Toolkit for Partnership with Community Based Doulas in Clinical Settings

CLINICAL SCHOLARS

A Robert Wood Johnson Foundation program

Toolkit for Partnership with Community Based Doulas in Clinical Settings

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ABOUT

This toolkit can be used to guide the development and implementation of community-based doula programming into clinical settings specifically to prevent maternal and infant mortality inequities in Black birthing families.

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Executive Summary

This Toolkit is a Heartfelt Tribute to the Memory of Nikita Smart
A courageous visionary who dedicated her life to advancing equitable and just healthcare for pregnant and postpartum families through her pioneering doula work. Her bold ideas and unwavering advocacy serve as a constant source of inspiration for our ongoing efforts. May her enduring legacy in the field of doula work continue to guide us.

Community Based Doulas: Reducing maternal and infant health inequities by institutional and community partnership.

High infant mortality (IM) and maternal mortality rates (MMR) continue to reflect the poor health of our nation. The US now claims the highest MMR in the industrialized world, with Black American women having MMRs 3-4 times higher than their white peers regardless of education, income, or other socioeconomic indicators.[1] Marked and persistent racial and ethnic disparities in IM/MM exist, disfavoring Black women and infants. In many areas of the US, IM rates for Black women are twice as high as those rates for white counterparts. **The 2013-2017 IMR in Buncombe County, North Carolina was 19.6 – nearly four times the IMR of white infants.**[2]

The mechanisms that lead to racial disparities in IM and MM are complex and multifactorial, and the toxic stress experienced by Black families due to racism seems to be a key mediator. Reasons for the wide racial disparities are not fully known, but institutional racism and implicit bias of providers are key factors. We must address institutional racial biases and structural forms of discrimination to reduce these racial inequities. To change outcomes and close the gaps in health conditions like IM and MM, racism must be dismantled. While many organizations undertake this type of work, there have been barriers to scaling up and spreading evidence-based strategies to reduce IM/MM. Some models only address the individuals' social needs while others initiate interventions that are not informed by the families and communities experiencing the poor outcomes.

This toolkit describes the partnership between Mountain Area Health and Education Center (MAHEC) and Sistas Caring 4 Sistas (an established community-based doula program) in Asheville, North Carolina, and University of North Carolina at Chapel Hill (UNC-CH). It can be used to guide the development and collaboration between healthcare clinics and community-based doulas to promote better maternal and infant health outcomes and to address the profound inequities of Black maternal and infant mortality in their communities. As clinical practitioners providing safety-net obstetrical care to the pregnant individuals of Western North Carolina, it is imperative to acknowledge structural and institutional racism as the root cause for inequities in maternal and infant mortality rates. Our Wicked Problem Impact Project addresses health disparities and seeks to improve maternal and infant outcomes by:

- Eliminating infant and maternal mortality inequities in our region, across the state, and beyond
- Solidifying a framework for racial health equity in our clinic
- Increasing access to and support for community-based doula programs

By incorporating racially and culturally concordant community-based doula care into our healthcare system, we strive to promote healthy outcomes for birthing families. This toolkit explores how we have approached this project, what we have learned thus far about partnership and collaboration between a healthcare institution and a community organization, and sustainability of efforts to disrupt Black maternal and infant health inequities in collaboration with community leaders.

Planning

Supporting a Community Effort

Our project arose in response to a need identified by members of Pisgah View Apartments, the largest subsidized housing development in Asheville. Through a Blue Cross Blue Shield Foundation grant, our clinical and community partners met with Black community members living there to:

- **Establish trust**
- **Foster communication regarding health needs**
- **Address structural causes of inequity**
- **Identify potential solutions for needs and concerns**

Most of these conversations occurred over lunch at picnic tables in Pisgah View. We intentionally slowed down and did not rush to offer our own solutions. We listened as these community members expressed a community-driven desire for better experiences and better outcomes for their mothers, children, and families. Through a Mother's Day event in 2016 at the Pisgah View Community Center, community leaders at those picnic tables were introduced to the doula service profession. As Black mothers, these community members reflected on their own births. Most of them shared negative experiences both with the support they received and in their individual poor obstetric outcomes. At those same picnic tables, members of the core collaborative team identified doula support as a strategy to combat health inequities for Black birthing families.

After launching a doula training in partnership with a local doula organization, Homegrown Families, the newly trained doulas continued to participate in the Mothering Asheville Collective. This was a partnership of community members, community-based organizations and healthcare institutions working on racial equity in Buncombe County. Together we created a sustainability plan for the newly trained doulas, then called the Pisgah View Apartment Doulas. The chair of Mothering Asheville (another community-based organization serving families in our community) met with departmental leadership at MAHEC and identified additional opportunities to sustain this work by offering employment at MAHEC through grant funding from the Blue Cross Blue Shield (BCBS) Foundation.

In 2017, the Pisgah View Apartment Doulas became Sistas Caring 4 Sistas (SC4S), and an innovative approach to tackling racial health inequities in Buncombe County was born! Through the commitment and passion of four pioneering Black women, this program was built *by* the community *for* the community. Mothering Asheville continued to explore capacity building pathways for the doulas such as childbirth education training, lactation peer support specialist training, and substance use disorder support to meet the evolving needs of families in the community.

Currently, MAHEC refers pregnant families to SC4S to receive community-based doula services. SC4S doulas offer pregnant and postpartum families physical, emotional, and educational support (including continuous labor support), and advocacy for their holistic healthcare needs. Through the prenatal period, doulas build relationships and provide evidence-based information to their clients and their communities. MAHEC partnered with the BCBS Foundation to offer this no cost doula service to clients who meet evidence-based referral criteria.

MAHEC

SISTAS CARING 4 SISTAS
Community Based Doulas for Social Justice

Research On Continuous Labor Support and Doulas:

- Supported by the American College of Obstetricians and Gynecologists
- Decreases the risk of c-section by 39%
- Lowers infant risk of low 5-minute Apgar score by 38%
- 34% of doula clients report fewer negative birth experiences
- Increased rates of breastfeeding
- Beneficial, protective outcomes for a population experiencing health inequities

Source: Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 2017, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6.

In Western North Carolina, doulas have historically been white women employed by white clients from middle income families. Doula fees typically range from $800-$1500—a cost-prohibitive expense for many birthing families in our region. By recruiting, training, and employing Black doulas from their own communities, it provides racially concordant care, creates social capital, and garners respect within the communities they so diligently serve. Doula participation in this proposed program is integral as their involvement enhances trust, communication, and participant compliance throughout the course of the intervention. These doulas may be better accepted by Black birthing people because they share similar backgrounds, life experiences, and neighborhood social networks.

Our goal is to eliminate the infant and maternal mortality inequity in our county and our state by strengthening the established SC4S community-based doula program, create “clinical shift” by preparing the health system (both hospital and clinic) to support and fully integrate SC4S (including important racial equity training that grounds this work), and giving resources to other communities who are interested in utilizing doula services as a multi-prong approach to creating change in our maternal health.

Project Team

Dolly Pressley Byrd, PhD, CNM: Project Director

Amanda Brickhouse Murphy, CNM: Project Director

Crystal Cené, MD, MPH: Health Equity Researcher, Implementation Scientist

Beth Buys, MD: Department Chair, MAHEC OB/GYN

Nikita Smart: Director of Operations, Certified Doula, and Peer Breastfeeding Support Specialist

Cindy McMillan: Director of Education and Marketing, Certified Doula, and Expert Consultant

Wakina Norris: Director of Mentoring, Certified Doula, and Peer Breastfeeding Support Specialist

Chama Woydak: Clinical Doula Coordinator, Program Manager, Doula Trainer, and Strategic Advisor

Mimi Healy: Project Manager

Key Skill Sets

There were several key skillsets that supported our project's development. Most importantly, we built our work on a foundation of community connectedness. Mothering Asheville has longstanding partnerships with community and public health organizations. One of our Project Director's was active within Mothering Asheville and served as a liaison between the academic, institutional, and community partners. Our team identified operational skills to understand and develop processes that were both beneficial for SC4S and health care institutions. Flexible budgets were created to meet the changing needs identified by the doulas. Strong communication skills were essential, especially in relation to having crucial conversations and communicating with academic and non-academic partners. Clinical Champions who understood the role of doulas and how to integrate them into the healthcare team were recruited, and referral processes were developed.

Moving at the Speed of Trust

Given the history of institutional mistrust informing how families engage with pre and postnatal health care, we felt it was important to support SC4S's vision of community partnership while bringing cultural humility to our care. For successful community partnership it is critical that both individuals and institutional systems are on a path to learning and understanding their own role, privilege, power, and complacency. It is vital that the institution both recognize and plan to address:

White Supremacy in Healthcare

- Social construct of race: We acknowledge the decades of research that proves that "race" is not a biological construct. It is a socio-political construct; a human classification system created for economic reasons to justify the continued enslavement of Black people. Race is a marker of exposure to structural racism and is primarily marked by skin color. Within the medical system, the poorer outcomes for Black patients across all outcome measures are not based on biological or genetic risk factors. Poor outcomes for Black patients are directly shaped by over 400 years of policies, practices, and laws that de-valued black lives and black people's suffering to maintain a system that privileged white people (white supremacy). Health care providers, scientists, and researchers actively participated in and benefitted from the suffering and harm caused to black people because of white supremacy.
- Historical understanding and context for mistrust in physicians and providers: This mistrust is due to multiple historical atrocities that causes toxic stress for patients relying on care within this system. Toxic stress is being in a state of "fight or flight", a mode which can cause weathering effects on the body–like constantly revving up a car engine. The hormones that are high during this fight or flight state are the same hormones that cause preterm labor. Preterm deliveries are the number one cause of infant mortality. Clinicians need to understand that care settings (e.g., clinic, hospital) can causes some of this stress individuals experience and its weathering effects. Healthcare institutions should provide training for clinicians and staff surrounding implicit bias and how it perpetuates and exacerbates racism- the root cause of health inequities in maternal and infant outcomes.

Healthcare System Collaboration with Community Partners

- Anti-racism in action: This is one step beyond Equity, Diversity, and Inclusion (EDI) work in an organization. It is a process of actively changing the policies and practices perpetuating racism at the institutional and structural levels. It is critical to have buy-in and partnerships across departments (Risk and Compliance, Talent Management, Ob/Gyn, Family Medicine) and organizational leadership to recognize, address, and dismantle gatekeeping policies and procedures that contribute to mistrust by communities.

- Healthcare institutions must invest in supportive infrastructure: provide doula uniforms, badges, office/administrative and storage space, computers, cell phones, gas cards etc.
- Healthcare staff education and orientations to educate teams about doulas and their roles: include printed materials in offices and hospitals, give presentations at staff meetings, make pre-recorded educational videos, etc.

Establishing Trustworthiness as an Institution or Healthcare System

- "Show up" and create true collaboration: Working towards being trustworthy as individuals and within a system are intertwined but are also different.
- Identifying community leaders and valuing the expertise they bring: This includes forging relationships with leaders within communities, attending listening sessions, funding community time, and creating shared language and understanding of context.
- Capacity building: SC4S incorporated and became an independent 501c3 organization. At the time, this transition was complicated as the doulas transitioned from healthcare institution employees into an affiliate relationship.
- Being trustworthy is the work of both institutions and individuals working within those institutions. Being trustworthy requires you to address the "institutional gatekeeping" that often results in power hoarding (by institutions), rather than power sharing with community-based organizations. While we understood the importance of sharing power, we were quickly confronted with the difficulty involved in doing so–especially when dealing with "wicked problems" that have structural racism at their core. Healthcare institutions often have many policies that are not easily explained or transferable to community organizations.

Funding

SC4S was built from braided funding across several foundations and community partners. This shared vision served as a catalyst to bring many public health organizations and our health care clinic together to bring the idea to life. Importantly, these different community partners represented many different sectors, and were leveraged for additional project resources and expertise. This collaborative approach ensured intersectoral collaboration, mutual benefit, and program sustainability. In short, funding was used strategically to transform community partnerships in ways that accelerated the possibilities of sustainable, systemic change toward the shared mission – to promote equitable outcomes for Black birthing families and to help build a culture of trusted health care.

- **Mothering Asheville:** Funded by BCBS Foundation and was pivotal in setting up the framework for this community work. Using the community-centered health approach, Mothering Asheville is working to reduce, and ultimately eliminate, racial disparities in infant mortality by changing institutional policies to address structural racism and increase access to preventive services in community-based settings. The collaborative, working in partnership with a safety-net obstetrical practice, developed a doula program that employs women from the community most impacted by infant mortality in the Buncombe County area.
- **BCBS Foundation:** Pivotal in funding this work with supporting the initial doula salaries and began the process of capacity building and financial sustainability for the program.
- **Institutional (MAHEC):** Funded a Clinical Doula Coordinator and Project Manager for program.
- **United Health Care:** SC4S participated in a pilot doula reimbursement program in which United pre-paid funds for doula services.
- **PCORI:** UNC partners received a $10 million PCORI award for a project entitled “Accountability for Care Through Undoing Racism and Equity for Moms (ACURE4Moms). Amanda Brickhouse Murphy, Dolly Pressley Byrd, and SC4S doula Cindy McMillan are co-investigators for the subaward. This award will fund interventions to evaluate improvement in health outcomes for Black women and infants in North Carolina and will pair racially/ethnically/culturally concordant community-based doulas with 20 practice site partners across the state.

Community Partnerships

Community partnerships can be the backbone to reducing health inequities among historically marginalized populations. However, these partnerships require consistent fostering, and it can be challenging to navigate the various cultural, organizational, and accountability issues these relationships can encounter. Our primary partnerships were with SC4S and the Mothering Asheville collaborative. These partnerships were key to our growth, learning, and successes in integrating doula services into our community health care clinic.

In a systematic review of the impacts of collaboration between local health care and non-healthcare organizations, 29 studies reported on factors shaping the success and functioning of organizational collaboration.[4] This included factors related to collaboration aims and motivation, resources and capabilities, cultures and relationships, governance, and leadership. These factors can overlap and interrelate, and sometimes come into conflict.

QUESTIONS TO CONSIDER FOR A COMMUNITY DOULA COLLABORATION

Motivation and Purpose

- What are the organization's vision and goals for integrating community-based doulas into maternal health services?
- What are the perceived benefits and barriers of this type of collaboration?
- Who are the key stakeholders responsible and accountable for making decisions about incorporating doulas as members of the health care team? They should be engaged early and often to ensure strategic alignment.
- Who will control the narrative of the partnership? What is your plan for both perceived and real tokenizing?
- What is both the short-term and long-term commitment to this partnership and services? How will you advocate on behalf of the community members for community capacity building, clinical care shift, and regional or state policy change?

Governance and Leaderships

- Who is going to be a part of the decision-making processes? And what weight will those decisions hold? How is this connected to the visions and goals of the services?
- How is the institution going to provide leadership support for all involved?
- Does your organization have experience with shared leadership with community partners?
- Will other departments such as Risk & Compliance, Talent Management, and Executive Leadership be on board? Have their concerns been heard and addressed?
- What is the implementation plan to incorporate doulas as valued members of the care team for both the internal clinic and external public education entail?
- What measures will senior leadership implement to ensure that doulas are recognized and appreciated as integral members of the healthcare team within clinics and hospitals?

Resources and Capabilities

- How will gatekeeping of institutional resources (including grant funding) be addressed?
- What kind of processes and infrastructure will need to be created? Will your organizational leadership be supportive of these changes at a policy level?
- If doulas will be employed by the healthcare institution, how will they be sustainably compensated for the care they deliver?
- If doula care is an affiliate service, how will referrals to these services be made?
- How will power be shared across program implementation, and who will be responsible for monitoring, advising, and feedback for course correction?
- What are the current staff skills and capacity to support an integration of community-based doula and clinical services?

Relationships and Cultures

- Does the organization offer ongoing anti-racism education and skills training for clinicians and trainees and is racism acknowledged as a root cause of maternal health inequities?
- Relationships take time… How much time can be allotted to creating partnership before any work actually begins?
- What does true cultural humility look like in an academic and clinical setting? How will you address differences in communication styles and approaches to complex problem solving?
- Who decides and manages the roles and responsibilities across teams, and how does this relate to decision making and accountability?

Project work

Our project began with community listening sessions related to concerns and needs of families living in subsidized housing. Doula training as an intervention to support Black families receiving prenatal care at MAHEC was born from those conversations. Subsequent educational offerings included tobacco cessation specialist training, peer lactation training, childbirth educator training, and an employee partnership between the core doula team and MAHEC. Four Black doulas were onboarded as employees and paid a living wage to provide support services to at-risk patients in MAHEC. Within 5 years, these community-based doulas were able to learn and grow into their own 501c3 non-profit organization and continue their relationship with MAHEC as an affiliate organization.

This was a groundbreaking journey of capacity building, clinical shift, and ultimately policy assessment in our institution. This is the work of partnering, which is not always easy, but the rewards are life saving for our community. Based on our experience below is a list of considerations and conversation to have ahead of any formal agreements made with a community-based doula organization. This list is not exhaustive and there might be more topics to discuss as needs arise.

CAPACITY BUILDING	COMMUNITY EDUCATION	CLINICAL SHIFT	POLICY CHANGE

Capacity Building: Initial Training and Sustainability Plan

The initial cohort of doulas were trained at Pisgah View Apartments in 2016. After the initial training, a mentoring program was set up with a community partner, Homegrown Families where the newly trained doulas could attend their first births and take their first private hires with the support of experienced doulas. From there, fundraising began to pay the doulas so they could attend births for community members that could not afford to pay for these services. From the original 6 doulas trained, 4 went on to become certified doulas through DONA International. To increase access and bring sustainability to these much-needed services, MAHEC received funding from BCBS Foundation and brought the doulas on as employees.

Marketing and Community Education: Community Utilizing Services

Many community members (including SC4S doulas themselves) had not heard of doula services before and therefore did not know how to utilize these services. The next step was to create education both in the clinic to providers and local hospitals through medical resident education, practice managers meetings, and Ob/Gyn grand rounds. Community education consisted of doulas tabling community events, food pantry pop-ups, community meetings, flyers, and news articles.

Clinical Shift

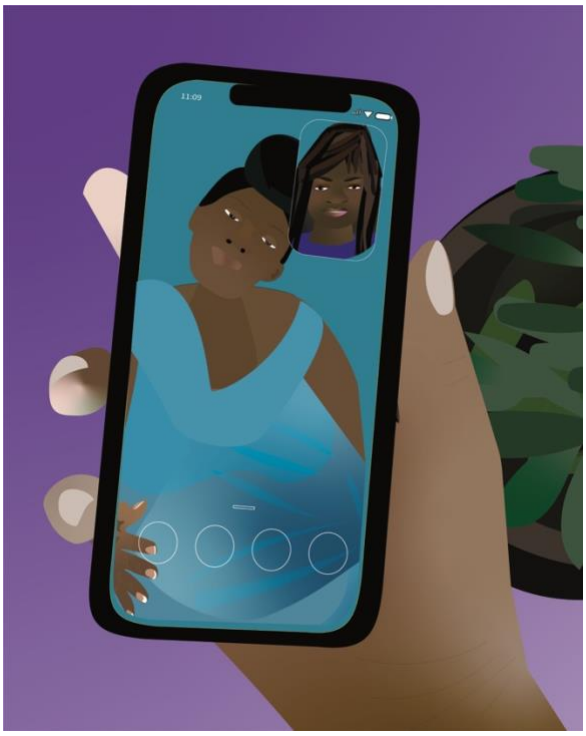
Our clinical shift is more than integrating doulas into clinical care and making space for their presence, it is also equally as important to listen to feedback from the doulas on the quality of patient care from their perspective. MAHEC in partnership with SC4S created a once-a-month “clinical shift” meeting in which the doulas would bring their patient experiences to clinical members of the OB/Gyn team for feedback regarding racist behavior towards Black families that included biases in care, selectively enforcing policies, and the overuse of routine technologies and interventions. This in turn would result in a ‘shift’ in the way our providers were delivering care. This could include centering informed choice by providing more information surrounding an intervention, or implicit bias trainings for providers to support them in providing equitable care.

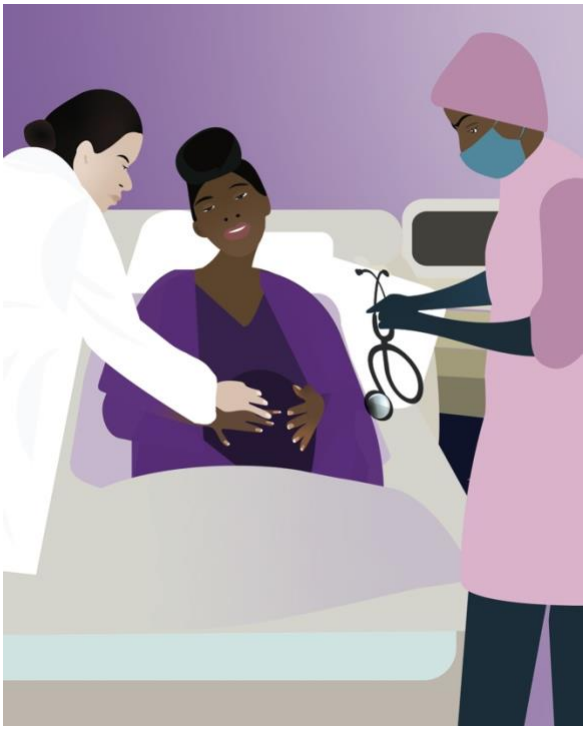
Policy Change

Substantive policy change proves to be the most challenging yet rewarding step in the process of true community partnership. It is imperative to identify and address institutional policies that reinforce precedence over true community collaboration. Additionally, advocate for policies at the state level that ensure the implementation of doula work that is sustainable and does not contribute to barriers to or exclude doulas looking to join the workforce.

The table below is an outline of two different models that Community Based Doulas can work with an OB/GYN healthcare clinic or organization.

ITEM	EMPLOYED	INDEPENDENT NON-PROFIT
Office space to meet with clients	Designated part of OB/GYN clinic space	Need contract and fair market value to lease space and meet compliance protocols
Referral system	Ability to work within internal referral system for client communication that is HIPAA compliant	External system that is HIPAA compliant and ensures appropriate information
Data collection	Patient lists and outcomes are part of the organizational data	Keep own data and outcomes in HIPAA compliant database
Data sharing: Have a written agreement on details	HIPAA compliant database for clients served	HIPAA compliant database for clients served Fee/patient for maternity neighborhood to have list of patient with data
Badge access to office space	Granted as employee status	Possible with contract and affiliate status
Meeting requirements of employee status	Comply with organization protocols for background check, immunization, OSHA training, etc.	Only need to meet affiliate status or community partner guidelines
Marketing	Comply with organizational language, message, and marketing oversight	Able to create own message
Fundraising/ Gatekeeping of Funds	Money raised through philanthropy comply with organizational guidelines and spending requirements	Able to fundraise and spend as desired
Grants	Apply for grants with guidelines, overhead, compliance procedures of organization	Can partner with organization for grants, some funders offer grants only to large organizations. Must have contract with organization for the deliverables of the grant.
Salary	Per organization and benefits	Per non-profit status, may not have benefits
Intellectual Property	As employees anything created as an employee is the property of the organization	As an affiliate non-profit, anything created in conjunction with the health care institution will need clear co-collaborative agreements





L and Quan's Story

I met L on a busy Thursday afternoon when she walked in complaining of lower abdominal pain. She was 26 weeks pregnant and had not been seen since her first prenatal visit at 13 weeks. She was very resistant to talk and seemed impatient, ready to walk out at any moment. As I evaluated her for the pain, I asked her if she had ever heard of a doula. She acknowledged that I said something, but there wasn't any discussion. It was weeks later that I learned she had connected with Nikita, a SC4S doula.

Nikita convinced L that I was a trusted provider, and she began seeing me for some prenatal visits. L did not trust healthcare organizations, especially the hospital, and told Nikita she had originally planned to give birth at home because of this. She was diagnosed with pre-eclampsia, a dangerous condition requiring a hospital admission for delivery with multiple interventions. She considered declining admission, placing her baby and herself at high risk.

It was Nikita who convinced her to be admitted, and her induction process was initiated… slowly. It took much time with each step for her to feel comfortable with the information she had and the role she was able to play with every decision. Nikita was there supporting her with her decisions and the discomfort of labor from the beginning to end – 3 days total – before her beautiful, healthy son, Quan, was delivered vaginally. Her son is now two years old, and she still communicates regularly with Nikita.

Evaluation and dissemination

Community-based doulas are being increasingly sought out as a way for the health care institution to address infant and maternal mortality disparities. As doula work is scaled across North Carolina, MAHEC is interested in understanding how community-based doulas impact health outcomes. Our evaluation efforts include:

1. **Developing a survey to measure patient satisfaction to be administered to patients that received doula services.**
2. **Collecting de-identified client-level data monthly to look at birth and other outcomes.**
3. **Creating a survey to be administered to clinical staff evaluating effectiveness of doula support and collaboration.**

Below you will find a list of assessments that can be administered to clients or clinicians:

- Mixed methods (quantitative and qualitative) evaluation: Data on referrals pipeline: referrals made, referrals accepted, doula births attended, comparison of outcomes (e.g., C-section, breastfeeding initiation rates, NICU admission, etc.) with and without doula presence for doula services.
- Patient experience and satisfaction: Based on surveys and testimonials
- Clinician satisfaction survey

Findings

Since October 2022, the SC4S doulas have:

- Provided labor support to 35 MAHEC patients resulting in 25 vaginal deliveries.
- Of those 35 deliveries, only 3 infants were admitted to the NICU.
- 8% of all births at MAHEC were attended by community-based doulas during that time.

Beyond these numbers it is important to note how patient satisfaction plays a role and these evaluations are ongoing.

Dissemination

During the project, our Clinical Scholars team has been approached to present at various places. We strive to collaborate with and include our SC4S partners for these events. Some examples include:

- Members of the Clinical Scholars team participated in the *2021 MAHEC African American Health Symposium*. Team member Amanda Murphy introduced the SC4S team and moderated their presentation. Additionally, team member Crystal Cene gave a separate presentation entitled “Advancing Equity & Dismantling Structural Racism: The Courage to Lead”.
- Core team members Amanda Brickhouse Murphy and Dolly Pressley Byrd have paired with SC4S doulas Cindy McMillan and Nikita Smart (deceased 08/21/23) to co-lead Maternal Health Equity & Education trainings for the ACURE4Moms project. These provider and doula pairs are traveling to 10 obstetrical practice sites throughout Western North Carolina to educate clinical teams regarding maternal and infant health disparities, benefits of community-based doulas, and incorporation of doula care into their practices.
- Beginning in Fall 2020 Dolly Presley Byrd, Amanda Brickhouse Murphy, Chama Woydak and the late Dr. Bill Gist has developed an innovative core curriculum centered around Implicit Bias Simulations for Medical Learners. This curriculum is being integrated into both faculty continuing

education and resident training programs, reflecting our commitment to cutting-edge education in this crucial area.

- During the period spanning August 2019 to March 2023, the core team actively engaged with CityMatch Birth Equity—a prominent national consortium comprising city and county health departments' maternal and child health (MCH) programs, along with leaders advocating for urban communities across the United States. Throughout this collaboration, our team diligently contributed to shared initiatives aimed at advancing equity, enhancing outcomes for maternal and infant health, and fostering the overall well-being of urban pregnant and postpartum families and communities.
- RWJF From 2029 to 2022 the Robert Wood Johnson Foundation Cross Sector Innovation Institute brought together members of the Clinical Scholars Team along with Sistas Caring 4 Sistas to build stronger, more sustainable connections to better meet the goals and needs of our community and ultimately improve health equity.

Lessons Learned

Differences in a shared understanding of purpose, inequitable distribution of power and resources, and a lack of alignment in communication between our institution and community-based doulas were identified as some of our top barriers to trustworthy collaboration. Although we had good intentions, it was important to remember that intentions do not equal impact. Historic relationships between our community and health care clinics in the past play a role in our partnership's development in the present. From lack of trust to cultural and professional differences with our community partner, the stones we tripped over allowed growth and a new level of relationship with community-based doulas that went beyond transactional and has become transformational**.**

Tripping Stones and Solutions

Due to a lack of clarity or explicit discussion of our sponsored programs and the financial impact of these grant agreements, a breakdown of trust in the relationship between the MAHEC team and community leaders ensued.

- Solution: Understanding the intersection between trust (a psychological state) and trustworthiness (the qualities that make our organization worthy of trust). There is a need to acknowledge mistakes, apologize, regroup, and gain a collective envisioning of how to move forward together.

There were cultural and professional differences. The organizational workflows, policies, and practices were new, complex, and often not in harmony with true community partnership. The quality and differences in communication affected various other factors such as trust and understanding between community-based doulas and MAHEC.

- Solution: Creating space for collective involvement of organizational leadership through a bi-weekly department wide SC4S operations meetings inside of MAHEC. This meeting was able to shape how our employee to affiliate collaboration could effectively function.

Finally, there was a lack of institutional equity work across departments or within organizational leadership before welcoming **our** community partners**.**

- Solution: Equity amongst organizational leadership and across departments is essential for community-engaged partnerships to be ethical and effective. Our program leaders realized the limitations of inequitable traditional power hierarchies and their impacts on community-professional relationships and worked actively to minimize their impacts.

Successes

- **Increased visibility and awareness of doula services:** 114 Clients had at least one connection with a community-based doula from 7/2021 - 6/2022. SC4S doulas partnered with clients in prenatal care, labor and delivery, and postpartum care. Hospital staff as well as providers incorporated referrals to SC4S into care plans. Clients and healthcare providers expressed appreciation and satisfaction for the value added by SC4S.
- **Medicaid transformation begins:** Increased Reimbursement for Doulas from $600 up to $1200 per Birth by some of the Medicaid providers. Effective advocacy ensured that Medicaid providers included doula services in reimbursement strategy for births in NC. This was a huge success in the integration of doula services and groundwork for sustainability of doula care.
- **Hosted 6 clinical doula debriefs between 7/2021 - 6/2022:** One of the key features of integration of SC4S into the healthcare team was the clinical debriefs. These were hour long discussions with CNM's, physicians, and doulas to review patient experiences. The sharing of doulas' perspectives while care providers listened was an opportunity for relationship building, information sharing, and trust building.

Shifts in Thinking

We initially aimed to create infrastructure to scale our small community-based doula program across the state to reach populations with limited access to community doula services. Other research funding prompted us to reconfigure our own relationship with our community-based doulas and the process of dismantling the root causes of Black health inequities. As a team, we realized we needed to continue to do our own work and "get our house in order" to ensure that programming was truly community centered, collaborative, flexible, and responsive to community and doula feedback.

- We recognized the need to shift to asset based language and approaches in maternal and infant mortality rather than deficit narrative language to describe the changes that needed to happen to support Black birthing families in having the best possible outcomes. This change puts the onus on the institution to create change rather than the Black birthing families experiencing harm.
- Based on the recent article by Tamari Macon *Language Matters: Why We Need To Stop Talking About Eliminating Health Inequities*, "the language of "eliminating inequities" centers Whiteness, is mathematically ambiguous, and emphasizes individual-level solutions."[5] We realized that instead of thinking about closing inequities, we could strive to improve outcomes to an ideal, yet possible, community-established standard defined by the community.
- As clinicians and institutional leaders, we realized that we needed to shift our power towards creating more truth and transparency within our current systems and advocate for deconstructing and rebuilding our institutions to better meet the needs of the community.
- Working to dismantle racism and other systems of oppression is emotionally, mentally, spiritually, and physically taxing. Individuals who do this work - particularly those from marginalized or minoritized backgrounds- who themselves are simultaneously victims of the system and warriors against it, may be at high risk for succumbing to the toxic stress involved in this work. This stress may exhaust one's resilience resources and lead to negating, potentially harmful coping mechanisms. Therefore, it is crucial to be intentional with self-care, closely monitor your own mental health, and build and maintain a community of trusted people (personally and professionally) around you that you can rely on as resilience resources.

Recommendations

We share our experience through this toolkit as an encouraging example of institutional partnership with a community-based doula organization. We hope this toolkit can be useful to Ob/Gyn, Family Medicine clinics, and hospital systems providing primary care to all families. Dismantling systems of oppression from an institutional side is messy work at best, and we do not claim to have a prescriptive template but rather an encouraging example to inspire change in your communities.

Getting Started

One crucial aspect is the importance of organizational leadership support and a willingness to approach the discomfort of change. Strong leadership support is essential for the successful implementation and sustainability of a collaboration. Leadership support sets the tone for the organization, fostering a culture that values and recognizes the contributions of community-based doulas. It helps overcome any resistance or skepticism from staff members, facilitates resource allocation, and promotes necessary policy changes to accommodate the partnership. By prioritizing and championing the inclusion of community-based doulas, organizational leaders demonstrate their commitment to patient-centered care and holistic support for expectant families, ultimately leading to improved birth experiences and better health outcomes.

When initiating a partnership with community-based doulas as a healthcare institution, it is imperative not to approach the partnership with a top-down or paternalistic attitude. Instead, foster an environment of mutual respect and value the expertise and knowledge that community-based doulas bring to the table. Recognize community-based doulas as partners in the health care team and involved in decision-making processes that affect the role and responsibilities.

It is critical not to underestimate the administrative and logistical support required for the partnership. Lack of clear communication, inadequate resources, or insufficient training can hinder the integration of community-based doulas into the healthcare system. Provide the necessary infrastructure, education, and ongoing support to enable doulas to perform their roles effectively. Regular communication channels and feedback mechanisms should also be established to address any concerns or challenges that may arise during the partnership.

Each member of the team is recommended to acknowledge their personal needs for self-care to maintain resilience in the work or project. Acknowledging previous traumas, issues that are triggers, and responses under stress is critical to on-going work.

Best Practices

Our team recommends the following:

1. Embed evaluation tools from the beginning and throughout the partnership. This will usually require a formal agreement with the community-based doula organization related to data sharing. These evaluation tools could include patient satisfaction surveys for clients receiving doula care and doula evaluations of the healthcare team (including provider at delivery, nursing, or clinical staff, etc.). Additionally, we recommend developing a template for doulas to report quantitative statistical outcomes monthly–see Appendix A.
2. Establish channels for referrals and create a process that uses evidence-based criteria to identify and refer patients/clients.
3. Consider sustainability and join advocacy efforts for doula service reimbursement through insurance or funding from large payer sources such as foundations.
4. If the community-based doula group is independent, ensure that your organization's marketing department operates in a way that highlights the services of the doula group itself and does not appear to tout the services as part of its own offerings.
5. In hindsight, it would have been effective to bring in external professional facilitation early on to help bridge the trust breakdowns that occurred between our Clinical Scholar's team and the community-based doula group with which we were partnering. A skilled facilitator- particularly one with knowledge and sensitivity to issues related to power and privilege, equity, and systems of oppression- could have worked with our team over time and it would have helped us better navigate the partnership and collaborate more effectively with our doula partners.
6. When identifying a community organization with which you plan to partner, recognize that while you may have the same mission, your vision or approach to achieve desired outcomes may differ. Work strategically to develop your approaches and ensure they align and/or work synergistically.
7. Meet with your community partner regularly with a clearly identified agenda for the meeting. Value their time and participation.
8. If the community organization is serving in a consultancy role, compensate members for their time and effort.
9. If your community partner represents a population that has been historically marginalized, recognize viewpoints that differ from institutions that are steeped in hierarchy, patriarchy, and structural racism. Don't assume that your viewpoint is the only (or correct) perspective.
10. Develop and discuss an exit strategy at the onset of the project. Unfortunately, not all partnerships persist indefinitely. If either organization opts to exit the partnership, thoughtful discussion from the onset could help foster an amicable end.
11. All members participate in self-care to deal with stress. White people may need to deal with tendencies of "white fragility" or "hero syndrome." Deal with personal implicit bias and risks for falling into patterns that don't support healthy relationships. Members from historically marginalized populations having support should be prioritized and supported by the team.

Appendix

Appendix A: SC4S Monthly Service Report

Month of Service (month, year):							
Total number of clients served (prenatal, postpartum visits, client intake, etc.)							
Delivery Information							
Number of deliveries attended							
	Wks Gestation	Induction (yes/no) Reason/Dx	Delivery Type (vag, c-section, vacuum, forceps)	Birth Weight	Breastfeeding at Delivery (yes/no)	NICU Admission (yes/no)	Interventions (Pitocin, artificial rupture of membranes, fetal scalp electrode, intrauterine pressure catheter, epidural
1.							
2.							
3.							
4.							
5.							
Postpartum Visits							
How many clients attended postpartum visits with doula?							
How many clients attended postpartum visits with OB or midwife?							
Breastfeeding | Lactation Consults							
Number of prenatal lactation consults							
Number of postpartum lactation consults							
How many clients are breastfeeding at delivery/in hospital?							
How many clients are breastfeeding at 4-6wk postpartum visit?							
How many clients are breastfeeding at 6 months postpartum?							

Appendix B: Mothering Asheville & Sistas Caring 4 Sistas Scorecard 2020-2022

Link: https://embed.clearimpact.com/Scorecard/Embed/75029

Appendix C: Doula Services Satisfaction Survey

Link: https://www.surveymonkey.com/r/SC4Sdoula

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