Home Visiting Embedded Doulas Alignment Crosswalk and Recommendations

Developed by the Raising Illinois Perinatal Supports Workgroup
Reviewed and approved by the ELC Health and Home Visiting Committee, September 12, 2024
Reviewed and approved by the ELC Executive Committee, September 16, 2024

Overview

In addition to recent recommendations for home improvement and alignment that were approved through the Early Learning Council, the Health and Home Visiting Committee has been tasked by the ELC Executive Committee to establish cross-system standards and coordination for doula services as an enhancement to existing home visiting services. The Raising IL perinatal supports workgroup shares this priority and is supporting a review of existing standards for doula services as currently implemented as an enhancement to intensive-home visiting services. This document aims to track and compare across IDHS DEC, ISBE Prevention Initiative, and Start Early Doula Best Practice Standards, and elevates recommendations for increased alignment of doula program standards across public funding streams.

Throughout, recommendations are directed toward the State of Illinois, recognizing that the current state funders of doula services (ISBE and IDHS) are undergoing changes as part of the transformation efforts and development of a single new Department of Early Childhood. Wherever possible, ISBE and IDHS should collaborate to align doula program standards in the next fiscal year; however, these recommendations are also intended to serve as a roadmap for the next iteration of centralized state administration of doula services embedded within home visiting once the new agency is operational in FY27. Recommendations are intended to supplement existing home visiting guidance.

The crosswalk is preceded by the recommendations for alignment. These recommendations will be reviewed by the Health and Home Visiting Committee, for later consideration by the ELC Executive Committee, if approved. Beyond the recommendations of the ELC, these efforts can inform the work of the Transition Advisory Committee and the eventual new centralized early childhood agency, as the administration builds out standard funding mechanisms, requirements, and program supports for doula services as a complement to intensive-home visiting services.

Key reference documents

- FY24 ISBE Prevention Initiative Compliance Checklist https://www.isbe.net/Documents/block-grant-pi-checklist.pdf
- FY23 IDHS DEC HV NOFO https://igrowillinois.org/wp-content/uploads/2023/04/IDHS-DEC-HV-NOFO-downloaded-2022.03.30.pdf
- FY23 Start Early PTS-Doula Best Practice Standards

High-level recommendations

The majority of the recommendations focus on alignment of existing standards across funding streams, with minimal changes and/or additions to the way that programs currently operate doula services. However, there are a handful of select recommendations that represent more

significant enhancements to existing program standards across all program streams. These two categories are summarized below, in reference to the detailed recommendations that follow.

New or significant recommendations

7. **Connection to long term home visiting:** Doula services funded within a home visiting program are fully integrated within the context of the evidence-based home visiting program model.

a. The funders should allow doulas to serve families that plan to engage only in doula services. Up to 20% of participants should be able to receive short-term doula services, though programs should aim to engage all expectant participants in doula and home visiting services.
b. The funders should create a new policy to allow doulas to serve long-term home visiting families that are enrolled as participants in another program that does not have doula services. As an example - a Prevention Initiative program should be allowed to have their doula serve a family enrolled in MIECHV home visiting, if that MIECHV funded program does not offer doula services, and this should not count against the 70% metric for the PI program. Programs should be allowed to establish MOUs that dictate the parameters of such partnerships, emphasizing shared communication with participants, standardized program expectations and timelines, use of consent forms for participant data sharing, and other collaboration efforts.
c. With the addition of doula services to the array of Medicaid covered services, the funders should additionally establish guidance on how programs that have doula services but are at capacity/have a waitlist for their funded slots can refer to independent doulas who are certified to bill Medicaid and then re-engage participants in home visiting after postpartum doula services are complete.
d. The funders should also prioritize a shared referral form from independent Medicaid provider doulas into home visiting. This shared referral form should cover all state funded home visiting, and should be used to direct doula clients to long-term home visiting. The funders should jointly create a one-pager or other simple overview that describes how clients of independent doulas can access home visiting services, if they so choose.

10. **Salaries**: All doulas and doula supervisors should be compensated in line with the minimum salary requirements included in the IDHS cost model.

16. Infant/Early Childhood Mental Health Consultation: Doula programs will utilize Infant/Early Childhood Mental Health Consultation (IECMHC) as described in the Illinois model for IECMHC. To find a consultant, programs can use the Illinois Registry of IECMH Consultants. The state will require programs to include Infant/Early Childhood Mental Health Consultation in doula program narratives, and per program will fund, at a minimum, $150/hour x 72hrs/year = $10,800 per year (across doula and home visiting).

Alignment recommendations

1. Service Initiation
2. Labor and delivery support
3. Birth plan support
4. Visit requirements
5. Topical Focus
6. Prenatal Groups
8. Caseloads
9. Staff Ratios
11. Clinical consultation
12. Supervision
13. Capacity requirements
14. Training
15. Curriculum
17. Community partnerships

Detailed recommendations on shared program standards for cross-funder alignment on doula services

1. **Service Initiation**: Doula services embedded in home visiting programs should aim to initiate services at the beginning of the third trimester. Programs should have memoranda of understanding (MOUs) or other mechanisms in place with prenatal clinics, WIC programs, etc. to ensure that pregnant persons in the program's population can be referred by the 28th week of pregnancy.
   a. For engagement very early in pregnancy, including before the third trimester, doulas can refer families to home visiting to work with the home visitor up until the beginning of the third trimester. Home visitors can then make the warm hand-off back to doula services prior to the third trimester. The state should develop sample MOUs for programs with WIC offices, OBGYN and other physician offices, community social service agencies, schools, health departments, and other common referral sources to improve the ability of doula programs to recruit pregnant people early in their pregnancies.
   b. The state should additionally offer guidance on the combined caseload across doula and home visiting. See the Doula Home Visiting Model in the Appendix for additional information.

2. **Labor and delivery support:** Doula support includes 24-hour availability for attendance during labor and delivery, and through recovery. The program must establish written protocols for when the doula will meet the laboring person at the home/hospital, backup procedures that comply with agency policies, communication procedures between the doula and doula supervisor, and on-call expectations (the window in which the doula must be available 24-hours a day in the event the participant enters active labor).
   a. The state should include cell-phone reimbursement or the provision of a work phone for doulas to enable consistent communication with expecting parents and doula supervisors while doulas are on-call. This should be reflected in the sample

budget for doula programs, beginning with sample budgets in development by IDHS based on the updated cost model.

3. **Birth plan support:** Doulas support each participant to develop a birth plan. A birth plan is focused on the participant's desires for the birth concerning areas such as pain relief, feeding, and doula and family involvement in the birthing room. The plan, sometimes referred to as a Birth Wish List, is shared by the participant with the medical providers either prior to or at the time of admission as a step in advocacy for the parent's desires.
    a. Programs should aim for at least 75% of all doula participants in a given program to have a doula attended birth.
    b. Birth plans do not need to be signed by the participant or doula, and are entirely voluntary. It is the doulas responsibility to educate the parent participant during prenatal visits about the role of the birth plan/Birth Wish List in communicating with providers. The birth plan is not a medical document and does not need to include the medical history of the participant, unless the participant feels it is important to offer context surrounding their desires for the birth.
    c. The state should develop a template birth plan to offer to programs as an example, however, there should not be a requirement to use this template/standardized template for all programs and participants.
    d. The state should additionally develop templates for birth plans with consideration for complex cases, prior loss history, cultural factors, etc.

4. **Visit requirements**: The number of doula visits should be determined by home visiting model, where applicable. If the home visiting model does not have specific requirements regarding the frequency and duration of doula visits, doula visits should be between 1 hour and 90 minutes. Visit frequency should be based on the Doula Home Visiting Model suggested prenatal and postnatal visit structure, including combined home visitor and doula visits. (see Doula Home Visiting Model in Appendix)

5. **Topical focus areas:**
    a. Breastfeeding: Doulas will support the autonomy of parents to make the right choice for their family regarding feeding. In line with the Centers for Disease Control and Prevention Healthy People 2030 objectives to 1) Increase the proportion of infants who are breastfed at 1 year and 2) Increase the proportion of infants who are breastfed exclusively through 6 months of age, doulas will utilize medically accurate information and curricula to share information about the benefits of breastfeeding and about risks of HIV transmission via breastfeeding.
        i. For participants who are enrolled in Medicaid, doulas will support education about and referrals to lactation consultants (as a covered Medicaid benefit). As the provider notice for lactation consultants is finalized, the state funders of doula services should jointly develop and disseminate referral guidance.
    b. Smoking: Doulas discuss the risks of smoking during pregnancy and provide smoking cessation materials to participants who smoke.

c. **Alcohol and other substances**: Doulas discuss the risks of alcohol use during pregnancy and provide materials about alcohol and pregnancy to participants as needed. Programs adhere to MIECHV guidance on Addressing Substance Use Issues and Providing Referrals.[1]
d. **Family planning and health:** Doulas provide all participants with information and support regarding the delay of subsequent births, effective family planning including; birth control and protection from STIs, including HIV/AIDS, using medically accurate curricula and materials.

6. **Prenatal groups:** Doula programs hold prenatal groups at least once per quarter. The ideal frequency for prenatal groups is at least once per six-to-eight week session. Prenatal groups provide opportunities for positive peer interaction among doula participants and provide relevant prenatal and postpartum health and parenting information.
   a. Programs may refer to Start Early Best Practice Standards for additional examples regarding session topics and activities.

7. **Connection to long term home visiting:** Doula services funded within a home visiting program are fully integrated within the context of the evidence-based home visiting program model.
   a. The funders should allow doulas to serve families that plan to engage only in doula services. Up to 20% of participants should be able to receive short-term doula services, though programs should aim to engage all expectant participants in doula and home visiting services.
   b. The funders should create a new policy to allow doulas to serve long-term home visiting families that are enrolled as participants in another program that does not have doula services. As an example - a Prevention Initiative program should be allowed to have their doula serve a family enrolled in MIECHV home visiting, if that MIECHV funded program does not offer doula services, and this should not count against the 70% metric for the PI program. Programs should be allowed to establish MOUs that dictate the parameters of such partnerships, emphasizing shared communication with participants, standardized program expectations and timelines, use of consent forms for participant data sharing, and other collaboration efforts.
   c. With the addition of doula services to the array of Medicaid covered services, the funders should additionally establish guidance on how programs that have doula services but are at capacity/have a waitlist for their funded slots can refer to independent doulas who are certified to bill Medicaid and then re-engage participants in home visiting after postpartum doula services are complete.
   d. The funders should also prioritize a shared referral form from independent Medicaid provider doulas into home visiting. This shared referral form should cover all state funded home visiting, and should be used to direct doula clients to long-term home visiting. The funders should jointly create a one-pager or other simple overview that describes how clients of independent doulas can access home visiting services, if they so choose.

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[1] https://igrowillinois.org/wp-content/uploads/2022/07/SUD-guidance-for-IDHS-MIECHV-2021.09.09-EI-Eligibility-Update.pdf

8. **Caseloads:** For a doula outside of their first year of service, the caseload at any point in time is 9-10 participants; 1 FTE doula serves 22-24 participants per year.
    a. The funders should establish joint guidance and expectations regarding how new doulas – within their first year of service – can "ramp up" to full caseloads. Reduced caseloads for doulas in their first year of service should not count against a program in monitoring.
    b. If a home visiting program is at capacity and cannot accept new referrals, the doula program should either be able to enroll participants in short-term doula services without counting against the 70% metric to enroll in long-term home visiting, or should be able to notify funders of a reduction in the doula caseload per year without impacting program standing or future funding.

9. **Staff Ratios:** Programs must employ 2 doulas or a doula-trained supervisor and 1 doula per program, at minimum, to ensure there is backup capacity (in case a participant goes into labor when their doula is away, or if the doula needs respite backup during labor and delivery). Programs must ensure doulas have access to regular, reflective supervision; a minimum ratio of full- time supervisor to staff of 1:6 is expected, and a ratio of 1:5 is optimal.

10. **Salaries:** All doulas and doula supervisors should be compensated in line with the minimum salary requirements included in the IDHS cost model.

11. **Clinical consultation:** Doula programs must contract with a perinatal clinical support consultant. Programs will ensure regular perinatal clinical support of Doulas and Doula Supervisors with face-to-face sessions that take place a minimum of once a month. Clinical consultation ideally will occur on site but may be conducted virtually if needed.
    a. A clinical consultant is part of the doula model so that doulas have the support they might need to serve participants who have medically complicated pregnancies. These consultants are generally registered nurses, midwives, or other professionals who have training in the medical aspects of pregnancy and childbirth.
    b. The funders will offer sample contracts and guidance for how new programs can identify a suitable clinical consultant.
    c. At a minimum, programs should access two hours of doula clinical support per month - ideally 1 - 1.5 and .5 - 1 hours for doulas and doula supervisors, respectively.

12. **Supervision:** Programs will ensure doulas have access to regular reflective supervision.
    a. Supervision should occur at minimum, twice monthly, and within 3-5 days after a doula attends a birth.
    b. Supervisors conduct observations of staff's direct work with families in groups two times per year.

13. **Capacity requirements:**
    a. Programs active for one year or longer must maintain a capacity of 85%; programs utilize a weighted caseload system under the Doula Home Visiting Model (DHVM).

b. See Doula Home Visiting Model caseload guidance in the Appendix.

14. **Training:** Doulas complete pre-service and in-service training requirements from the Start Early Professional Learning Network; the state should develop standard budgeting guidelines for training costs and should ensure these are added/included in every doula program budget. Doula training should be fully covered by state funding as part of the per-slot calculation in accordance with the IDHS cost model.
    a. Doulas complete model specific (home visiting) training in addition to doula core training.
    b. The state should, biannually, survey doula programs regarding additional training topics that doulas would like to access. This can be done in conjunction with the biannual INCCRRA staffing and salary survey. The state should work with the Professional Learning Network and/or other training entities to fund and make available additional professional development opportunities available to doula programs. THis may include training on bereavement/working with families who have experienced loss; working with families with experiences of trauma; working with LGBTQIA+ families; and other topics related to supporting priority populations.

15. **Curriculum:** Programs identify at least one Doula Home Visiting curriculum in their Program Narrative.
    a. Programs will provide doula services that are culturally and linguistically responsive to the populations served.
    b. The state will offer sample guidance of acceptable curriculum.

16. **Infant/Early Childhood Mental Health Consultation:** Doula programs will utilize Infant/Early Childhood Mental Health Consultation (IECMHC) as described in the Illinois model for IECMHC. To find a consultant, programs can use the Illinois Registry of IECMH Consultants.
    a. The state will require programs to include Infant/Early Childhood Mental Health Consultation in doula program narratives, and per program will fund, at a minimum, \$150/hour x 72hrs/year = \$10,800 per year (across doula and home visiting).

17. **Community partnerships:** All programs must have, at minimum, a Memorandum of Agreement with birthing hospitals serving the target population that specify that hospitals will allow Doulas to have access to labor and delivery.
    a. The state should offer additional sample MOUs for referral partners including prenatal clinics, WIC programs, etc. to ensure that pregnant persons in the program's population can be referred prior to the start of the third trimester.

<u>Crosswalk of program standards across public funding streams</u>

Color coding for the crosswalk is as follows:

Aligned to a significant extent
Aligned in principle, but could benefit from more explicit guidance, data collection, or other standards

Not aligned or not accounted for in program standards

	Start Early	IDHS DEC	ISBE PI
		SERVICE REQUIREMENTS	
Service initiation	Programs initiate Doula services at the beginning of the third trimester of pregnancy (80% of participants by seventh month of pregnancy)	Programs initiate Doula services at the beginning of the third trimester of pregnancy (80% of participants by seventh month of pregnancy). The program should also have memoranda of understanding (MOUs) or other mechanisms in place with prenatal clinics, WIC programs, etc. to ensure that pregnant persons in the program's population will be referred by the 26th week of pregnancy.	All expectant families participating in PI funded home visiting can voluntarily choose to participate in supplemental PI funded doula services. Doula services are not required. ** All doula services are fully integrated within the context of the evidence-based home visiting program model. **If the doula has an opening and no PI families are wanting doula services, the PI doula supervisor can offer doula services to another home visiting program that may have a home visiting family wanting doula support.
On-call expectations for birth support	Doula support and advocacy includes 24-hour availability for attendance during labor and delivery. Doulas provide continuous support from the point of active labor through recovery, with respect to agency policy, backup procedures, and the overall well-being of both the mother and doula.	Doula expected to be on-call 24/7 for births;	Not included in FY24 PICC *The FY25 PICC will include a policy and procedures section

	Start Early	IDHS DEC	ISBE PI
	Doula programs have established written protocols that outline procedures when Doulas go to the hospital, when Doulas call and utilize backup, and what communication is expected between the Doula and the Doula Supervisor while the Doula is at the birth.		
Birth support	Doulas develop a birth plan with each participant (90% benchmark). 75% of Doula participants have a Doula-attended birth	Doulas support labor and delivery; 75% of participant births receive doula support.	PICC: Birth plan must include, but is not limited to: Date the plan was created; Signature of expectant parent and doula; List of who the plan will be given to; Expectant persons medical history; Who will be present for the birth; Pain management preferences; Environment of birthing room; Birth position preferences; Once newborn arrives needs while still in hospital; Feeding preferences; Postpartum care
Visit requirements	Doula Home Visits last between one and one and a half hours (80% of visits is benchmark).	None specified outside of home visiting model frequency.	*The program is held to their evidence-based model's expectation. Currently, ISBE has no such requirement for home visitors or doulas.

	Start Early	IDHS DEC	ISBE PI
	80% of expected visits at contracted level are completed.		
Topical focus	**BF:** Doulas document discussions with participants about breastfeeding in case notes. 75% of participants initiate Breastfeeding See HVDN BF standard rationale https://docs.google.com/document/d/18sq8Lev5vgGojdzLGDKtoG0wRZ2qbzBG/edit?usp=sharing&ouid=106133468766338406192&rtpof=true&sd=true **Smoking:** Doulas discuss the risks of smoking during pregnancy and provide smoking cessation materials to participants who smoke. **Alcohol**: Doulas discuss the risks of alcohol use during pregnancy and provide materials about alcohol and pregnancy to participants as needed. **Fam planning and health:** Doulas provide all participants with information and support regarding the delay of	75% of participants initiate breastfeeding	

	Start Early	IDHS DEC	ISBE PI
	subsequent births, effective family planning including; birth control and abstinence (as the only 100% protection from risk), and protection from STIs, including HIV/AIDS, using medically accurate curricula and materials.		
Prenatal groups	Expectation that programs hold prenatal group services. Each Prenatal Group meets for a minimum of one and a half hours as part of a six-to-eight-week session. Programs hold a minimum of 24 Prenatal Group sessions per fiscal year. Programs hold 90% of planned Prenatal Group sessions.	Expectation that about 10 percent of a doula's time is spent facilitating prenatal groups.	
Connection to long-term HV	No more than 20% of Doula participants receive short-term. Doula Services Programs enroll 80% of Doula participants in long- term Home Visiting services.	Doula services are not intended to be standalone; 80% of doula participants are assigned to a long-term home visitor.	All doula services are fully integrated within the context of the evidence-based home visiting program model. All expectant families participating in PI funded home visiting can voluntarily choose to participate in supplemental PI funded doula services. Doula services are not required.

<table>
<tr><th></th><th>Start Early</th><th>IDHS DEC</th><th>ISBE PI</th></tr>
<tr><td colspan="4">STAFFING POLICIES</td></tr>
<tr><td>Caseload</td><td>Caseload at any point in time is a minimum of 9; 1 FTE doula served at minimum 23 participants per year.</td><td>Caseload at any point in time is 9-10; 1 FTE doula serves 22-24 participants per year.</td><td>ISBE refers to the evidence based home visiting models to provide this type of guidance.</td></tr>
<tr><td>Staff Ratios</td><td>A minimum ratio of full- time supervisor to staff of 1:6 is expected. A ratio of 1:5 is optimal.</td><td>2 FTE home visitors for every 1 doula.

2 doulas or a doula-trained supervisor and 1 doula per program, at minimum, to ensure there is backup capacity</td><td>PI program must, at least, maintain 1 FTE ISBE PI funded Home Visitor.

If the program employs only one doula or one hybrid doula, the program must employ one back-up doula. If the program has multiple doula or hybrid doula positions, those staff members will act as back-up doulas for each other.</td></tr>
<tr><td>Salaries</td><td></td><td>Doula required; supervisor recommended.

<table>
<tr><td>Doula Cook County</td><td>$46,800</td></tr>
<tr><td>Supervisor Cook County</td><td>$59,598</td></tr>
<tr><td>Doula Greater IL</td><td>$37,485</td></tr>
<tr><td>Supervisor Greater IL</td><td>$48,058</td></tr>
</table></td><td>No salary expectations in PICC. ISBE is looking into this for home visitors as well as doulas. Hopefully, this information will be shared with the field in FY25.

When ISBE developed the budget for the new doula programs, we allocated $60,000 for 1 FTE doula and $30,000 for benefits. The hybrid doulas were allocated $30,000 for .5 FTE and $15,000 for benefits. Doula supervisors were allotted $70,000 for 1FTE and $35,000 for benefits.</td></tr>
</table>

	Start Early	IDHS DEC	ISBE PI
Clinical consultation	Doula programs ensure regular perinatal clinical support of Doulas and Doula Supervisors with face-to-face sessions that take place a minimum of once a month on site.	A clinical consultant is part of the doula model so that doulas have the support they might need to serve participants who have medically complicated pregnancies. These consultants are generally registered nurses, midwives, or other professionals who have training in the medical aspects of pregnancy and childbirth. They are generally contracted for about 10 hours per month .	The program maintains a contract with a medical professional that has labor and delivery as their specialization, to serve as a resource for the doula(s), hybrid doula(s), if applicable back-up doula(s) and the doula supervisor.
Supervision	Each staff member receives 46 individual supervisions per fiscal year. Supervisors conduct observations of staff's direct work with families in Doula Home Visits and Prenatal Groups two times per year.	Follow the home visiting model's required supervisor/home visitor ratio to ensure adequate supervision. Provide home visitors with the individual reflective supervision hours required by the model. Maintain documentation of supervision, team meetings, field observations, training, and other	ISBE follows the recommended supervision as outlined in the evidence-based home visiting program model.

	Start Early	IDHS DEC	ISBE PI
		staff development led by the supervisor.	
		QUALITY COMPONENTS	
Capacity requirements	Programs must maintain a capacity of 85%; programs utilize a weighted caseload system under the Doula Home Visiting Model (DHVM).	Programs active for one year or longer must achieve 85% of maximum caseload capacity.	
Training	Doulas attend the FSW track of HFA Integrated Strategies or, at a minimum, the two-day PAT Model Implementation training within the first six months of their hire date and attend the first available Doula Basic training in relationship to their hire date. Doulas and Doula Supervisors complete DONA training within three months of hire. Doulas attend FANA training and complete certification within one year of hire.	The program will be offered technical assistance from the SE Professional Learning Network. New doulas must receive pre-service and in-service training from the SE Professional Learning Network.	ISBE funded programs access technical assistance from the SE Professional Learning Network. Along with SE trainings, doulas must attend the evidence-based program model training as well as the 3-day core DONA training. It is up to the program to pay and register for DONA core training.
Curriculum	Programs identify at least one Doula Home Visiting	IDHS lists core program services but does not mention doula curriculum.	*Doulas need to be certified in the program model for home visiting as well as the SE required trainings for doulas

	Start Early	IDHS DEC	ISBE PI
	curriculum in their Program Narrative.	Provide doula services that are culturally and linguistically responsive to the populations served. .	and the 3-day core DONA training through an independent DONA certified trainer.
I/ECMHC	Use of IEMHC not explicit in standards.	Utilize Infant/Early Childhood Mental Health Consultation (IECMHC) as described in the Illinois model for IECMHC (GOECD).	This is not a requirement for home visitors but is suggested as best practice. In turn, doulas will receive MHC if the program participates. Programs with supplemental doula services are to have a contract with a medical professional, that has labor and delivery as their specialization, to serve as a resource for the doula(s), hybrid doula(s), if applicable back-up doula(s) and the doula supervisor. (no one with only doula training can serve in this capacity)
Community partnerships	Programs must describe their mechanism for tracking births within the target population and include incoming referral sources and the number of anticipated referrals per month per referral partner. Programs must specify written agreements with hospitals stating that	The program should also have memoranda of understanding (MOUs) or other mechanisms in place with prenatal clinics, WIC programs, etc. to ensure that pregnant persons in the program's population will be referred by the 26th week of pregnancy.	This will be added to the FY25 PICC.

	Start Early	IDHS DEC	ISBE PI
	hospitals will allow Doulas to have access to labor and delivery.		

Appendix

Start Early Doula Home Visiting Model

ENROLLED PARTICIPANT	# Doula Visits	# Combined Visits*	Total suggested Doula visits	# HV Visits	Total # of Visits	Total # suggested visits
Prenatal Month 7**			2-4			3-5
Prenatal Month 8			3-5			4-6
Prenatal Month 9			3-5			4-6
Total Prenatal Visits			8-14			11-17
Postnatal Month 1			4-5			4-6
Postnatal Month 2**			2-3			3-5
Total Postnatal Visits			6-8			7-11
Total Visits to Participant			14-22			18-28

SHORT-TERM PARTICIPANT	# Doula Visits	Total # of Visits	Total # suggested visits
Prenatal Month 7**			2-4
Prenatal Month 8			3-5
Prenatal Month 9			3-5
Total Prenatal Visits			8-14
Postnatal Month 1			4-5
Postnatal Month 2**			2-3
Total Postnatal Visits			6-8
Total Visits to Participant			14-22

WEIGHTED CASELOAD SYSTEM								
Level 1P	Level 1	Level 2	Level 3	Level 4	DHVM*	CO	CO-TO	CO-TR
2	2	1	.5	.25	2	.25-2	.25-2	.5

**when a participant is enrolled in both the home visiting and Doula components, the Doula Home Visiting Model (DHVM) level is used*

*Combined Visit refers to a single home visit where both a Doula and home visitor (for an enrolled participant) or Doula and a community partner (for a short-term participant) are present.

**Programs may choose to have Doulas visit prior to the third trimester of pregnancy or after the baby turns three months old, but there are no contractual expectations for these visits.