on the cost effectiveness of doulas, the authors found that “Cost-effectiveness analyses indicate potential savings associated with doula support reimbursed at an average of \$986 (ranging from \$929 to \$1,047 across states)...Based on associations between doula care and preterm and cesarean birth, coverage reimbursement for doula services would likely be cost saving or cost-effective for state Medicaid programs” (Kozhimannil, Harderman, et al., 2016, p.1). To achieve the results noted in the study, the state model for doula care must include antepartum as well as labor/birth and postpartum doula service coverage.

[Recommendation #12: Examine the Doula Role as an Extension of Existing Roles.](#) Key stakeholders described flexible ways that doula services could be systematically incorporated into other social service or medical roles, such as maternal and child case managers, visiting home nurses, or people who have chosen to enroll in more than one Traditional Health Worker type. Examining the existing cases where this has occurred, creating documentation that outlines the job duties, description, and implementation of these roles for the hiring organization, and disseminating this information to community-based organizations, clinics, and hospitals would help overcome the barrier of learning how to potentially utilize doulas as part of existing services and roles.

[Recommendation #13: Expand the Utility of the THW Birth Doula Registry.](#) Doulas would like more information about state approved THW Birth Doulas to be available on the THW Registry. Currently, there is no information on the website about what language a doula speaks, what additional credentials they may have, and the racial and ethnic identification of the doula. Ensuring a THW registry that reflects the goal of culturally-specific and linguistically-specific doula services is crux.

[Recommendation #14: Mandate CCO Involvement in the THW Birth Doula Program.](#) Like providers, Coordinated Care Organizations (CCOs) serve as a “gatekeeper” to the successful utilization of THW Birth Doulas. CCOs must transparently communicate to patient members the role of THW Birth Doulas and the Medicaid coverage specifics. Moreover, CCOs must create pathways by which doulas can bill and must be available to take doula emails, phone calls, and meetings as initial establishment and ongoing partnerships occur. Too often, doulas find that CCOs are “unaware” of the THW program and the legislation that mandates coverage. Moreover, doulas find that CCOs are unwilling or lack the technical expertise necessary to create pathways for reimbursement. Because of their role as gatekeepers to both billing and to patient access, CCOs must be held accountable to the THW program by the Oregon Health Authority and their involvement is crucial to its success.

[Recommendation #15: Advance Efforts of the Oregon Doula Association.](#) The Oregon Doula Association (ODA) plays a key role in supporting effective implementation of the landmark legislation and the ultimate success of the THW doula program. Key informants and doulas suggested that the ODA create a strategic plan specifically around workforce development goals and that the organization increase human resource capacity, including paid staff, for working on workforce development and associated state advocacy efforts.

Finally, underpinning these specific recommendations is a broadly-writ recommendation to ensure that THW Program captures a visible and holistic picture of the doula landscape in Oregon. Networking and establishing partnerships with doulas, agencies, community-based organizations, hospitals, clinics, and professional associations will be key to the State’s ongoing implementation of the THW Program. Documenting best practices and showing exemplary successes will also be central to ensuring accessible information that all stakeholders can use to expand reach and impact.

## Conclusion

This report is the first-ever workforce needs assessment of the doula landscape in the State of Oregon, and the first of its kind nationally as well. Using a mixed methodology and community-engaged approach, perspectives of doulas, employers, and key informants provided rich data for understanding the complexity of the landscape. Results of the project clearly identify the emergent barriers and successes for the doula workforce in Oregon, specifically as they relate to culturally and linguistically appropriate doula care for underserved communities and utilization of the THW Birth Doula Program. Recommendations provided outline a roadmap for the Oregon Health Authority and partnering stakeholders moving forward, as we work in collaboration to realize the full potential of this landmark legislation and to advance health equity for all childbearing families in Oregon.

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## Author Bios

**Courtney L. Everson, PhD** is a medical anthropologist, birth & postpartum doula, and the Vice President of the Oregon Doula Association. Dr. Everson is also the Dean of Graduate Studies and Academic Faculty at Midwives College of Utah, the Vice President of the Association of Midwifery Educators, the Director of Research Education for the Midwives Alliance of North America (MANA) Division of Research, and on the Board of Directors for the Midwifery Education Accreditation Council and the Academic Collaborative for Integrative Health. Dr. Everson's teaching, research, and service foci include doula models of care, midwifery models of care, health equity, culturally safe care, evidence-informed practice, interprofessional collaboration, community engagement, and mixed methodologies.

**Courtney Crane, MPH, MS** is working on completing her PhD in Health Systems and Policy at the Oregon Health Sciences University & Portland State University School of Public Health, where her research focuses on patient experience of care, policy analysis techniques, and maternal and child health. Her dissertation, *Increasing Access to Doulas in Oregon: A Delphi Study*, will be complete in early 2019. When not working to complete her dissertation, Courtney works to maintain an active role in ongoing neurodiversity and disability advocacy efforts while she raises a young family experiencing disability.

**Raeben Nolan** is the President of the Oregon Doula Association and the doula representative chair on the Traditional Health Workers Commission for the State of Oregon. Raeben is also the Specialized Programs Coordinator at Birthingway College of Midwifery, serving as a labor and postpartum doula trainer, educator and mentor.

## Authorship Contributions

Dr. Everson served as the primary investigator for this project, including leadership on project design, research activity oversight, and research team coordination. Dr. Everson also conducted secondary analyses on health inequities data, registry data, and claims data presented. Dr. Everson served as lead author on manuscript writing.

Ms. Crane served as the research associate hired by the Oregon Doula Association to carry out the research activities of this project. Ms. Crane conducted the research activities for each phase with the assistance of Ms. Leja Loucks. Ms. Crane took lead on the results section of this manuscript.

Ms. Nolan provided overall project management for this project, including being the primary liaison between the Oregon Office of Equity and Inclusion and the Oregon Doula Association for this grant-funded, commissioned project. Ms. Nolan provided final review of this manuscript.