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**Friday, November 12, 2021**

**Virtual Meeting Via Zoom Conference Call**

**MEMBERS PRESENT:**

Rep. Melissa Minor-Brown, Co-chair

Christina Andrews, Co-chair

Leah Woodall

Dr. Garrett Colmorgen

Mona Liza Hamlin

Dr. Michelle Drew

Dara Hall

Dr. Priscilla Mpasi

Erica Allen

Dr. Liz Brown

Susan Noyes

Wayne Smith

**HMA SUPPORT STAFF PRESENT: Diana Rodin and Akiba Drew**

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| **TOPIC** | **FINDINGS, CONCLUSIONS & RECOMMENDATIONS** | **ACTIONS & FOLLOW-UP** | **PERSON RESPONSIBLE** | **STATUS** |
| I. Call to Order | The meeting was called to order by Rep. Minor Brown, Chair, at 1:34pm.  | No further action required. | Rep. Minor Brown, Chair | Resolved |
| II. Co-chair Introduction  | Rep. Minor Brown introduced the new co-chair of the committee, Christina (Tina) Andrews. All members did a round robin of introductions following co-chair introductions.  | No further action required. | Rep. Minor Brown, Chair  | Resolved |
| III. Meeting Norms | Christina Andrews, Co-chair, reviewed the meeting norms with the group. Additional meeting norms can be added at any time, as the group agrees.  | No further action required. | Christina Andrews, Chair | Resolved  |
| IV. Value of Doula Services | Christina Andrews provided a summary of the value of doula services, which highlighted the positive impact on outcomes and potential to reduce racial disparities in birth outcomes. This included the role/ definition of community doulas, who have a role of connecting birthing people to resources and navigation systems of care, as well as advocating for their needs. Other summary points included:* + Racial disparities persist in birth outcomes in Delaware and outcomes are worse overall than U.S. rates
	+ Summary of evidence of impact of doula care on outcomes and costs – potential prevention of negative health outcomes and reduces the need for high-cost interventions
	+ Increases satisfaction with birth experiences and breastfeeding rates, improves postpartum mental health, parent/baby attachment
	+ Many moms in recovery or dealing with mental health challenges, trauma (including related to birth experiences, medical care, trauma from life that impacts birth experiences) – areas where doulas can provide support
 | No further action required. | Christina Andrews, Chair | Resolved  |
| V. Draft Charter  | Leah Woodall discussed the draft group charter. DHMIC has kicked off various workgroups with charters that will roll up into the broader work of the DHMIC. Recommended changes to the charter are welcome by email or in the chat to refine expectations and scope of work for the group. Charter discussion topics included:* + Strategies/goals draft based on initial conversations last year – some of these may take 1-3 years or longer. These emerged through discussion.
	+ Core competencies/role of doulas
	+ Training/curricula
	+ Potential need for registry of doulas/way to promote access
	+ Reimbursement models
	+ Outreach/recruitment/workforce
	+ Barriers, challenges, how we address them

Rep. Minor brown advised everyone to review the draft charter and send their feedback for edits/ revisions. | Members to provide additional feedback on draft charter.  |  | Ongoing  |
| VI. Strategies and Goals  | The co-chairs led a discussion around the proposed strategic goals. 1. *Develop DE-specific standards of practice/core competencies for Community Doulas (Completion of DE Certification and Training, and/or CHW Training?)*
	* *Review state best practices or promising approaches for core competencies, state infrastructure, and sustainability*
2. *Identify 1-3 community doula educational curricula.*
3. *Develop statewide doula/community doula registry (some work has already been done to identify existing curricula/state approaches)*
4. *Conduct outreach to recruit community doulas, grow the community doula workforce, and educate the community about the role of doulas, community doulas in the birthing process*
5. *Monitor HWHB mini-grant funded pilot programs and get updates on progress, accomplishments, and barriers*
6. *Establish partnerships with health systems and health care providers to promote awareness of and advocacy for doulas*
7. *Develop a plan for the funding sustainability to include Medicaid reimbursement*

**Group discussion question: What would participants like to see prioritized?*** Johns Hopkins has had a model where nursing students can take classes to become doulas. Have put together a semester-long course for doula training to be birth companions that is now in use in DE. Trained but the certification would be separate and come after if they continue. This model includes 7 weeks of classes, 2 hrs./week delving into issues and resources. Students are paired with a parent and with a backup so that there’s always someone providing support. This model includes at least one postpartum follow-up. This program has been well-received by students and embeds health equity.
	+ Maybe a student could join one of the meetings to discuss their experience in the program.
	+ Just had an information session with UD to talk about their experiences
* Members of the group want to see actionable steps and see this move forward (do not need more pilots for paying for doula services but want to ensure we move forward with urgency and with a lens of equity).
	+ VA covers doula care at $898 for women in Medicaid; important not only that women have access but that doulas are adequately compensated. As we see from work of Rachel Hardemann, Ancient Song, cultural congruence and adequate payment are key.
		- MN and NY were paying $300, no relation to cost of living
		- Baltimore program wasn’t paying women to do required practice in the community, requiring Black doulas to do unpaid labor, not an acceptable model
		- Predominantly white institutions across the country with hospitals doing voluntary doula training and students and volunteers don’t look like the community; how do we address the needs of the community if students don’t reflect the community they’re serving? Must center and support the needs of Black birthing people. At every opportunity we must be rooted in centering the needs of clients.
		- Need to see doulas get paid fairly
		- Potential models to consider include VA, NY, MD, CA, MN
* Members question how we will start working through these goals? We need to think through how/whether we need to certify people, what are we going to do re doulas who are currently practicing?
* We must consider what each state has done re: certification and reimbursement
* Certification: need to look at what is accepted and what isn’t (this gets to the heart of a lot of the key issues). States sometimes go with big organizations who have extensive, expensive certification programs and aren’t necessarily culturally competent. This is not always a good fit for community doulas and would potentially exclude women who are currently participating as doulas, and instead favor white doulas.
	+ NJ requires NPI numbers and monthly training webinars which doulas didn’t necessarily find was adding something useful.
	+ There is no national certification; this is a tricky issue
* Could consider inviting Nikita Lee from Richmond VA or Ancient Song in NY/NJ – could talk with them about how they went through the process in their states.
* Members expressed the need to make sure to listen to women in the community whom we serve. On Medicaid reimbursement process:
	+ States that have covered doula services in Medicaid have all faced challenges leading to low participation, e.g., narrowly targeting the benefit so that it’s not reaching enough people
	+ It would be great to hear from VA who is working on a paper. Some members have been in touch with Medicaid agency colleagues in VA.
	+ Let’s not reinvent the wheel, but every state’s Medicaid program is different. We need to make sure we maximize the services we provide and comply with the program requirements to get the federal match (we need to make sure to follow CMS structure).
	+ Have started talking with doulas and are happy to have further conversations with anyone else in doula community who would like to.
	+ Want to set up a program that can succeed; want to avoid preventable pitfalls. Really want to collaborate.
* A few members expressed the need to conduct outreach, recruit community doulas, and to educate about what community doulas do. That can be part of this work too. Talking about a day during Black maternal health week with a focus on education, showing Black birthing people the role of doulas so that’s more of a conversation in DE. Will need to do that at the same time as the work on reimbursement and other issues.
* Next steps include to look at other state best practices on qualifications but also what DE would need to make reimbursement happen.
	+ DMMA has some of this information. Is this the venue for those discussions or is it a smaller workgroup that can move these things along. Once every 2 months would result in a longer timeline. Smaller group meeting monthly?
	+ Important to ensure that all stakeholders are included in the smaller workgroups, so that the outcome works for everyone who should have input, e.g., doulas.
 | On-going |  | On-going |
| VI. Next Steps  | Create a timeline with milestones and finalize the strategies that need to be prioritized for this group  | On-going |  |  |
| X. Adjourn-ment  | There being no further business before the Committee, the chair adjourned the meeting at 3:00 pm. | No further action required |  |  |

 **Minutes prepared by: Akiba Drew and Diana Rodin**

 **Minutes reviewed by:**

 **Minutes respectfully submitted by:**

 **Minutes reviewed and approved by CHAIR:**

**Upcoming Doula Ad-Hoc Committee Meetings via Zoom. (Zoom invite to follow):**

* **Tuesday, January 25, 2022 1:30 – 3 pm**