

Tackling Maternal Health Disparities: A Look at Four Local Organizations with Innovative Approaches

Maternal health disparities have many causes, but disparate social conditions and a lack of prenatal care or substandard maternal care are often key factors. Community-based maternal care models can help to narrow the disparities in maternal health outcomes by providing expanded prenatal, childbirth and postpartum support that is respectful and culturally relevant to at-risk women. These models may also focus on breastfeeding and parental development. This issue brief highlights four programs from across the country, examines the importance of community-based maternal care models and offers recommendations for supporting and expanding them.

Maternal Health Disparities

The United States has some of the worst rates of maternal and infant health outcomes among high-income nations, despite spending an estimated \$111 billion per year on maternal, prenatal and newborn care.¹ For example, Black, American Indian and Alaska Native² women are more likely to experience complications during pregnancy and are nearly four times more likely to die from pregnancy or childbirth than white women.³ Latina, Asian and Pacific Islander women generally have birth outcomes that are similar to those of white women, but some reports show that certain subgroups fare worse than white women.⁴

Many of the poor maternal health outcomes that women of color experience are due to systemic barriers that create unequal social conditions. Compared to white women, women of color are:

- More likely to experience discrimination, which can increase cortisol levels with adverse effects on maternal and infant health.⁵ Racism can have negative consequences on the birth process and labor and birth outcomes.⁶
- More likely to live in poverty and have less wealth.
- More likely to experience food insecurity.
- More likely to live in hazardous conditions.
- Less likely to have health insurance. Pregnant women who do not have health insurance often delay or forgo prenatal care during the first trimester,⁷ which is associated with higher rates of maternal mortality, higher rates of infant mortality, and increased risk of low birth weight.⁸
- More likely to have high risk pregnancies.⁹

Community-Based Care Models as a Solution to Maternal Health Disparities

Community-based maternal health care models offer enhanced care and support from the prenatal through postpartum periods, including doula and midwifery childbirth services to pregnant women who face barriers to care.¹⁰ Community-based models like these fill gaps in the health care system by providing wraparound services and high-quality interventions that address social factors that negatively affect maternal and infant health. They increase access to care, assist people in connecting with social services, and bridge cultural gaps between providers and clients.¹¹ Community-based models often provide increased access to midwives, doulas and birth companions who can provide a range of reproductive health care services and achieve promising maternal health outcomes.¹² There is also some research that suggests that expanded prenatal and postpartum care models reduce the overall cost of care due to fewer emergency visits, reduced cesarean births and fewer postpartum hospitalizations.¹³

In this brief, we focus on community-based maternal health care models serving women who are predominantly low-income, at-risk and/or of color. Building on the evidence of the effectiveness of other community-based interventions, such as community health workers and doulas, these models go beyond the scope of services offered by conventional clinical providers because they also provide psychosocial support, cultural concordance and care coordination that is grounded in reproductive justice.

METHODOLOGY

The National Partnership for Women & Families research team visited Mamatoto Village in Washington, DC and conducted the interview in person; the other three interviews took place as conference calls. The National Partnership developed a standardized interview tool that was used across all the interviews. The conversations were wide ranging, however, and not all of the same topics were covered across all four interviews. The National Partnership also consulted the groups' websites and other publicly available information. Leaders from participating organizations shared background documents and evaluations that supplemented the interviews and reviewed a draft report for accuracy.

The four organizations were selected based on several criteria including that they serve women of color and/or women with low incomes; provide maternity care services in the community; offered geographic diversity; and their willingness to participate. The four organizations are not necessarily representative of all community-based maternity care programs, nor are the case studies intended to be a comprehensive review of community-based models of care.

Commonsense Childbirth, Winter Park, Florida

Background

Founded in 1998 by midwife Jennie Joseph in Winter Park, Fla., Commonsense Childbirth consists of two distinct programs aimed at providing maternal health services for pregnant women. Anchored in the belief that no woman should be turned away when seeking prenatal care, regardless of risk, health, immigration status or the ability to pay, Commonsense Childbirth has grown from a home birth practice to a thriving community-based maternity medical home.

The founder of Commonsense Childbirth describes their services as “life-saving wraparound support.” These services include midwifery care, social service navigation, doula attendance at birth when available, childbirth education and lactation consultations, as well as standard prenatal care. Services are provided in English, Spanish and Portuguese.

Commonsense Childbirth includes a birthing center, whose main clients are typically covered by private insurance, and Medicaid, or have the ability to pay out of pocket, and an Easy Access Clinic™ aimed at reaching clients who experience barriers to maternal health care. Women receiving services through the easy access clinic may give birth at the birth center or a hospital. After birth, clients can return to Commonsense Childbirth for up to six weeks of postpartum care. In 2017, Commonsense Childbirth provided prenatal and postpartum care and support to nearly 1,000 women.

The clients served by Commonsense Childbirth’s Easy Access Clinic™ are primarily women of color and/or low-income women. The majority of clients are Black, Latina and Brazilian. Many of the clients that Commonsense Childbirth sees are uninsured when they first seek services, but Commonsense Childbirth can help them enroll in Medicaid, which covers prenatal, childbirth and postpartum care.

Clients come to Commonsense Childbirth through word of mouth from friends and family. Some clients were themselves delivered as babies by Commonsense Childbirth and now require services for their own pregnancies, and additional clients are referred from providers who are unable/unwilling to offer services due to the client’s profile.

Commonsense Childbirth also provides perinatal health worker training and certification through its online Community Outreach Perinatal Educator (COPE) training program. Commonsense Childbirth anticipates that its School of Midwifery will be accredited by the Midwifery Education and Accreditation Council sometime this year.

Care Model

Commonsense Childbirth’s care model is called the JJ Way®. The model provides trauma-informed care predicated on respect, choice and access.¹⁴ Clients have often experienced marginalization and negative experiences within more conventional health care encounters. Commonsense Childbirth’s aim is to not re-traumatize clients with disrespectful behavior, but instead to provide an atmosphere where women are heard, listened to and valued.

Commonsense Childbirth's Easy Access Clinic™ is open three days per week. In addition, Commonsense Childbirth identifies localities where women experience high maternal vulnerability with few resources or support. These places are designated as "maternal toxic zones." In an effort to reach the most high risk and disadvantaged women in these areas, Commonsense Childbirth offers services in what they call a "Perinatal Safe Spot" at readily accessible sites such as a local community center or neighborhood resource centers.¹⁵ Clients also have access to an emergency help line twenty-four hours a day, seven days a week.

Payment Model

Commonsense Childbirth's financial model is predicated on "what's fair, equitable and doable." If clients are unable to afford prenatal and postpartum services, Commonsense Childbirth can offer services at a lower rate, on a payment plan or at no charge.

The majority of Commonsense Childbirth's clients are enrolled in Medicaid, and the majority of Commonsense Childbirth's reimbursement comes from contracts secured through Florida's statewide Medicaid managed care organizations (MCOs). Commonsense Childbirth reports that securing MCO contracts requires hard work and diligence.

Key Performance Indicators

Independent evaluations of Commonsense Childbirth demonstrate outcomes for Black women that are substantially better than Orange County and Florida state averages and are closer to county and state averages for the total population.¹⁶

The JJ Way® attained a preterm birth rate of 8.6 percent for Black women, while the county and state rates are at 13 percent. The model also produced better low birth weight rate outcomes for Black women than county and state averages at 8.6 percent versus 13.1 percent.

For Latina mothers, the pre-term birth rate was 4 percent, a rate less than half of the county and state rates for Latinas. Latinas using the JJ Way® had low birth weight rates of 1 percent versus the average county and state rates of 7.5 percent.

The JJ Way® also produced better outcomes for white mothers for preterm birth and low birth weight. Additionally, the cesarean rate of Commonsense Childbirth's clients is only 8 percent in comparison to the 30-50 percent rates found at local hospitals.

Point of Pride

"I take great pride in creating the JJ Way®, and developing Commonsense Childbirth into a community-based model that provides respect, power and equity to both clients and staff members. I believe we have found a way to create and support perinatal safety for all Americans, regardless of zip code, race or ethnicity." — Jennie Joseph, Founder and Executive Director

Mamatoto Village, Washington, D.C.

Background

Mamatoto Village is a community-based organization that provides comprehensive maternity support to Black and low-income women in Washington, D.C. Mamatoto is Swahili for “the connection between mother and baby,” and at Mamatoto Village, women find themselves surrounded by a team of trained providers dedicated to strengthening that bond. Mamatoto Village’s office serves as both a teaching space for communal learning and safe haven for clients and their families.

Mamatoto Village’s motto and vision is “healthy mamas, healthy babies, healthy communities.” To achieve this vision, Mamatoto Village utilizes a three-generation approach that harnesses the strength of families and the greater community to support and facilitate women through healthy pregnancies and birth experiences.

Each year, Mamatoto Village provides services to roughly 400 women and their families. Overall, the clients served by Mamatoto Village are primarily Black women and/or low-income women, are extremely high risk, are financially insecure, lack safe and or affordable housing and do not have reliable transportation. Women are referred to Mamatoto Village from Medicaid MCOs, providers, clients, other community-based organizations, word of mouth and social media campaigns.

An essential part of Mamatoto Village’s program is to create career pathways for women of color, specifically in public health and human services. Mamatoto Village recognizes that “the women we serve are the women who serve.” To facilitate this, Mamatoto Village trains Perinatal Health Workers within a community health model. Mamatoto Village currently employs 23 women, 20 of whom went through this training. Mamatoto Village believes in equitable pay and is intentional in recognizing the value and effectiveness of community health workers by providing adequate reimbursement to support them. Mamatoto Village provides comprehensive training, leadership and management training and a living wage to its employees.

Each community health worker trains for six and a half months in the classroom and spends 18 months in the field, while completing 1,500 hours. Trainees can choose one of four career paths: perinatal community health workers, perinatal family support workers, community birth workers or lactation specialists.

Care Model

Mamatoto Village created a home visitation model that is grounded in a social justice framework. Their approach is to use assets within the community, including clients, to address maternal health disparities and economic insecurity. To do this, the staff members at Mamatoto Village build strong relationships with family members, social service providers, health care providers and leaders in the community who are invested in combating the maternal health crisis.

When clients first engage with Mamatoto Village, they are given a modified version of the American Academy of Family Physicians (AAFP) risk assessment tool to determine the level of care needed, including the scope and scale of services. Each woman is assigned to a care team that supports her during her pregnancy.

Services include home visits, care coordination, prenatal support, health and wellness advice, attending social services appointments with clients, support in hospitals or birth centers during labor and birth, lactation support including 24-hour rounding immediately following birth, and postpartum follow up for three to six months with half-day and overnight support if needed.

Payment Model

The majority of Mamatoto Village's revenue comes from reimbursement through Medicaid managed care organizations. In 2015 Mamatoto Village was approached by an MCO that proactively reached out to begin a partnership with Mamatoto in an effort to better serve Medicaid-eligible, pregnant women. After several months of negotiation, Mamatoto Village was awarded its first MCO contract and three others soon followed.

Mamatoto Village's Medicaid reimbursement provides adequate funding to cover maternity support for their clients and to pay their employees a salary. The four MCOs that Mamatoto Village is contracted with cover 100 percent of the care they provide up to 12 weeks postpartum on a fee-for-service basis. The MCO contracts provide 75 percent of Mamatoto's revenue, and reimbursement is sufficient enough that the program can pay for itself.

Mamatoto Village also receives grants and they also actively solicit donations via their webpage and the Catalogue for Philanthropy and hold several funding drives throughout the year to raise revenue. A small portion of clients out of network pay for services based on a sliding scale that is capped at \$1,500 or 1 percent of the family's gross income.

Key Performance Indicators

Analysis of a sample of 355 clients found that despite the majority of clients being high risk for health and social factors, results were positive:

- 97 percent of the women in Mamatoto Village's care had a live birth.
- 90 percent of women-initiated breast feeding.
- 85 percent carried to full term.
- 82 percent had normal birth weight babies.
- 80 percent attendance at six-week postnatal provider visit.

Point of Pride

"The things I am most proud of are the culture of nurturing, healing and support we have created for both clients and staff, our successful track record of advocating for women, improving maternal health outcomes and providing economic security for women in the community."

— Aza Nedhari, Executive Director and Co-Founder

Breath of My Heart Birthplace, Española Valley, New Mexico

Background Information

Breath of My Heart Birthplace is a community-based clinic that provides maternal health services to people in the Española Valley of New Mexico. The name of the birthplace comes from an Indigenous term of endearment towards a beloved child, “navi pin haa un mu,” means “you are the breath of my heart,” and is from the Native American Tewa language.¹⁷

In 2010, Breath of My Heart Birthplace started as a home birth practice in the Española Valley, with the intention of creating a practice framed by the Native, Chicano and indigenous communities’ rich history of midwifery care. In 2013, Breath of My Heart Birthplace opened the doors of its walk-in clinic to serve clients who are primarily low income, LGBTQ, young parents and people of color. It is the only midwifery practice in the valley.

Española Valley is a primarily rural county with a large population of Native Americans, Chicanos and other indigenous ethnicities. Eighty percent of Breath of My Heart Birthplace clients are people of color, 25 percent identify as Native American and about 75 percent identify as either Chicana or Mexican. Ninety percent of the clients identify as low-income or very low-income, and a quarter of the clients served by Breath of My Heart Birthplace are designated as “young parents,” under the age of 22. There are six Native American reservations in the Valley and many of the clients served by Breath of My Heart Birthplace are part of the reservation community.

The people of the Española Valley exist in what is described by the organization as “concentrated disadvantage” or a general state of being overwhelmed. Breath of My Heart Birthplace clients experience various negative health effects, including a higher number of stressful life events in the year before and after birth than most Americans. Incarceration, violence, hunger, substance use disorder, homelessness and poverty all contribute to high rates of postpartum depression and adverse maternal and infant health outcomes. The historical systems of oppression, ranging from colonization to modern day immigration enforcement has resulted in such extreme poverty, social isolation and disenfranchisement that many of the clients served by Breath of My Heart Birthplace have extremely high social risk factors, even though they present with low physiological risk.

On average, Breath of My Heart Birthplace provides health care to roughly 200 clients and midwifery specific care for about 40 clients per year. Recently Breath of My Heart Birthplace has seen a steep increase in the number of births per year as knowledge of Breath of My Heart Birthplace increases around the community. Women who want out-of-hospital births are often referred by other medical providers, including the Indian Health Service. Breath of My Heart Birthplace also finds clients through advertising campaigns using billboards and radio ads, and their weekly presence at the local farmer’s market.

Breath of My Heart Birthplace is also an apprenticeship site for midwives and reserves spaces specifically for training midwives of color in New Mexico. Their goal is to train community health workers to provide midwifery care, doula services and lactation consultations. Trainees are then given the opportunity to practice and develop their skills at Breath of My Heart Birthplace.

Care Model

A history of hostile and marginalized treatment, along with inadequate funding for Indian Health Service has led to mistrust between the community and health care providers. Breath of My Heart Birthplace works to build trust by relying on the tradition of midwifery care found in indigenous communities to balance the importance of holistic and traditional medicine along with modern best practices.

Breath of My Heart Birthplace provides many services to families seeking care. Their walk-in clinic offers a range of maternal health services including midwifery care, lactation support services, perinatal depression interventions, preconception care, HIV and STD testing, annual exams, and counseling for those trying to conceive, LGBTQ families and single parents. Breath of My Heart Birthplace also offers a support group for young parents in an effort to facilitate engagement and growth.

Services are accessed at a walk-in clinic in a newly opened facility where clients can seek licensed family counselors, Medicaid enrollment assistance and WIC peer counselors. Midwives provide services in the birth center and at clients' homes, hospitals and other facilities that are convenient for the client. Breath of My Heart Birthplace also provides five postpartum home visits in the first two weeks after birth and an in-office visit at six weeks postpartum in an effort to assist with continued breastfeeding and early detection of postpartum depression.

Payment Model

Breath of My Heart Birthplace receives funding from multiple sources with a revenue breakdown of about 60 percent fee for service and 40 percent grants and charitable donations. Breath of My Heart Birthplace contracts with MCOs for the majority of their revenue and is in the process of building more relationships with MCOs.

Eighty-five percent of their clients are Medicaid eligible, and roughly 10 percent pay privately. About five percent of Breath of My Heart Birthplace clients are uninsured, but a state-run program subsidizes services and allows Breath of My Heart Birthplace to discount some services to zero fees if the clients are unable to pay more. There is also a payment plan available for clients who are unable to pay for births out of pocket.

The majority of Breath of My Heart Birthplace clients are enrolled in Medicaid.

Key Performance Indicators

Breath of My Heart Birthplace's goal is to have outcomes that are equal to or better than average outcomes for the overall population. For example, the current cesarean rate is 2 percent for women who are actively engaged at Breath of My Heart Birthplace throughout their pregnancy, in comparison to the statewide rate of 23 percent, and Breath of My Heart Birthplace also has extremely low rates of preterm births and low birth weight babies.¹⁸

Breath of My Heart Birthplace also uses walk-in clinic utilization to gauge their community impact. The Breath of My Heart Birthplace walk-in clinic has a return rate of 65 percent, and a quarter of patients retain their services for midwifery care.

Point of Pride

“My biggest point of pride is the extraordinary development of young parents we see. Many of our clients live in areas of concentrated disadvantage that makes parenting extremely difficult, but we intentionally work with young parents to help them develop successful parenting skills.”

— Jessica Frechette-Gutfreund, Executive Director

Mama Sana Vibrant Woman, Austin, Texas

Background

Mama Sana Vibrant Woman is a thriving community-based organization dedicated to improving the birth outcomes and lives of women in Austin, Texas. Mama Sana Vibrant Woman empowers women to build healthy and sustainable families and communities.

Mama Sana Vibrant Woman developed out of community organizing efforts that surveyed the needs of low-income women and women of color in the Austin area in 2008. Consistently, challenges relating to childbearing emerged as an area of great community need. A group of mothers in the community recognized that the social safety net was fragmented, unreliable and insufficient for meeting the needs of low-income women with children.

The clients who seek services from Mama Sana Vibrant Woman are typically Black and Latina, low-income and high risk. In a typical year, Mama Sana Vibrant Woman provides an intensive level of services to about 150 women and their families. Clients come to Mama Sana Vibrant Woman through word-of-mouth referrals, social media campaigns and outreach events. They also receive client referrals from clinics, hospitals, providers and various social service agencies. Mama Sana Vibrant Woman also advertises their services on a mural depicting a beautiful woman of color in the late stages of pregnancy.

Mama Sana Vibrant Woman currently employs seven employees as administrative and operations staff and contracts with nine birth companions, two midwives and multiple child care providers. Mama Sana Vibrant Woman also provides a birth companion training (aka doula) program with certification. Students are trained in the basic knowledge and skills of traditional doula programs, but they are also given intensified training in consciousness raising and understanding the root causes of current social conditions and health inequities.

Model of Care

Mama Sana Vibrant Woman uses a model of care grounded in a maternal justice framework.¹⁹ The care and services they offer to women are rooted in the philosophy that every pregnancy deserves love and attention, and that women should be given the tools and agency to decide how they want their pregnancy and births to proceed. The model strives to improve maternal and infant health outcomes, while allowing for client empowerment and self-determination.

Mama Sana Vibrant Woman’s model attempts to interrupt a cycle of systemic oppression and marginalization they describe as “womb-to-prison” by providing social services that act as a safety

net. Mama Sana Vibrant Woman's model of care emphasizes choice. They support their clients in their decision making process and do not advocate for certain types of care over others.

Their grounding in maternal justice also directs their attention to community and system-level interventions. Mama Sana Vibrant Woman plays a critical role in community development through social justice and policy work, and they were integral in working with jails in Texas to implement concrete changes in the treatment of pregnant incarcerated women.

Mama Sana Vibrant Woman offers a variety of maternal health support services to their clients. Mama Sana Vibrant Woman provides birth companions, a role that provides advocacy and support for pregnant women, birth attendance and six postpartum home visits. Mama Sana Vibrant Woman also runs several wellness clinics with midwives that offer prenatal and postpartum massage and yoga, childbirth preparation workshops, and postpartum parenting circles. For all of the services they offer, Mama Sana Vibrant Woman also provides transportation, childcare and meals.

Mama Sana Vibrant Woman offers services in a variety of locations around the city that are more accessible to low-income communities of color. They also offer services in low-income apartment buildings, public housing and community recreation centers.

Payment Model

Mama Sana Vibrant Woman's primary funding source is a reimbursement contract awarded through the city of Austin's health department to organizations that address health disparities. Clients who receive group and prenatal services from Mama Sana Vibrant Woman do not pay out of pocket; rather Mama Sana Vibrant Woman bills the city and receives reimbursement every month for provided services.

Mama Sana Vibrant Woman also received an 18-month grant from a private funder that covers the cost of birth companions and postpartum facilitators and receives donations from both one-time and long-term private donors. They also actively solicit donations via social media and hold several funding drives throughout the year to raise revenue. Mama Sana Vibrant Woman does not receive funding or reimbursement from Medicaid.

Key Performance Indicators

Mama Sana Vibrant Woman has several key performance indicators that demonstrate the success of their organization. A six-month snapshot of their evaluation shows the following promising results:

- 36 mothers delivered their babies at term (37 weeks or more)
- 37 mothers had healthy birth weight babies
- 100 percent of mothers initiated breastfeeding

They also measure their impact based on clients maintaining a relationship with Mama Sana Vibrant Woman. Many of the clients served by Mama Sana Vibrant Woman return to the program to be trained as birth companions, childcare providers or volunteer in other capacities.

Point of Pride

“The thing I’m most proud of is supporting women, many of whom come to us as high risk or who have experienced poor birth outcomes in the past, achieve the love, care and attention that every pregnancy deserves. This is part of our larger vision for a just and loving world.” — Paula X. Rojas, Co-Founder, Midwife and Education and Training Director

Common Themes and Policy Recommendations

Community-based maternal health care models are promising models of care for low-income women and women of color. They provide an alternative model of care delivery tailored to address maternal and infant health disparities. These models demonstrate that culturally-relevant services predicated on choice, autonomy and respect can improve maternal and infant health outcomes and have the potential to narrow health disparities. Outlined below are strategies enacted by the four models that were highlighted, as well as related policy recommendations for providing care to women who face high risk social factors.

Securing Sustainable Revenue Streams

All four programs discussed the desire to expand the scope and scale of services offered to better meet their community’s needs. All four groups also cited the need for increased funding to do so. Three of the four groups reported experiencing deficits in revenue and shortage of staff, and they are all currently concerned about operating without an adequate number of midwives.

Because these models do not provide labor and delivery services for the majority of women they serve, the majority of maternal health care payments accrue to the hospital where the mother chooses to give birth despite the positive, upstream work that community-based models do to improve outcomes.

Because Medicaid payments through managed care is the predominant form of payment for the populations served by these models, there are opportunities for managed care organizations to support community-based maternity care programs and secure beneficial services for their members. Taking advantage of those opportunities will mean addressing challenges reported by many of the community-based maternity care programs. One of the four organizations highlighted above reported receiving adequate, reliable, timely and sustainable reimbursement through their MCO contracts for a broad range of nonclinical community perinatal health worker services. Two groups described securing MCO contracts and receiving the negotiated reimbursement rate upon billing as challenging due to the resource (time and personnel) consuming nature of negotiating with MCOs. (The fourth group did not receive any funding from Medicaid or managed care organizations.)



Aza Nedhari (left), executive director of Mamatoto Village, **Jennie Joseph** (center), executive director of Commonsense Childbirth, and **Jessica Frechette-Gutfreund** (right), executive director of Breath of My Heart Birthplace, at Birth Summit IV in Santa Fe, N.M., April 2019

The three groups that bill Medicaid also reported difficulty in billing for the full range of their services. For example, one group explained that they cannot bill for childbirth education, birth attendance or additional social and paraprofessional support, all of which they consider essential services for their clients. Another group described the labor-intensive process and administrative burden associated with securing reimbursement for services due to an uptick in claim denial and billing errors from MCOs.

Grants are a welcome source of revenue for these organizations, but can be hard to secure in some instances. Services and staffing are vulnerable if grant revenue is not maintained. One group is sustained almost entirely through a large, single, multi-year grant (with uncertain renewal), and another explained that despite years of work in the community and partnership with the local hospital where most clients choose to give birth, only one modest grant was recently awarded.

RELATED POLICY RECOMMENDATIONS:

- *Provide sustainable funding for community-based models (CBMs).* Each of the organizations in this brief are engaged in providing a vast array of services to high need clients on very modest budgets. Increasing funding streams to CBMs would allow these organizations to expand the size and scope of their operations to scale and more adequately address maternal health disparities.
 - More MCOs should pursue contracts with community-based maternity care models; seek to provide adequate, sustainable reimbursement; and allow billing for non-traditional types of service that are essential to improving maternal and infant health outcomes, such as psychosocial support, birth companionship, care coordination and lactation consultations.
 - MCOs should reimburse providers who contract with CBMs at a more competitive rate than they currently do to maintain quality and continuity of care.
 - State and local level governments should appropriate and distribute health equity funds to community-based health care models that are designed to address maternal health disparities.
 - Public and private payers should develop and implement maternity care home and episode alternative payment models that improve quality and birth outcomes by covering enhanced community-based services that have not been conventionally been billable.²⁰
- *The Centers for Medicare and Medicaid Services (CMS) should clarify and strengthen support for perinatal community health workers.* CMS should issue guidance clarifying and encouraging reimbursement for community-based perinatal health workers and the services they provide.

Grounding the Models in Reproductive Maternal or Social Justice Frameworks

All four community-based care models are rooted in reproductive, maternal or social justice frameworks, which advocate for the human right to maintain personal bodily autonomy, to determine for one's self whether or not to have children, how to have children, and to parent children in safe and sustainable communities.²¹ The organizations recognize that women of color face overlapping issues of systemic barriers, racism, current inequities and the legacy of coercion and exploitation within the health care system. To begin to account for historic and ongoing barriers, the models are trauma-informed, multi-generational and seek to address both individual and community-level needs, and are designed based on the specific needs of their community.

The framework of each model emphasizes providing respectful care that is non-judgmental and centered on empowerment and choice. Many of the clients served by community-based models have had previously poor experiences with the health care system, including disrespectful and biased treatment based on insurance status, age, immigration status and race/ethnicity. Community-based maternal care models prioritize listening to the needs and preferences of women as an integral piece of the care model. These models actively work to create inclusivity and advocate for women to have autonomy and choice in the type of pregnancy and birth experience they desire. To achieve this goal, these models offer individual care plans that are culturally relevant and support pregnant women's choice of birth provider and setting.

RELATED POLICY RECOMMENDATIONS:

- *Increase the number of community-based models.* Currently there are not enough CBMs nationwide to serve the number of low-income and at-risk women in need of prenatal through postpartum care and support services. Programs provided by CBMs play an essential role in providing services in communities and neighborhoods where many people experience barriers to care. Increasing the number of programs implementing CBMs would provide more opportunities for women and their families to seek the prenatal, childbirth and postpartum care and wraparound services they need.
- *Rigorously evaluate current models.* Each of these models demonstrate promising results for narrowing maternal and infant health disparities; however more information is needed to identify which aspects of their models should be replicated to produce similar and potentially more beneficial results. Evaluating each model could allow for more targeted approaches to care delivery and potentially further narrow gaps in maternal and infant health outcomes.

Providing Wraparound Services

Across each of the organizations, the importance of addressing social factors was highlighted as an essential component for improving the health and wellbeing of their clients. The clients served by these models are often food insecure, experience domestic violence, lack access to reliable transportation and work multiple service jobs — often without access to basic family-support benefits including paid family and medical leave, paid sick days or health insurance — in an effort to attain financial security. Lack of access to basic necessities like stable housing and safe living environments can increase maternal mortality and morbidity.²² The models highlighted provide an array of wraparound services to address the basic needs of their clients including assistance in securing health insurance, stable housing, affordable food, childcare and reliable transportation. They also provide access to both childbirth education and parenting classes to facilitate the growth and development of their clients into successful parents. These services align with recommendations from the American College of Obstetricians and Gynecologists, who suggest addressing and improving the social determinants of health for underserved women to improve maternal health outcomes.²³

Community-based maternal models recognize that lack of basic necessities often makes prenatal, childbearing and postpartum experiences difficult, and therefore assist clients in connecting with social services.

RELATED POLICY RECOMMENDATIONS:

- *Address the social determinants of health.* Clients who use community-based care models to access prenatal through postpartum care and support often face adverse social and environmental factors that affect their health and well-being. Policies that provide access to safe affordable housing, reliable transportation, and safe and nutritious food should be implemented to improve the health of women, children and communities. This can be addressed with a maternity care home, or the model of a primary care patient-centered medical home, that trains, resources and tasks personnel to link women to needed community and social services and help them navigate clinical care.
- *Increase access to paid, job-protected time away from work.* Clients of community-based maternal health care services need access to paid family and medical leave and paid sick days to take time to care for themselves and their families. Public policies for paid leave and paid sick days should be enacted or expanded so that clients of community-based maternal health care models can take time off to attend prenatal and postpartum appointments and care for their families without fear of retaliation or loss of pay.²⁴

Harnessing and Developing Community Power

Each of the organizations recognizes that the communities they work in have untapped resources and assets. The organizations actively invest in their communities and seek out members of the community to partner with. They also regularly engage in advocating for local, state and federal policies that have direct impacts on both their models of care and their greater communities.

Each of the models recruits, hires and develops their staff from people in the community. The founders of each of the models recognized that many of the clients they serve experience challenges that went well beyond the traditional scope of training that most midwives or doulas receive. The models provide enhanced training for these two distinctive roles that incorporates a historical analysis of systemic oppression into the care model, to help community-based maternal care workers better understand the social context in which their clients exist. The training standards in each of the models also require deep respect and unconditional acceptance of all who come in contact with clients. In response to the challenges of young parents, several groups also provide extended parental support that goes well beyond conventional maternity services.

Additionally, to address the dearth of birth workers of color, each of the organizations has designed a pathway to increase the training received and the number of practicing birth workers of color. They place emphasis on training employees to recognize social conditions that cause trauma, and on being deliberately and reliably welcoming, nurturing and kind.

RELATED POLICY RECOMMENDATIONS:

- *Require diversity in maternal mortality oversight.* Maternal mortality review boards and other governing, oversight and investigative bodies should contain members who are community-based health care providers and people of color including community clients/service users clients/service users and people closest to pain. Too often maternal mortality review boards consist of members who do not come from the groups most affected by maternal mortality. To expand the

perspective of review boards, members should be diverse and representative of the communities most affected by the maternal health crisis.

- *Create more direct pathways for birth workers of color.* In many communities of color there is a lack of clinical providers of color, despite historical traditions of midwifery and birth support care in those communities. Creating and expanding pathways for birth workers of color will diversify the birth worker workforce and create a field of practice that is more inclusive, enriches the experiences of women of color and reinforces the notion of culturally relevant and appropriate care.

Conclusion

For women who often exist on the margins of society or who have had negative experiences within the health care system, community-based models provide an opportunity to receive a prenatal through postpartum experience that is centered on their needs, preferences and goals. Community-based maternal care models offer an opportunity to narrow the disparities in maternal health outcomes by providing expanded prenatal, childbirth and postpartum support that is respectful and culturally relevant to at-risk women.

Community-based care models not only offer trusted, culturally concordant support for women, they also provide high quality care and choice in type of maternal care. The array of services they provide often act as a lifeline for women and their families who face social risk factors that make prenatal care unaffordable or difficult to access.

Community-based models like these fill gaps in the health care system by providing wraparound services that address social factors that negatively affect maternal health and high quality interventions aimed at reducing maternal and infant health disparities. They increase access to respectful care, assist people in connecting with social services, and bridge cultural gaps between providers and clients.²⁵ Community-based models also provide increased access to midwives, doulas and birth companions who can provide a range of reproductive health care services and help achieve promising maternal health outcomes.²⁶ There is also some research that suggests that expanded prenatal and postpartum care models reduce the overall cost of care due to fewer emergency visits, cesarean births and postpartum hospitalizations.²⁷

Women need access to support during the prenatal, childbirth and postpartum periods regardless of their access to insurance or type of insurance, immigration status, health status or how far along their pregnancy is when they first seek services. In this way, and many others, these programs fill a gap in the health care system.

Community-Based Maternal Health Care Models at a Glance

	COMMONSENSE CHILDBIRTH	MAMATOTO VILLAGE	BREATH OF MY HEART BIRTHPLACE	MAMA SANA VIBRANT WOMAN
Location	Winter Park – Orlando, Florida	Washington, D.C.	Española Valley, New Mexico	Austin and Travis County, Texas
Number of Clients Served	~ 1,000 per year	~ 400 per year	~ 250 per year	~ 150 per year
Services Provided	<ul style="list-style-type: none"> ○ Prenatal medical care ○ Midwifery care ○ Care coordination ○ Social services navigation ○ Childbirth classes ○ Health and wellness support ○ Lactation support 	<ul style="list-style-type: none"> ○ Labor support/ birth companion ○ Home visitation ○ Care coordination ○ Social services navigation ○ Childbirth classes ○ Parenting classes ○ Health and wellness support ○ Lactation support ○ Family counseling ○ Support groups ○ PMAD interventions 	<ul style="list-style-type: none"> ○ Medical care ○ Midwifery care ○ Postpartum depression interventions ○ Fertility counseling ○ Care coordination ○ Social services navigation ○ Childbirth classes ○ Parent support groups ○ Lactation support ○ Family counseling 	<ul style="list-style-type: none"> ○ Midwifery care ○ Birth companion ○ Care coordination ○ Childbirth classes ○ Parenting classes ○ Massage and yoga
Payment Model	<ul style="list-style-type: none"> ○ MCO contracts ○ Grants ○ Private donations 	<ul style="list-style-type: none"> ○ MCO contracts ○ Grants ○ Private donations ○ Fee for service 	<ul style="list-style-type: none"> ○ MCO contracts ○ Grants ○ Private donations 	<ul style="list-style-type: none"> ○ Grants ○ Private donations
Workforce Development	<ul style="list-style-type: none"> ○ Perinatal health worker training 	<ul style="list-style-type: none"> ○ Perinatal health worker training <ul style="list-style-type: none"> ● Perinatal community health worker ● Perinatal family support worker ○ Lactation specialists ○ Community birth worker 	<ul style="list-style-type: none"> ○ Midwifery training ○ Perinatal community health worker training ○ Lactation specialists 	<ul style="list-style-type: none"> ○ Birth companion training

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