COLORADO
Department of Health Care Policy & Financing
303 E. 17th Ave. Suite 1100
Denver, CO 80203

April 29, 2024

RE: Doula Stakeholder Engagement Deliverables

The following document includes a key deliverable produced by Doulas in Denver, LLC for the Colorado Department of Health Care Policy and Financing. The document represents the findings of a focused stakeholder engagement process that was conducted January-March of 2024. This included a series of hybrid in-person/online meetings and an online survey.

These deliverables have been and will be included in Department considerations of doula policy design. Additional considerations by HCPF include discussions with other state Medicaid agencies, key informant interviews with community partners, negotiations with federal partners, facilitated conversation with the Department's Maternity Advisory Committee, Department systems' possibilities and limitations and adherence to other state, federal and Department policies.

Per SB23-288, the Department will use these deliverables and other listed impacts on policy design to:

> Submit a report to the general assembly as part of the state department's "SMART Act" presentation required by section 2-7-203. The report must include findings and recommendations from the stakeholder process as described in subsection (2) of this section. The state department shall work with the maternity advisory committee to create the report.

That report will be submitted in January 2025.

A key reminder that this document does not reflect any final Department policy decisions and is solely a summary of stakeholder feedback and a recap of the process. We look forward to sharing Department updates tomorrow on enrollment, billing and policy design.

Notably, our stakeholder work is not done. We are grateful for the work of Doulas in Denver and the time, passion, and energy that all our stakeholders brought to each meeting.

Despite the benefit launching in July, we anticipate continued conversations and opportunities for evolving and dynamic policy change in this space to ensure we continue to offer an equitable, accessible and successful benefit to our members. While the Department and our vendor have attempted to solicit feedback from a diverse audience and capture the inherent diversity of opinions, partners are welcome to submit feedback on the content in the deliverable to: hcpf_maternalchildhealth@state.co.us.

Thank you.

Stakeholder Engagement Sessions Report & Findings

Colorado Medicaid Doula Benefit Stakeholder Engagement Project

P24-188173

Prepared by
Doulas in Denver, LLC

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OVERVIEW OF THE STAKEHOLDER ENGAGEMENT PROCESS

Through Senate Bill 23-288, the Colorado Legislature approved funding for a Medicaid doula benefit for eligible Health First Colorado (HFC) members. Doulas in Denver LLC, along with sub-contractors Scott Solutions LLC, TLC LLC, and TLB Consultants LLC was contracted by the Colorado Department of Health Care Policy & Financing (HCPF) to inform the policy of the new Benefit. The contractor designed and facilitated a community-based and equity-driven process to seek input and data from all interested stakeholders. The nine key decision points that were at the core of the engagement strategy were:

- Code of Ethics/Standards of Practice
- Training & Certification
- Reimbursement Structure
- Scholarships
- Mandatory Reporter
- Doula Hub
- Provider Relations and Cross-System Integration
- Doula Referrals
- Member Communications

Equity Principles

Doulas in Denver is sensitive to the complexity and layers of concern around these topics, believing it is crucial to the stakeholder engagement process to remain neutral and recognize the many voices and varying opinions. Doulas in Denver is committed to impartiality and embraces four principles of equity to guide the engagement process.

1. Accessible to all and supporting of all representation
2. Inclusive language and cultural sensitivity
3. Mutual respect and safe space
4. Value individual perspective and knowledge

The above equity principles were addressed in multiple ways, including offering Spanish translation, ADA accessibility, and online/virtual options. Meetings were conducted at public facilities in four locations throughout Colorado–Northern, Metro Corridor, Southern, and Western Slope. Childcare, breakfast, and lunch were provided at no charge to participants and those who were in attendance without requirement by an employer were offered reimbursement for their time in the form of a gift card.

Purpose

The purpose of the stakeholder engagement process was to solicit feedback from a broad base of interested parties and stakeholders for the formation and implementation of the Doula Benefit. The goal was not to find consensus among the participants, but rather, to collect the thoughts, feelings, insights, perspectives, viewpoints, experiences, and expertise of the

participants so that the data could be used by the Colorado Department of Health Care Policy & Financing (HCPF) to create a benefit that was informed by the stakeholders in Colorado.

Objectives

The Engagement Plan outlined four distinct objectives for the project:

1. Identify the stakeholder groups and how best to solicit community engagement.
2. Determine and utilize an effective method to solicit, sort, and record genuine feedback.
3. Assess and evaluate feedback to identify possible considerations.
4. Propose pathways forward to address considerations.

Successful completion of this project will be represented through wide-reaching engagement (geographic, ethnic, and socio-economic diversity, varying professions, multiple languages, and both HFC members and non-members), capturing authentic voice and input from multiple engagement strategies, analyzing of the data to identifying considerations for informed policy making, and completed deliverables.

RESEARCH DESIGN AND METHODOLOGY

A mixed-method research strategy was used to gather both qualitative and quantitative feedback to provide a comprehensive understanding of the complexities and nuances that are specific to the healthcare field and the doula profession. The process provided an opportunity for interested parties to give feedback by participating in one of four hybrid stakeholder meetings, and/or an online survey.

The comprehensive Doula Benefit Stakeholder Engagement Plan consisted of three phases.

1. **Phase 1: Research and Strategy Development:** Background research, identification of stakeholders and sampling method, determination of the meeting content, dates, and locations, and development of a survey tool.

2. **Phase 2: Stakeholder Engagement Meetings and Online Survey:** Collect feedback through the meeting and survey engagement tools.

3. **Phase 3: Final Reporting of Findings, Analysis, and Considerations:** Data compilation, analysis, formation of considerations, addressing limitations, and creation of the Survey Data Summary Report and the final report: Stakeholder Engagement Sessions Report and Findings.

Phase 1: Research and Strategy Development

Background Research: Prior to developing the agenda for the stakeholder meetings and the survey questions, extensive research of existing programs across the US was conducted. There are thirteen (13) states actively reimbursing doula services and eleven (11) more states in the formative and implementation stages. Additionally, the National Health Law Program manages The Doula Medicaid Project (https://healthlaw.org/doulamedicaidproject) and has created a comprehensive spreadsheet of every state's current status and process. Doulas in Denver and its subcontractors reviewed each of the existing state programs' requirements and conducted phone interviews with representatives of state programs and a sampling of doulas from those states to learn more about their programs. Further research included an in-depth review of "The Doula Network" that is currently being used by other states to better understand the logistics and management of the benefit in those states.

Identification of Stakeholders and Sampling Design: The audience for the engagement process was identified (at a minimum) to be: "doulas, obstetric providers, families, and advocates." Because of this requirement, purposive sampling was selected to gather feedback from the audience for whom this Benefit will have a direct impact. (Purposive sampling selects participants based on specific criteria relevant to the research and is utilized when specific expertise is required.)

The contractor expanded the audience to provide an opportunity for related fields to give feedback. The different categories included in the sample were:

- Health First Colorado (Medicaid) Member
- Doula and/or Newborn Care Specialist
- Clinical Providers (Pediatrician, OB, Midwife, Nurse Practitioner, etc.)
- Nurse (RN, BSN, etc.)
- Allied Health Professionals (CNA, NA, Phlebotomist, etc.)
- Other licensed care providers (Chiropractor, Physical Therapists, Lactation Specialist etc.)
- Health Care Administration and Staff (non-medical)
- State Partner or Public Health Worker (WIC, Public Health, Case Managers, etc.)
- Other (please specify)

Participants who engaged in providing feedback throughout any phase of the engagement process were asked to identify with one of the above categories so that data could be analyzed collectively and by specific areas of expertise.

Development of the In-Person Meetings: The Department of Health Care Policy and Financing (HCPF) requested stakeholder feedback on the nine topics listed in the Overview. These topics, along with a description of the Stakeholder Engagement Process, appropriate definitions, and some parameters for participation formed the agenda for the four meetings. The agenda

remained the same for each meeting. To reach as many stakeholders as possible, it was determined that meetings should be spread across Colorado, so four areas were selected– Northern, Metro Corridor, Southern, and Western Slope. ADA-accessible public facilities were selected and times arranged that represented both weekday and weekend options.

A registration process was developed to determine the projected attendance and identify any needed inclusions (childcare and language interpretation) to ensure equal opportunity for participation. Additionally, all four meetings were designed to be offered via an online option with interactive features and a dedicated monitor of the online chat boards. Food suppliers were engaged by utilizing BIPOC/minority-owned, local, small businesses where possible.

Development of the Online Survey: Doulas in Denver utilized the information from the above-detailed research and the nine key decision points to construct the survey questions. (Initially, the design utilized value ranges for items that were designed to measure a quantity, but feedback from reviewers suggested the items be open responses to encourage all ideas.) The survey was reviewed for language considerations–reading level and comprehension–and was translated into Spanish through HCPF. Requested demographic information was collected through the survey.

Additional Meetings: Doulas in Denver participated in a meeting held by the Maternity Advisory Committee on February 27th to gather additional feedback regarding the benefit. This committee is made up primarily of a diverse group of Health First Members, who meet regularly to discuss challenges faced during pregnancy and postpartum as well as to provide input on Medicaid policies.

Phase 2: Stakeholder Engagement Meetings and Online Survey

Outreach to Identified Stakeholders: Various channels including peer connections, organizational partnerships, and personal associations were utilized in an endeavor to reach as many persons as possible. A substantial email and personal calling strategy was employed. The registration information from the last two years of Doula Con - the industry's annual local convention - and Doulas in Denver's and HCPF's extensive contact lists were used to begin the email campaign. An online search using the key terms "Doulas in Colorado," "Doulas," "Doula Services," "Doula Collectives," "Doula Agencies," "Birth Centers in Colorado," "Colorado Midwives," "Colorado Family Medicine," "Women's Health," "Birthworkers," "Colorado OB/GYN's," "Infant Feeding," and "Teen Pregnancy" revealed additional contact points. Facebook and other social media were also used to identify potential groups and individual stakeholders. Where emails were not available, personal calls were utilized to reach the identified parties. Before each meeting, outreach to county-specific entities that provide services to families was made via email or phone. This large-scale effort resulted in over 700

persons being contacted directly, not including those who received the information second-hand. (Further descriptions regarding the sampling population are attached in Appendix B.)

Each of the contacts was encouraged to pass along the meeting information and the survey link to anyone they deemed might be interested or have a stake in this process. The resulting numbers from this residual strategy were not tracked.

Conducting the In-person Meetings: Stakeholder meetings were held in four different regions of Colorado to make them accessible to everyone and to ensure feedback from communities that have high populations of Medicaid members. Participants could join in person or online. (Fig. 1)

Location	**Date**	**Attendance** **IP = in-person*
Pueblo Rawlings Library	January 19, 2024	**Total:18** (IP: 13 Virtual: 5)
Greeley LINC Library	January 26, 2024	**Total: 19** (IP: 12 Virtual: 7)
Denver Denver Health Hospital	February 10, 2024	**Total: 54** (IP: 31 Virtual: 23)
Grand Junction Community Hospital	February 16, 2024	**Total:15** (IP: 4 Virtual: 11)
Total Stakeholder Meeting Participants		**106**

(Figure 1)

On-line participation varied, as some participants only joined for portions of the meetings, some joined for multiple meetings, and others registered but never commented or contributed in the online comments nor completed a post-meeting evaluation.

Each meeting was approximately 5.5 hours in length and had the same agenda covering the nine key decision points.

Feedback from the in-person meetings was collected from numerous resources during each of the four meetings. The meeting was recorded and transcribed using an AI Software called Fathom. Utilizing Fathom, detailed video, audio, and transcribed records of each meeting were captured. Additionally, virtual participation was recorded through three mechanisms: virtual participants were recorded using Fathom, the chat feature on Zoom, and an online Google Jamboard where participants entered feedback, asked questions, and participated in the full meeting discussion. Data from Fathom, the Zoom chat, videos, and the Google Jamboard were compiled.

Breakfast and lunch were provided at no charge to participants and those who were in attendance without requirement by an employer were reimbursed at the rate of $25/hour for their time.

Post-meeting evaluations were emailed to each registered participant, both in-person and online, and asked for feedback about the process and content of the meeting. Information gathered from these evaluations was utilized to enhance each remaining meeting although the meeting agenda remained the same.

Online Survey: Doulas in Denver and HCPF conducted a state-wide survey to solicit feedback on the nine key decision points (as listed in the Overview). The survey consisted of thirty-three (33) questions, was open online from 2/15/24-3/4/24, and was available in both English and Spanish versions.

The outreach strategy (as detailed in Phase 1) was utilized to ensure as many responses as possible, resulting in 207 (201 in English: and 6 in Spanish) respondents. Results from the survey are shared throughout this report in more detail.

The survey had the option for anonymity and was conducted through the survey software SurveyMonkey. It could be printed or conducted via phone to ensure accessibility. However, no paper surveys were received and no phone surveys were requested.

Phase 3: Final Reporting of Findings, Analysis, and Considerations

Findings from the In-person Meetings and Online Survey: Data from the in-person meetings and the online survey are grouped by key topic in the next section “KEY TOPIC FINDINGS.” Within that section, both qualitative and quantitative results are summarized and then analyzed for common themes, disparities and notable open response ideas. Further considerations are also included within this section.

Data that was obtained specifically through the survey is further detailed in the "Survey Data Summary Report." That report was designed to provide a quantifiable summary of the raw data collected from the online survey. Where applicable, the mean (average), the median (the middle), and the mode (most common) for each question were calculated. The Summary Conclusions within that report further recap the data and provide any necessary explanations or insights into possible anomalies in the findings.

KEY TOPIC FINDINGS

Topic 1: Code of Ethics/Standards of Practice

Feedback on a Code of Ethics and a Standards of Practice guiding document was solicited from respondents during the in-person meetings and on the survey.

In-Person Meetings Findings

During each stakeholder meeting, twenty (20) statements regarding conduct and practice (compiled from current state doula programs and doula organizations) were reviewed. Each statement was discussed among participants (in-person and virtual). There was general agreement that a code of ethics or conduct would be helpful in defining a doula's role and responsibilities. Some of the discussions included definitions of and differences between a code of ethics/conduct and scope of practice or standards of practice and the need to potentially separate the statements into the appropriate categories. Further discussion included removing negative words and language such as "doulas do not…," "argue with providers," and "interfere with" and also removing any clinical words specifically around mental health and outcomes. Final concerns included over-regulation limiting doula autonomy, enforcing "personal conduct," including cultural humility/anti-racism, and biases in subjective language.

Participants agreed that respectful communication and offering inclusive and compassionate care should be included in the statements. Other important ideas to be included were competency in providing emotional support, being advocates to encourage open client communication with providers, caring respectfully without judgment, and supporting patient rights. Additionally, statements that defined doulas as not being medical providers nor performing any medical procedures were also essential to include, and there was overwhelming support for simplifying the statements.

Survey Findings

The survey presented a Code of Ethics/Conduct and Standards of Practice document with the same twenty (20) statements regarding conduct and practice (compiled from current state doula programs and doula organizations). Respondents were asked to review the document and provide general feedback as well as a Yes/No/Not Sure approval of the document. A significant portion of respondents (70.95%) answered "Yes" to approve the statements as written. This high rate of approval indicates a consensus among respondents regarding the acceptability and relevance of the items contained within the document. However, there were write-in responses in a subsequent question that cited concerns about certain requirements or language in the document that could potentially impact the work of doulas.

Analysis of Meetings and Survey Findings

Both the in-person meetings and survey provided support for having a document that outlines the services a doula will provide as well as general practice guidelines. Common themes from both the meetings and survey emphasized the importance of excluding negative language and clinical terms to further clarify that doulas are not medical providers.

Further Considerations

See Appendix C for a suggested Code of Conduct & Standards of Practice document that incorporated feedback from both the meetings and the survey.

Topic 2: Training & Certification

Feedback on the training and/or certification requirements for becoming a Colorado Medicaid Doula was solicited from respondents during the in-person meetings and on the survey.

In-Person Meetings Findings

Discussions in the meetings included consideration of multiple pathways for training and certification and several examples from existing programs were reviewed. Consensus for the existence of more than one pathway was overwhelming, specifically the inclusion of an Experience pathway that recognized previous life work as a doula and not just formal training or certification. Additional discussion favored not creating barriers by requiring training from one or a few training organizations. Participants were asked to provide a value for formal training hours (Pathway 1). These responses were recorded and grouped into the same value fields used for the survey summary. The most chosen value field was 20-39 hours, for formal training followed closely by 0-19. (Fig. 2- see Analysis below).

The responses from discussions in the meetings surrounding the measurement of prior experience (Pathway 2) mirror the findings in the survey. The majority of recommended hours of experience hovered around the 100-hour mark, the number of prior births attended was most often listed as 3-5, and letters of recommendation came up as an option when respondents were asked “What other means would be appropriate for measuring experience?” Additional pathways or ways to measure experience were: a core competency test, shadowing

or apprenticeship, on-the-job training (OJT), attestations, community experience based in other countries, and grandfathering-in to the Medicaid program for those doulas who are already certified.

An additional topic covered in the meetings was Core Competencies. This discussion was included in the meetings because it is a requirement being adopted by some states and is a recommendation for consideration from Amy Chen from The Doula Medicaid Project (previously detailed in the Research and Strategy Development Section above). Ten competency categories were initially presented in the meetings for participant feedback. Discussion indicated approval of utilizing competencies in lieu of requiring specific training organizations and further discussion led to the identification of possible additions to the ten competencies including trauma-informed care, surrogacy, PMAD's recognition, informed consent, and culture competency/sensitivity. There was overwhelming support for the ten competencies presented and for two additional, trauma-informed care and cultural sensitivity.

Survey Findings

The survey asked six specific questions for the purpose of further refining credentialing requirements. Details of these findings are contained in the Survey Data Summary Report, but summaries are listed here.

For Pathway 1 - Formal Training, respondents were asked about the optimum hours of formal training and the requirement of prior birth attendance. The majority of respondents wrote in values that fell into 2 categories: 0-19 and 20-39 hours of formal training, with the first group having slightly more responses. (Fig. 3) Respondents were also asked if "prior births attended" should be part of the requirement. The large majority (64%) agreed that prior birth experience should be a part of Pathway 1 requirements.

For Pathway 2 - Experience, the survey offered a list of options for respondents to choose from in order to measure a doula's prior experience and then gave respondents the opportunity to quantify those options. The most popular choice among respondents was to measure experience by the number of previous births attended, followed by letters of recommendation and hours of experience.

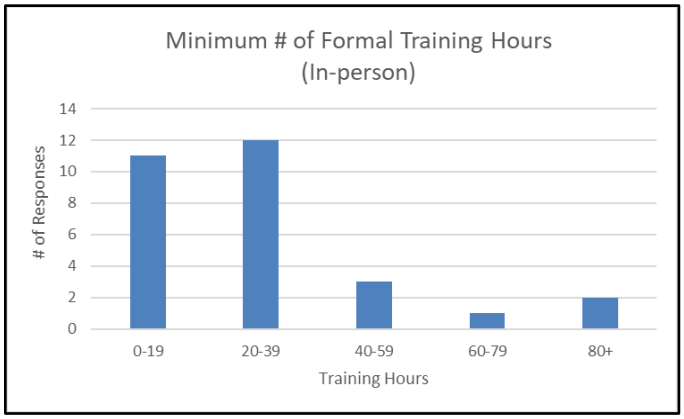
When asked to quantify these measurements of experience, respondents entered values for numbers of birth attended, hours of experience, years of experience, number of letters of recommendation from providers and clients, and number of clients served. Focusing on the three most chosen measurements of experience, the findings revealed 3-5 births attended as the optimum number, (however, 10 births was the largest single response (mode)), 2-3 letters from both clients and providers and 0-99 hours of experience, (followed closely in the results by 100-199 hours).

An additional question on the survey asked respondents to weigh in on agreement or disagreement with continuing education as a requirement once enrolled as a Medicaid Doula. Sixty-four (64) percent were in favor of this requirement (with 18% not in favor and 18% unsure).

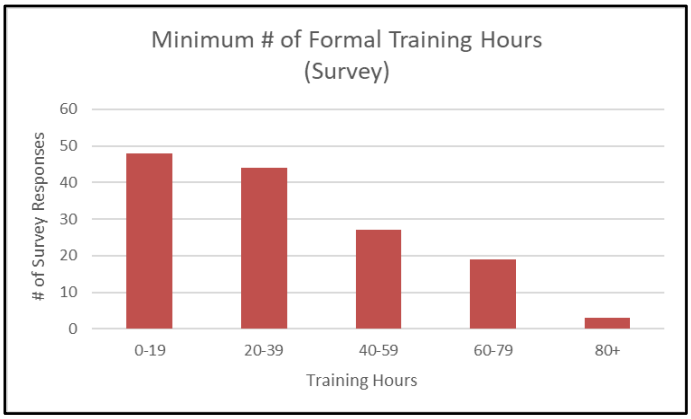
Analysis of Meetings and Survey Findings

The overwhelming majority of measured responses were in favor of more than one pathway for becoming a Medicaid Doula. Participants in the meetings and the survey willingly shared many different perspectives on the standards for training and measurement of experience and although there were outliers in most categories, there was still an evident majority on many of the requested data points. There was definite consensus from stakeholders for more than one pathway and support for utilizing core competencies in the qualification process (in lieu of a stringent list of only a few accepted training providers, as is the case in some states).

Figures 2 and 3 show a slight difference in the majority of answers between in-person and survey respondents for required formal training hours. It is the only noticeable variation between the two groups in the area of training and certification.



(Figure 2)



(Figure 3)

Further analysis of the survey results by specific areas of expertise (Fig. 4) showed higher numbers for formalized training hours, for required hours of experience, and for the number of previous births attended. (For example, in Pathway 1 - Formalized Training, the average open response from nurses was 67.8 hours and the average open response from HFC members was 31 hours.)

	Minimum # Formal Training Hours	Minimum # Hours of Experience	Minimum # of Births Attended
HFC Members	31 hours (average)	276 hours (average)	10 births (average & mode)

Clinical Providers	37 hours (average)	208 hours (average)	15 births (average)
Nurses	67.8 hours (average)	227 hours (average)	24 births (average, minus 1 outlier of 500)

(Figure 4)

Reducing barriers and increasing access were common themes among the participants and respondents. Additionally, the topic of management and logistics of the process of qualification and continued education came up frequently in open discussions. These concerns seemed to have some influence on the discussion about requirements. Some individuals requested more information regarding the management and oversight before they could provide feedback on those potential requirements.

Further Considerations

Creating a final policy for training and credentialing should consider the need for balancing accessibility, options for training, and competency. It is important to note the expectations of HFC members (Figure 3) about the level of knowledge and experience of the doulas that will be supporting them. The perspectives of health care team members (clinical providers and nurses) should also factor into formation of the standards because doulas will work alongside health care staff and in a health care environment. Setting the requirements for multiple pathways toward qualification should include a review of a variety of evaluation options and additionally, a determination of how those requirements will be managed.

Topic 3: Reimbursement Structure

Feedback on the allocation of funds across doula services associated with birth was solicited from respondents during the in-person meetings and on the survey.

In-Person Meetings Findings

During the meetings, participants were presented with examples from other states on how existing Medicaid programs are reimbursing doulas. Participants were asked to discuss and then provide feedback on the number of prenatal and postpartum visits. Participants were then asked how they would distribute the $1,500 total benefit per member across the areas of prenatal visits, postpartum visits, and birth support.

The majority of participants (66%) said the ideal number of visits for prenatal support was 1-3 visits. A 60% majority also said the ideal number of visits for postpartum support was 1-3 visits. There was an emphasis on 5-6 total visits that can be flexed between prenatal or postpartum visits according to the member's needs.

Participants distributed the $1500 in a variety of ways. Some listed an hourly rate for visits, some listed a single rate per visit, some provided a dollar range per visit, while others provided a total amount to be allocated toward all visits. The majority of participants (52%) fell within the range of $900-1049 total to be allocated to just the labor/birth support.

The discussion also included comments that proposed reimbursement rates could also be influenced by length of birth, type of birth, multiples, and complications.

Survey Findings

Five questions (Q15-Q19) asked about areas pertaining to pregnancy, birth, and postpartum. These summaries provide an overview of the diverse responses and perspectives shared by survey participants regarding prenatal and postpartum visits and birth support and the associated reimbursement rates in the context of Colorado's Medicaid Doula Benefit.

When asked about the number of prenatal visits that should be included in the Benefit, the majority of open responses (61%) fell within the 1-3 visit range, with 2 visits identified as the optimum. The majority of open responses (60%) also fell within the 1-3 visit range for postpartum visits. The majority of open responses on the survey (39%) fell within the $100-149 range (per visit) for reimbursement of prenatal and postpartum visits.

For birth support, the majority of open responses (38%) fell within the $900-1049 range for reimbursement - when billed separately. The single largest response (mode) was $1000.

Analysis of Meetings and Survey Findings

The in-person meetings allowed and encouraged more fluid discussion regarding reimbursement, than did the survey. The open discussion provided participants with opportunities to generate creative ideas and robust conversations around sustainability, a living wage, the value of doula support, and the needs of HFC members. The survey focused more on quantifiable values and apportionment.

There was overwhelming support for flexibility to best meet the client's needs, including the allocation of the visits. Additional comments included strong consensus to continue to grow the $1,500 amount in the future, specifically for postpartum care.

Further Considerations

When determining how to allocate the Benefit, consideration should be given to making the Benefit work for individual HFC members, rather than a one-size-fits-all solution. Additionally, the sustainability of a doula workforce, a living wage, and appropriate remuneration for a doula’s time should be a priority. An equitable solution might look like 6 total visits that could be flexed to either prenatal or postpartum visits, each receiving $100 per visit and $900 for labor/delivery support.

Topic 4: Scholarships

A provision for scholarship funds was included in the approved legislation for the Colorado Doula Medicaid Benefit but feedback was requested to provide insight on how the funds could be best allocated. Information was gathered from both the meetings and the survey on specific categories that could benefit from scholarship monies.

In-Person Meetings Findings

During the meetings, the following five potential areas for scholarships (as predetermined by HCPF) were shared:

1. Initial training for new doulas (individually)
2. Initial training (through organizations)
3. Subsidized additional components of training (books, transportation, etc.)
4. Additional required training (ex. HIPAA)
5. Continuing education

It was also shared that the scholarship funds would go to someone who is experiencing financial hardship (a provision already stipulated in the legislation). Participants were asked to share feedback regarding the five areas in an open forum discussion. The majority shared a positive reaction and dialog regarding the topics. Areas of concern that surfaced centered around the details and the management of the scholarship funds including, who would review applications, if there would be any limitations regarding funds per individual or per entity, and how financial hardship would be measured. Additionally, participants discussed how the funds could support building a doula workforce and prioritizing BIPOC and Spanish-speaking doulas as needed, especially in rural communities.

Survey Findings

One question on the survey asked respondents to review the five potential scholarship areas (previously identified) and to provide feedback. The majority of respondents to this open question expressed support for scholarships for doula training, with many emphasizing the importance of financial assistance for aspiring doulas. Suggestions included subsidies for initial training costs, continuing education opportunities, support for childcare, and funding for BIPOC and LGBTQ+ individuals to increase diversity in the doula workforce. Some respondents highlighted the need for careful selection of training organizations to ensure quality and inclusivity in doula education programs.

Analysis of Meetings and Survey Findings

There is overwhelming support from all stakeholders for both scholarship funds and the five potential award areas. Feedback suggests that scholarship funds be easily accessible and that the award process and management of the scholarship disbursement be clearly defined.

Further Considerations

Utilizing the funds to help build a doula workforce, particularly in rural areas, and training culturally diverse doulas is not only important but is essential to the success of this Benefit. It is important to make the scholarship application process and oversight transparent and easily accessible. This information could be included in the Doula Hub.

Topic 5: Mandatory Reporting

Current Colorado statutes do not require doulas to be mandatory reporters. There is a potential for this statute to change, as all current Medicaid providers are required to be mandatory reporters. Therefore, it was important to facilitate a discussion about doulas as mandatory reporters, since they will be considered providers under Medicaid.

In-Person Meetings Findings

The topic of Mandatory Reporting was introduced by showing a definition from the Colorado Revised Statutes with additional information from the Department of Child Welfare. The open forum nature of the meetings allowed individuals to share their thoughts about any future change to the current mandatory reporter status. During the meetings, there were strong opinions voiced by a few participants advocating against this requirement. Concerns against the requirement are that it could hinder the relationship between doulas and the clients (HFC members). Support for the requirement was also present during the meetings stating that doulas could be the only advocates for babies in the home and should know what to do and what to look for in the event they observe a harmful environment or situation. Despite the differing opinions, all agreed that anyone (including doulas) is capable of reporting abuse or neglect and that resources should be available (potentially through the Doula Hub) if doulas want to voluntarily report at any time.

Survey Findings

The survey asked four questions (Q21-Q24) about Mandatory Reporter status for Colorado Medicaid doulas. All questions were Yes/No/Not Sure responses and no open responses were solicited, however, some respondents wrote in comments and concerns at the end of the survey that pertained to Mandatory Reporting.

A slight majority of respondents (46.58%) agreed that Colorado Medicaid doulas should take the Mandatory Reporter training to fulfill their role effectively. However, a significant percentage (34.93%) disagreed with this requirement. Additionally, a notable percentage (18.49%) of respondents were uncertain about the necessity of Mandatory Reporter training for doulas working with HFC members.

A significant majority, (80.14%) of respondents, supported the idea of making Mandatory Reporter training available to doulas even if it is not required.

Two questions were designed to solicit feedback specifically from healthcare providers (Q23) and from HFC members (Q24). Question 23 was selected as applicable by 92 of the 144 respondents. Of those to whom it was applicable (providers), 50% were in favor of Mandatory Reporter training for doulas while 36% were not in favor and 14% were unsure.

Question 24 was selected as applicable by 60 of the 145 respondents (HFC members). Of those, 50% said it *would not* stop them from utilizing doula services and 19% shared that a Mandatory Reporter requirement *would* stop them from choosing a doula. Another 32% of respondents were unsure of the effect that this requirement might have on their choice.

Analysis of Meetings and Survey Findings

There is a notable contrast between the strong opinions (on both sides) observed during the in-person meetings and the responses collected through the survey. The meetings provided an opportunity for all individuals to openly express their comments and concerns, which sparked dynamic discussion. The survey questions were more specific, and provided a more direct (yes/no/not sure) measurement of an overall opinion on the Mandatory Reporter requirement for doulas. There is a possible discrepancy in the survey relating to the number of respondents that answered questions 23 and 24. The demographic qualifying categories show different numbers than the number of responses received for these two questions. (See Survey Data Summary Report for details.) Overall, the Mandatory Reporter requirement remains a sensitive issue among doulas but findings do support access to the Mandatory Reporter training for all doulas, and furthermore show insight into the opinions of other stakeholders, including HFC members.

Future Considerations

Further exploration of this topic to determine the impact on HFC members could help inform the policy. If a change is made to the current statutes to list doulas as Mandatory Reporters, a significant focus on education and training should be prioritized.

Topic 6: Doula Hub

The necessity of a comprehensive location (virtual, online, software, etc.) for information about the Benefit and all relatable items is understood. Ideas about the specific content and how this portal could be utilized was the topic of a discussion in the meetings and on the survey.

In-Person Meetings Findings

At each of the four stakeholder meetings, participants were divided into small groups and asked to brainstorm regarding items to include on an inclusive web portal that would function as a “one-stop shop” for doulas, referring entities, and HFC members. Each group created a list on a supplied sheet of paper. Following the discussion, the sheets were collected and consolidated.

Discussions included the benefit of having all information in one place and being accessible to all stakeholders. It could function as a resource for necessary steps and forms for utilizing the Benefit by clients. Similarly, the hub could also function as a recruitment tool and resource for doulas to become more familiar with how to apply to become a Medicaid doula and then, how to appropriately document and file paperwork as they begin to serve clients. Other ideas included having a communication platform doula to doula, where doulas could share information and request backups; a list of doulas and resources by county; educational videos; information about liability insurance; additional trainings of interest to doulas; state advocacy organizations; provider lists; news, updates, and community events; compassion fatigue resources; hotline; and scholarship information.

Dialog also raised concerns associated with accessibility and barriers. Ideally, all HFC members and Medicaid doulas would have access to the internet, but respondents encouraged an alternative option where the contents of the hub could still be accessed easily. Language concerns were also noted; “Would the hub be available in other languages” or “would translation be an option” were common questions raised among the group.

Survey Findings

The survey contained a proposed list of possible inclusions for an all-access hub for HFC members, providers, doulas, and community partners. A preliminary list of possible inclusions was shared with the respondents. Q29 and Q30 asked for feedback on that list.

Survey responses ranged from creating chat spaces and communication forums for doulas to seek support and resources, providing modules on establishing healthy client boundaries, filing complaints, offering resources on training requirements and certification, and creating customer service channels for billing and Benefit questions. A database of doulas that contain specific cultural or ethnic backgrounds and languages spoken could also be included.

Furthermore, respondents generally did not identify specific items to be removed from the Doula Hub site, indicating that the existing content and features were deemed relevant and necessary for supporting the Doula Benefit program effectively.

Analysis of Meetings and Survey Findings

There was overwhelming support for the idea of a centralized (virtual) hub. Both the meeting participant feedback and the survey responses showed the potential for the depth and breadth of available inclusions for both doulas and HFC members.

Further Considerations

It is conceivable that the hub would not initially be able to accommodate all of the suggested items, but it should evolve to be a comprehensive, intuitive, and user-friendly tool that would integrate all of the stakeholders and support the successful implementation of the Doula Benefit.

Topic 7: Provider Relations and Cross-System Integrations

Understanding existing stakeholder relationships (providers, doulas, community workers, organizations and other entities), can help facilitate a comprehensive and inclusive roll-out of the Benefit.

In-Person Meetings Findings

During the stakeholder meetings the following 4 questions were posed to the participants:

1. When you hear cross-system integration what does it mean to you?
2. What is working in these relationships?
3. What are areas of improvement?
4. How can we utilize the opportunity of the new Medicaid Benefit to elevate relationships?

An open discussion opportunity was provided for participants to share comments and dialog with one another.

Many participants shared similar ideas around improvements and opportunities to enhance relationships with providers, including clarification of a doula's role and understanding of what support a doula can provide. Some participants shared that language and cultural factors were barriers as well as a lack of overall collaboration. Participants suggested ideas around meet-ups and events that would allow for doulas and providers to build connection and trust, as well as provide education and information to nurses and support staff, including administrative staff. Various marketing strategies and media avenues were discussed as well as virtual events such as seminars and trainings on doula support and their role on the care team.

Survey Findings

The survey contained three questions (Q25-Q27) that asked respondents to give feedback and suggestions to increase the effective launch and utilization of the Doula Benefit for HFC members. Additionally, respondents were asked to identify other capacities in which they interact with HFC members including what works well in those connections, areas of improvement, and ideas for further engagement.

Respondents shared positive experiences working with HFC members, including collaborative care approaches, successful community education programs, and effective care coordination with care teams. Common barriers identified by respondents included lack of knowledge about doula services, cultural factors impacting trust and comfort, language barriers hindering effective communication, fear related to mandatory reporting requirements, and complexity in accessing doula services.

Solutions suggested by respondents to remove these barriers included education and awareness campaigns, a diverse and culturally competent doula workforce, streamlined processes for access and simple paperwork including contracts, enhanced communication strategies, and improved support mechanisms for members navigating the system.

Respondents provided a diverse range of suggestions for engagement opportunities to help providers, members, and community partners understand how to access and use the Doula Benefit. Suggestions included conducting town hall meetings, webinars, education nights, and meetings with healthcare organizations and nonprofits, as well as creating a robust marketing campaign.

Analysis of Meetings and Survey Findings

This topic shares important insight into the impact of relationships and communication among the entire care team. The in-person meetings and survey provided similar responses in suggestions for improvement and how the Benefit can impact care coordination.

Further Considerations

The new Doula Benefit gives an opportunity to bridge the gaps between doulas and other members of the care team, by shedding light on the important support role doulas can fulfill and by providing increased access to doulas for HFC members. Providers will now have the opportunity to work with doulas more often and begin to build relationships as well as share with HFC members about the benefits of doula support.

Topic 8: Doula Referrals

There are many entities and persons that interact with HFC members. It is important to identify all potential organizations that could distribute information or refer HFC members to doula support.

In-Person Meetings Findings

At each of the four stakeholder meetings, participants were divided into small groups and asked to brainstorm “Who needs to know about the Doula Benefit?” and “What are other services that doulas can refer their clients to?”

Each group created a list on a supplied sheet of paper. Following the discussion, the sheets were collected and consolidated. The meetings produced the responses listed below:

Referrals to Doulas

Alternative medicine groups	Headstart	Online Apps (SNAP, CHIP, M, etc)
Any underserved community	Health District Dental	Other community partners
Birth Centers	Health fairs	Teen Mom Centers
Birth Classes	Hospitals	Pediatricians

Private CBE educators	Housekeepers	Play Groups
Boys and Girls Club	IBCLCs	Prisons
Breastfeeding services	Breastfeeding Coalition	School Nurses
La Leche League	Kids Councils	County Health Depts.
Childcare Providers	Early Start	Social services
Chiropractors	Libraries	Social workers
Churches	Meal services	State advocacy organizations
CIPs	Medicaid Members	Teacher
Community Colleges	Medicaid Office	Teen parent groups
Schools & school programs	Medicaid Providers	WIC
Community Events	MHPs	WINGs inpatient substance abuse
Community Health	MILL	Fertility Clinics
DHHS	Mom Groups	High Schools
DV Shelters	Mother House	Dept. of Child Welfare
Food Banks	NFP's	Child & Family Services
FQHC	Non-profit groups	Mother House

Referrals from Doulas to other services

Acupuncturist	Diaper/Food/Formula Banks	Placenta Services
Birth Partner Support	Massage Therapists	Religious groups
Bodywork	Mental Health Support	Therapists
Breastfeeding specialists	Milk Banks	Tongue Tie specialists
Chiropractors	Pelvic Floor Therapists	WIC

Additional points of discussion included the need to educate providers about what a doula does and what the Doula Benefit covers so they can confidently refer HFC members to doulas.

Survey Findings

The survey asked one open-response question regarding entities that may make referrals to doula services.

The responses highlighted various community entities and specific suggestions included WIC offices, public health staff, OB offices, social workers, community health advocates, schools, churches, pregnancy resource centers, lactation professionals, housing authorities, Early Start programs, nonprofits, and other organizations that support maternal and family health.

Analysis of Meetings and Survey Findings

The list above is an extensive but not an exhaustive list of potential entities, organizations, or individuals that either refer HFC members to doulas, or to whom doulas may refer their clients. The survey produced some duplicate and similar responses to the in-person meeting feedback.

Further Considerations

Education and outreach will be an essential component to the success of this Benefit. Since the Benefit is new, it is going to be necessary for the known entities (known to the HFC member) to become a partner in sharing information about how to access the Benefit and encouragement to explore this resource. Collaboration amongst entities is paramount to getting HFC members connected to the care and resources that are available to them. Doulas will play an integral role in that collaboration. Furthermore, as the information about doulas is disseminated through various avenues, there will be a positive impact on growing the doula workforce.

Topic 9: Member Communications

This topic sought feedback on communication channels specific to HFC members to ensure effective rollout strategies.

In-Person Meetings Findings

At each of the four stakeholder meetings, participants were asked to brainstorm regarding how best to communicate information to HFC members about the Doula Benefit. The following question was put to the groups for consideration. “How can this Benefit best be communicated to HFC members?” Discussion included what details needed to be shared about the Benefit and how that information could be best shared. There was considerable overlap in the feedback with this topic and the Doula Referral and Provider Relations. Some specific topics to include in the communication to HFC members were: an explanation of the process for accessing the Benefit, how to find a Medicaid doula, what a doula does, and what the Benefit will cover. Cultural and language considerations were also mentioned.

Survey Findings

In the survey, questions 31 and 32 asked for ideas about what information would be beneficial to HFC members about the Benefit and how to best share that information. Responses varied but in general, the suggestions included “as much information as possible” should be shared. More specific feedback from respondents recommended members be informed about the benefits of using a doula, the process of accessing the Benefit, the cost coverage (especially if it is free), the advantages of having doula support during pregnancy, birth, and postpartum, and the statistics on how doula support can positively impact birth outcomes and overall maternity experience.

Respondents provided a range of suggestions for disseminating information about the Doula Benefit to HFC members. Recommendations included sending messages through provider portals, billboards, pamphlets, emails, texts, and provider offices. Additionally, suggestions stated promoting the Benefit through general practice/family medicine, pediatricians,

counselors, social workers, case managers, gyms, apps, posters, social media platforms, midwives' and OBGYNs' websites, government offices, post offices, grocery stores, schools, restaurants, housing shelters, domestic violence shelters, and various healthcare provider offices. The responses highlighted the importance of utilizing multiple communication channels to reach members effectively.

Analysis of Meetings and Survey Findings

Participants agreed clear communication about the role and services of a doula are an important first step in helping HFC members determine if they would benefit from utilizing those services. Participants pointed out the need to use multiple avenues to ensure all HFC members are made aware of the Benefit.

Further Considerations

Educating all stakeholders would help create clear expectations and further define the advantages of doula support. Informational and promotional materials could be distributed on both micro (Ex: domestic violence shelter or provider office) and macro levels (Ex: billboards and public educational campaigns). Attention should be given to providing materials in multiple languages and should consider cultural factors.

Limitations to the Stakeholder Engagement Process: The methodology utilized for this stakeholder engagement process was developed and executed with the original intent in mind: gather information, thoughts, opinions, insights, experiences, and knowledge from any person thought to have an interest in the Medicaid Doula Benefit. Given these parameters, the best methodology was to cast a wide net rather than risk omitting any individual or organization that might have even a minimal connection to the Benefit. Even with this approach, the possibility exists that there were some interested parties or persons that may not have received notice about the engagement effort or reversely, participation by some who might not be true stakeholders. Survey respondents were not screened prior to having access to the survey nor were any proofs of eligibility required for participation in the meeting or survey. The survey items were evaluated by multiple parties during the design stage and were modified for clarity but the possibility of inference bias still exists.

SUMMARY

The Colorado Medicaid Doula Benefit Stakeholder Engagement Process was conducted from January 19, 2024, to March 31, 2024, by Doulas in Denver, LLC. The stakeholder process was designed to encourage and gather a variety of feedback from interested parties including

doulas, HFC members, and professionals related to the doula industry. The outreach strategy included email, personal phone calls, social media, and community outreach with over 700 personal contacts made to potential stakeholders. Feedback was received from 207 persons online and 106 persons through hybrid meetings. There was a wide demographic representation including HFC members and non-members, responses from 23 counties, English and non-English speaking participants, and representation from multiple professions. The participation numbers indicated a large interest in the Benefit and its policy formation.

Data collected through the meetings and survey tools can be used to help policymakers better understand how doulas serve their communities, reasonable expectations for qualifying a doula to become a Medicaid Doula, and how the Benefit can best be structured to meet the needs of HFC members. Further insight gained from the data includes ideas about the use of scholarship funds, ideas for disseminating information to HFC members, providers, and doulas, and how a centralized Doula Hub could be used for a large list of things including but not limited to doula recruitment, training and retention, member to doula connection, help with filing forms, paperwork and billing, scholarship information, and as a portal for referrals.

Common themes that occurred throughout this process centered around increasing access, eliminating barriers, and education about doula support. There was discussion and empathy for healthcare disparities and there was excitement for new opportunities and the chance to support an underserved population. This naturally led to conversations about language and cultural considerations that will need to be addressed as the Benefit details begin to solidify.

The Stakeholder Engagement process produced data for which the Department of Health Care Policy & Financing was seeking clarification but it also revealed several additional topics for further research and definition (See Appendix D). This outcome should further help to focus the effort toward building the parameters of the Benefit and addressing some of the heretofore unknown elements that may have a direct bearing on the Colorado Medicaid Doula Benefit’s successful implementation.

APPENDIX A
DEFINITIONS and TERMINOLOGY

ACRONYMS, ABBREVIATIONS AND OTHER TERMINOLOGY

Acronyms, abbreviations, and other terminology are defined at their first occurrence in this Stakeholder Engagement Report. The following list (made available by HCPF) is provided to assist the reader in understanding acronyms, abbreviations, and terminology used throughout this document.

CHP+ – The Colorado Child Health Plan Plus.
CDEC – Colorado Department of Early Childhood
CDHS – Colorado Department of Human Services
CDPHE – Colorado Department of Public Health and Environment
HCPF – Colorado Department of Health Care Policy and Financing

Contractor – The individual or entity selected as a result of this solicitation to complete the Work contained in the PO.

Community Partners – trusted community-based organizations or members of the community that engage in, work with or have a lived experience with doula work.

Doula – a trained professional who provides continuous physical, emotional, and informational support to their client before, during, and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible. (Definition from DONA).

Doula Hub – Definition to be explored. Preliminarily: a place for new and existing doulas to access on-demand training and resources on how to obtain an NPI, enroll in Medicaid, and bill for services. May also include Continuing Education modules for all doulas on how to serve Medicaid members, including modules on cultural competence, providing care coordination and connection to community resources, and helping members receive their prenatal and postpartum care. An ongoing supportive doula community infrastructure to support doula retention that includes mentorship and group meetups for doulas to share best practices and process vicarious trauma from attending births.

Health First Colorado (HFC) – Colorado's Medicaid program.

Health Insurance Portability and Accountability Act (HIPAA) – The Health Insurance Portability and Accountability Act of 1996, as amended.

Stakeholder – A person, Project team member, or participant internal or external to the Department's organization or system with an interest or concern in its business or success.

State – The State of Colorado, acting by and through any State agency.

APPENDIX B
SAMPLING

In-person Meeting Sample

Total participants: 106 (virtual and in person)*Some individuals attended 1 or more meetings and their attendance is counted at each meeting.

Location	**Date**	**Attendance** **IP = in-person*
Pueblo Rawlings Library	January 19, 2024	**Total:18** (IP: 13 Virtual: 5)
Greeley LINC Library	January 26, 2024	**Total: 19** (IP: 12 Virtual: 7)
Denver Denver Health Hospital	February 10, 2024	**Total: 54** (IP: 31 Virtual: 23)
Grand Junction Community Hospital	February 16, 2024	**Total:15** (IP: 4 Virtual: 11)
Total Stakeholder Meeting Participants		**106**

Online

Survey Sample

Total Participants: 207 (201 in English: 6 in Spanish)

38	Health First Colorado (Medicaid) Member
119	Doula and/or Newborn Care Specialist
29	Providers (Pediatrician, OB, Midwife, Nurse Practitioner, etc.)
19	Nurse (RN, BSN etc.)
0	Allied Health Professionals (CNA, NA, Phlebotomist etc.)
19	Other licensed care providers (Chiropractor, Physical Therapists, Lactation Specialist etc.)
9	Health Care Administration and Staff (non-medical)
17	State Partner or Public Health Worker (WIC, Public Health, Case Managers etc.)
13	Other (please specify)

	Medicaid provider, MAC Member, Integrated Behavioral Health, provider, Provider, person who utilized a doula, Birth photographer, Licensed massage therapist, International Board Certified Lactation Consultant, Mental health therapist, LCSW, Academic Researcher, Community Member

APPENDIX C
CODES OF CONDUCT and STANDARDS OF PRACTICE
for Colorado Medicaid Doulas

The State of Colorado expects all Medicaid doulas to uphold a high level of ethical responsibility and personal conduct and to act with cultural humility and respect for human rights.

Doulas will maintain professional practices in relation to record-keeping, confidentiality, professional boundaries, business competence, and professional growth.

Codes of Conduct

(Definition: A code of conduct outlines general principles, values, and ethical standards that individuals within an organization or profession are expected to uphold and focuses on including ethical behavior, integrity, honesty, fairness, respect, and other similar principles.)

1. Doulas offer compassionate care by approaching clients with sensitivity and respect, acknowledging their ethnic, cultural, and individual diversities while providing non-judgemental support.
2. Doulas foster an improved experience for their clients and promote equity in high-quality healthcare services.
3. Doulas respect the confidentiality, privacy, and trust of individuals, families, and communities that they serve. Doulas also understand and abide by employer policies, as well as state and federal confidentiality laws that are relevant to their work.
4. Doulas communicate effectively and respectfully with clients, colleagues, care providers, and other professionals. Doulas also encourage clients to have open communication and discussions directly with their healthcare providers.
5. Doulas regularly engage in continuing education and training in order to improve skills, competencies, and professional knowledge, and maintain an awareness of new procedures/protocols and developments that are relevant to doula practice.

Standards of Practice

(Definition: Standards of practice, are specific and detailed guidelines that define the expected level of performance or behavior within a particular profession or field.)

6. Doulas provide high-quality care through a variety of support services including physical, emotional, and informational support.
7. Doulas provide clients with appropriate resources and providers when the client's needs are outside the doula's scope of practice.
8. Doulas are not medical providers and do not perform medical procedures or interventions, do not provide medical advice, do not diagnose or provide treatment for medical conditions or ailments, or take the place of any medical care provider.
9. Doulas provide a safe space for clients to express their feelings, emotions, thoughts, and concerns.
10. Doulas protect themselves and their businesses by:
    a. Maintaining professional liability insurance
    b. Employing best practices and appropriate protocols for personal safety
    c. Being aware of their own physical, mental, and emotional well-being and limitations
    d. Communicating with integrity about their services and capabilities

APPENDIX D
FURTHER TOPICS AND QUESTIONS

The below questions and topics were captured during the stakeholder meetings as topics for HCPF to explore further.

Further Topics for the HCPF to Consider
Reimbursement Topics
How will backup be covered for doulas as far as reimbursement goes?
Will bereavement, c-section, stillbirth, miscarriage, and surrogate support be covered?
If a doula attends a prenatal or postpartum visit with the client at a doctor's office can both the doula and the provider bill for the same visit? There should be a different code for doula and provider so they can both get paid.
How much time is allowable for Labor & Delivery attendance?
When is the baby considered a Medicaid member? How will a stillborn situation be handled?
Is there a set minimum or maximum time for prenatal or postpartum visits?
How will multiples be handled?
If the baby is not delivered and the doula has reached an hourly limit, can the doula still get their reimbursement? Could there be a code for extended labor that would open another pool of money?
As soon as the baby is born and becomes a member, can the Benefit be used for postpartum support?
Will virtual support be covered? Do in-person and telehealth visits both get covered and if so are they covered at the same rate?
Tricare allowable birth is $725, needs to stay in line with industry standards.
What can doulas charge Medicaid members for outside or continued services - Tricare has a "non-covered services agreement" that both parties sign
Ensure the contract or agreement with each doula includes the fee structure, reimbursement instructions, how backup is handled, what codes to charge, etc.
Scholarship Topics
How do you prove financial hardship for the scholarship?
Could scholarship funds be used by a seasoned doula's as a pathway to student midwifery?
What happens if someone doesn't use their scholarship funds as they're supposed to? How will the state know?
Standards Maintenance
Will doulas be evaluated so that they can continue to remain a Medicaid doula or be "let go" if they are not upholding standards?
Does the state want to include a list of "prohibitive behaviors" or "violations" that would be cause for automatic dismissal including around filing fraudulent claims, and making false statements on services similar to what other states like Arizona have.
How will providers be informed of the "code of conduct/scope of practices" that doulas are being upheld to? Will providers be able to provide feedback on doulas?
Will background checks be required?
How will feedback be collected from members on doulas? How will grievances with Doulas be handled?
Other Topics
Will the HUB be connected to the state's planned SHEI database?
HCPF needs to define record-keeping requirements and involvement with HIPPA.
How can Medicaid doulas find other doulas to cover shifts at the last minute?
Does a doula have to "work under" a provider to be covered as a Medicaid doula?

