To:	Chairman Thomas Brinkman, House Insurance Committee
From:	Jessica Mead, Director of Government Affairs, Ohio Market
Date:	June 8, 2020
Re:	House Bill 611 – 2nd hearing – Proponent Testimony

Thank you, Chairman Brinkman, Vice Chair Antani, Ranking Member Boggs and members of the House Insurance Committee, for the opportunity to provide proponent testimony and additional information in support of House Bill 611.

CareSource is a nonprofit health plan based in Dayton, Ohio that serves over 1.2 million Ohioans who are enrolled in Medicaid. Additionally, we serve over 55,000 Ohioans enrolled through the Ohio Marketplace and almost 30,000 in MyCare Ohio. CareSource was established in Ohio over 30 years ago and we currently employ over 4,000 people.

CareSource is committed to improving the quality of life and health outcomes of our mothers, infants, children, and their families; we believe doulas play a pivotal role in supporting high risk and underserved mothers throughout their pregnancy and into motherhood – ultimately leading to better health outcomes for mother and baby. We have dedicated staff and resources to advance our maternal & child health initiatives; our department is led by the Director of Women and Child Health with a team of maternal & child health staff. The department includes regional coordinators, nurses, quality improvement specialists, case management and Healthcheck/EPSTD staff.

In addition to our internal resources and programs, CareSource leverages community partners and collaborations to meet our goal of improving the quality and health of our moms and babies. CareSource continues to work in the community to find ways to leverage doula services for Medicaid members. A part of this work is to develop pilot opportunities for doula services. The funding and certification are two important issues currently impacting a mother's ability to receive these services -- House Bill 611 provides an avenue not only for reimbursement, but for certification and registration of those providing doula services today.

Below I have included a brief overview highlighting the value of doula services; the document includes references for additional studies and information about the success of doula programs. We hope you find this information useful as you consider passage of House Bill 611.

Thank you for the opportunity to share this supporting information. Our Ohio Market Medical Director and/or our Director of Women and Children Health are available if you have questions or would like to further discuss doulas.

Doula care to mitigate maternal demise and improve birth outcomes for Medicaid members in the State of Ohio

Women of color, especially black and brown women, and women living in areas of high poverty face persistent health inequities and disparities related to birth outcomes and maternal demise compared to white non-Asian women in Ohio. Doula care is an evidence-based non-medical practice with proven benefits to reduce these health inequities and disparities (Dekker, 2019). There are multiple clinical studies published in the medical literature that support the use of doula care throughout the maternal life course that lowers the likelihood for women of color and low income of having a cesarean section, labor with epidural or other pain medication, birth with forceps or vacuum assistance, negative child birthing experience and a baby with a low five minute Apgar score (Hodnett et al, 2013).

Doulas can help with the early identification of leading indicators for maternal and infant morbidity and mortality improving health outcomes for all pregnant women in Ohio and especially those who face persistent health inequities and disparities. Doulas facilitate an integrated holistic approach to maternity and the life course in women's health (Dekker, 2019). Of particular significance, community-based doulas primarily focusing on the social determinants of health have a positive effect resulting in healthy maternal-infant outcomes in women of color and low income (Gentry et al., 2010).

Making the case for doula care for Medicaid members

Doulas are trained (and many have national professional certification recognizing competency) to provide non-medical emotional, physical and informational support for women before, during and after labor and birth. Specifically, birth doulas provide hands on comfort measures, share resources and information about labor and birth and facilitate positive communication between women and their maternity care providers by helping women articulate their questions, concerns preferences and value. Doula functions also include continuous support during labor and birthing, help with newborn feeding and other infant care, provide emotional and physical recovery from birth, and make house visits throughout the life course of the woman's maternity. Doulas are not a substitute for other professionalmaternity care providers. Doulas function more as a collaborator and advocate for women during the maternity life course. (Decker, 2019).

Community-based doulas are specially trained community health workers who are particularly well-suited to address issues related to discrimination and disparities. They are usually trusted members in the communities they serve and are better able to bridge language and cultural gaps as well as functioning as health navigators between the women and their maternity care providers (Gentry et al, 2010).

Concerns for cost and the well-being of women and infants has led policy stakeholders to identify innovative solutions that align with the National Quality Framework of the Triple Aim: improving the experience of care, improving the health of populations and reducing the total cost of care (Berwick et al, 2008). Specifically, Medicaid reimbursement for doula care would significantly increase access to this

evidence-based non-medical service and would improve the quality and value of publically funded maternity care by improving the care experience through increased access to safe patient-centered non-medical maternity care enhancing the overall quality of care and member engagement, improving health outcomes for mothers and babies enrolled in Medicaid and reducing the total cost of care by eliminating non- beneficial medical procedures, avoidable complications and preventable chronic conditions.

In March of 2014, a consensus statement was released to the public as a joint statement from the American College of Obstetricians and Gynecologists and the Society for Maternal and Fetal Medicine explicitly endorsing the greater use of "one of the most effective tools to improve labor and delivery outcomes, the continuous presence of support personnel, such as a Doula" (Coughly et al, 2014). The consensus statement is supported by substantial clinical outcomes of decreased maternal demise and improved infant mortality in a review of randomized control trials of doula support during labor, which also show stronger effects for women who are low income, socially disadvantaged or who experience cultural or language barriers to care (Hodnett et al, 2013). Despite the evidence linking low income , negative sociodemographic factors and adverse birth outcomes, effective and efficient means of reducing known risks, including doula care, have not been widely implemented or made widely accessible (Lu et al, 2003; Lu et al, 2010).

A review of 41 birthing practices published in the American Journal of Obstetrics and Gynecology in 2008, using the grading system of the United States Preventive Services Task Force, concluded that doula support was among the most effective of all birthing practices reviewed and one of three (out of 41 reviewed) to receive an "A" grade with a good quality of evidence rating (Berghella et al., 2008).

There is an urgent need to address non-medical social determinants of health in order to stem rising perinatal costs of care in a time of increasing fiscal pressures on the health care delivery system as a whole and state Medicaid annual operating budgets (Kozhimannil et al, 2016). In August 2013, Centers for Medicare and Medicaid Services (CMMS) released research findings after convening an Expert Panel on Improving Maternal and Infant Outcomes in Medicaid/CHIP supporting the non-medical coverage for continuous doula support during labor and birthing (ASTHO, 2019). Currently, only Minnesota and Oregon allow reimbursement for doula services through the Medicaid program (ASTHO, 2019).

Compared to the absence of continuous non-medical labor and delivery support, evidence from multiple randomized controlled trials demonstrated that doula-provided labor support has been shown on average to:

- Reduce cesarean births by 28 %
- Reduce the use of any pain medication by 9 %
- Reduce the use of synthetic oxytocin to accelerate the first 2 stages of labor by 31 %
- Reduce the reporting of a negative birthing experience by 34 %
- Increase the chances of a spontaneous vaginal birth by 12 % (Hodnett et al, 2013).

The drivers of maternal morbidity include improved documentation and surveillance of maternal health (i.e., better capturing and reporting of outcome measures), delayed childbearing into the 4th and even 5th decade of life, increased cesarean birth rates for convenience and malpractice concerns, emerging infections related to poor antimicrobial stewardship, history of preterm labor and increasing prevalence of pre-pregnancy obesity and other underlying chronic conditions (e.g., hypertension, diabetes mellitus) (Lu et al, 2015; Creanga et al, 2015).

There are well documented studies that correlate maternal and/or infant demise related to persistent disparities by race and ethnicity, especially between black and non-Asian white women. Evidence reported in the literature notes that the mortality rate for black non-Latina women is three times that of white non-Latina women and the maternal morbidity rate is two times that of white non-Latina women (Creanga et al., 2014). The literature identifies the following contributors to these disparities including poor preconception health states, prevalence of obesity and other co-morbidities including hypertension, diabetes mellitus and depression, low poverty and other negative social determinants of health such as food insecurity, unstable housing, residential segregation and lower educational attainment (Louis et al., 2015; Sarto et al., 2013).

Black infants have a mortality rate that is twice that of white non-Latina infants; this difference reflects both black infants' higher rates of low birth weight and the higher mortality among black infants' of normal birth weight. Trying to understand whether racial bias and discrimination against black women and infants is supported by a higher rate of adverse clinical outcomes, researchers studied infant mortality rates between college-educated black and non-Latina white mothers and the potential correlation to whether race and its attendant stresses play a role in this gap when controlling the sociodemographic variables between the two groups of mothers. In contrast to black infants in the general population, black infants born to college-educated parents have higher mortality rates than similar white infants because of their higher rates of low birth weight babies. Black and non-Latina white infants of normal birth weight have equivalent mortality rates (Schoendorf et al., 1992).

According to the 2019 Health Value Dashboard Equity Profile published by the Health Policy Institute of Ohio (Health Value Dashboard Equity Profile, 2019), compared to white Ohioans accessing prenatal care,

- 1.7 times worse for Black Ohioans
- 1.6 times worse for Hispanic Ohioans
- 3.3 times worse for women without a high school diploma.

With respects to infant mortality, compared to white Ohioans,

- 2.9 times worse for Black Ohioans
- 1.4 times worse for Hispanic Ohioans
- 2.5 times worse for people without a high school diploma.

Recognizing that there is racial bias and overt discrimination against women of color and women in high poverty that supports the claim of a higher maternal and infant morbidity and mortality rate compared to non-Asian white women and infants, Gentry et al (2010) published their research on improving clinical outcomes for women of color and high poverty by using a community-based doula program for

single adolescent pregnant women. The primary focus of this study was to help pregnant and parenting adolescents navigate multiple social settings that often serve as health barriers to positive maternal and child health outcomes and secondarily, help prevent repeat adolescent pregnancy. Findings from this study highlighted the positive and perceived valuable relationships that community doulas were able to establish with pregnant and parenting adolescent women by addressing social, psychological and economic issues unique to this population of women.

Thomas et al (2017) compared doula support vs no doula support over 5 years (2010 to 2015) for pregnant women of color and those in areas of high poverty in a Healthy Start Program. The study investigated the influence that doula support may have on birth outcomes among populations' of pregnant women of color with high rates of chronic disease (i.e., obesity, hypertension, and diabetes mellitus) and negative social determinants of health including poverty, racism and exposure to violence in women of color. The chart bellows summarizes the clinical outcomes for doula vs no doula support.

	Preterm Birth Rate	Low Birth Weight	Cesarean Section Rate
Doula Support	**6.3 %**	**6.5 %**	**33.5 %**
Control	**12.4 %**	**11.1 %**	**36.9 %**

Thomas et al, 2017.

Participants in this study indicated doula support was highly valued and helped give women of color and high poverty a voice in consequential birthing decisions. Results of this study suggest that doula support may be a critical factor to address birth inequities and disparities.

Gruber et al (2013) studied the impact of doulas on healthy birth outcomes between two groups of socially disadvantaged mothers at risk for adverse birth outcomes, one receiving prenatal assistance from a certified doula and the other representing a sample of birthing mothers who elected to not work with a doula. All of the mothers were participants in a prenatal health and childbirth education program.

Research findings noted that expectant mothers matched with a doula had better birth outcomes. More specifically, Doula-assisted mothers were four times less likely to have a low birth weight (LBW) baby, two times less likely to experience a birth complication involving themselves or their baby, and significantly more likely to initiate breastfeeding. Communication with and encouragement from a doula throughout the pregnancy may have increased the mother's self-efficacy regarding her ability to impact her own pregnancy outcomes.

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