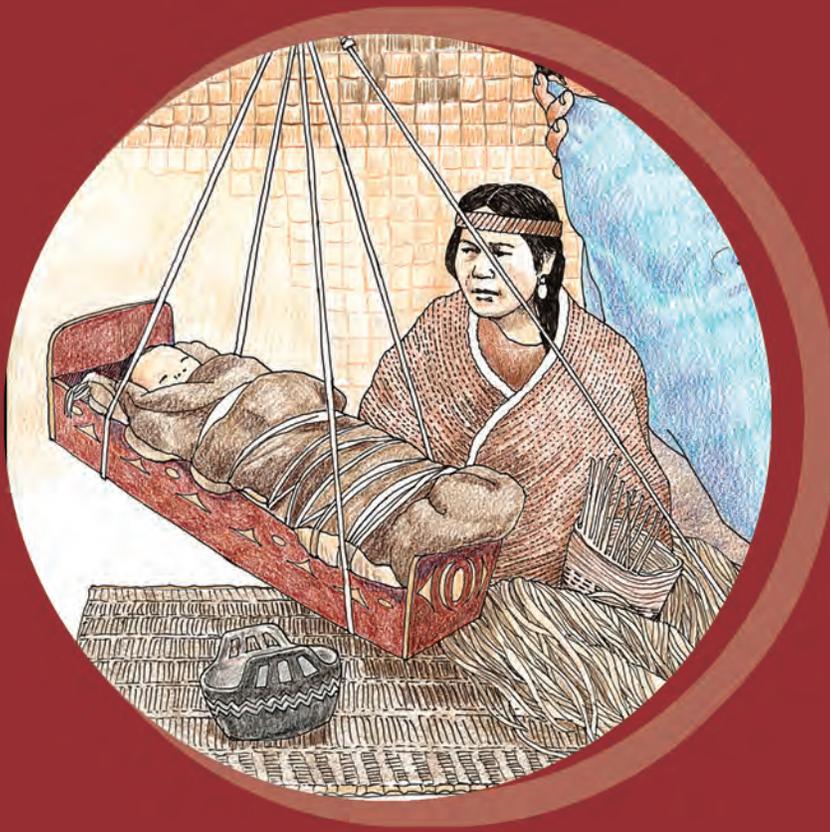


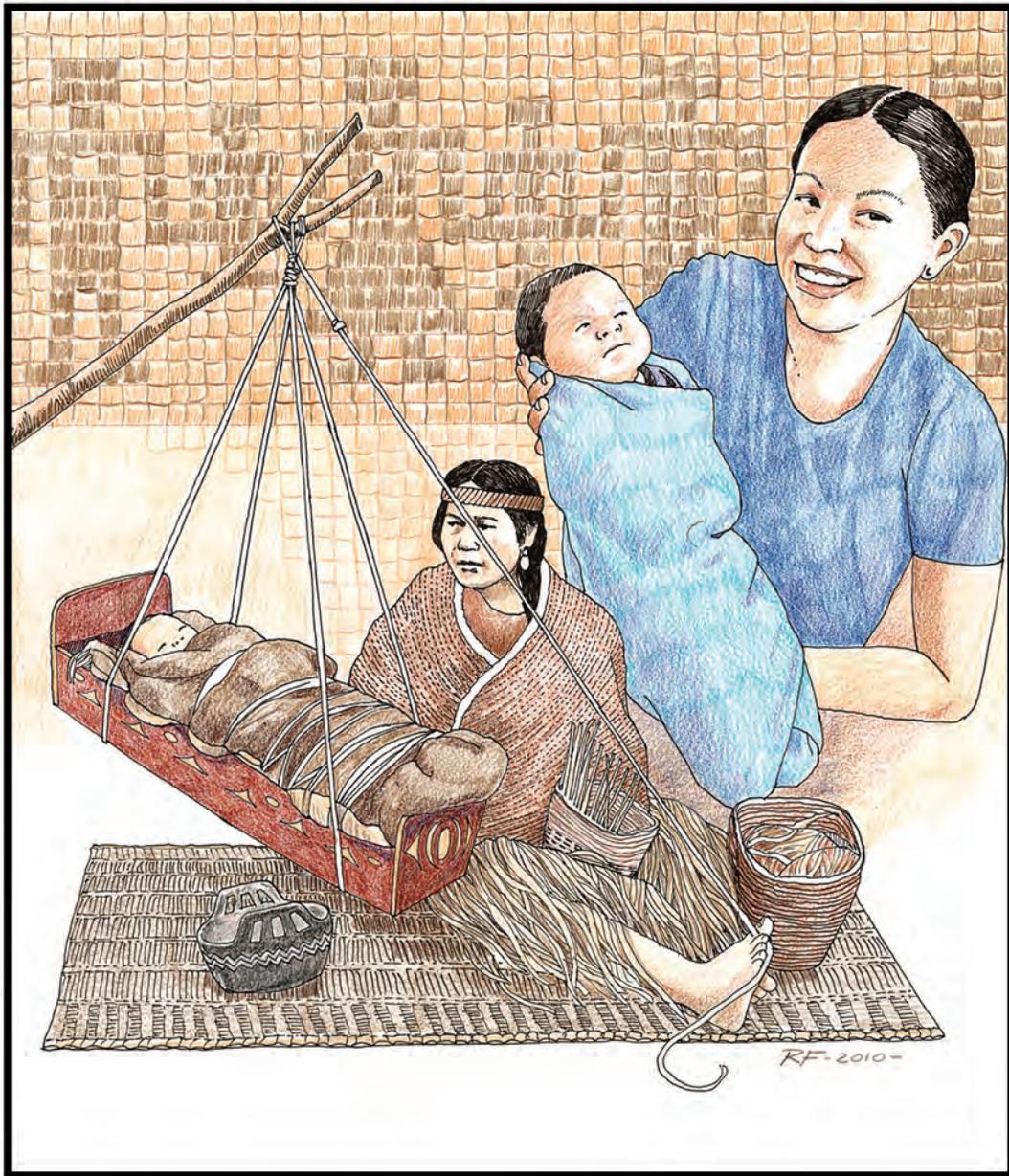
Healthy Communities:
A Tribal Maternal – Infant Health
Strategic Plan



American Indian Health Commission
for Washington State

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Healthy Communities: A Tribal Maternal – Infant Health Strategic Plan



American Indian Health Commission
for Washington State

December 2010

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American Indian Health Commission for Washington State Tribal Maternal and Infant Health Strategic Plan

December 2010

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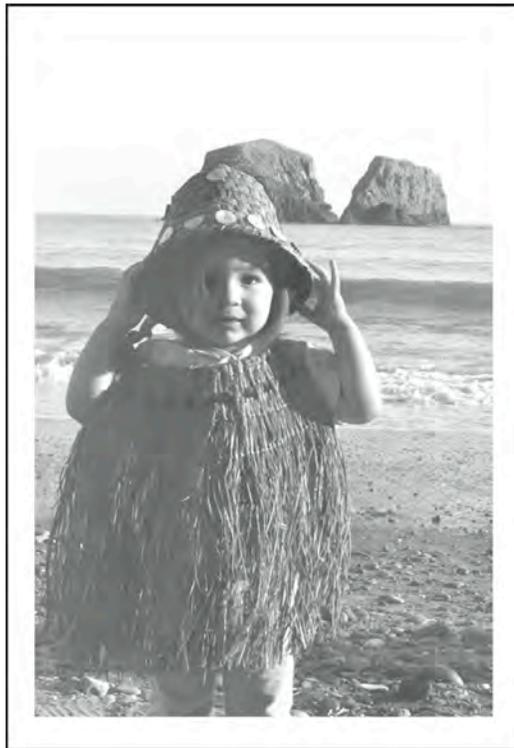
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INTRODUCTION



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Introduction

American Indian Health Care Delivery Plan for 2010-2013

The American Indian Health Commission for Washington State (AIHC) and the Washington State Department of Health (DOH) in August 2009 adopted the American Indian Health Care Delivery Plan for 2010-2013, “Opportunities for Change: Improving the Health of American Indians/Alaska Natives in WA State.” The plan documented health disparities among American Indians in Washington State and identified opportunities for change. Improved Maternal and Infant Health (MIH) was the second of five goals in the plan:

Goal Two: Improve the poor health status for AI/AN pregnant women and infants with appropriate, multiple approaches as a shared goal with state government.¹

Three of the four objectives outlined to meet this goal are the subject of this strategic plan²:

Objective 2.1: Establish a Maternal-Infant Health Workgroup to: a) research causes of poor health status and birth outcomes among Indian women; b) identify promising practice models from tribal and urban delivery of MIH services nationally and in WA State.

Objective 2.2: Identify specific barriers to tribal/urban Indian health program participation in the DOH Women, Infants, and Children (WIC) Program and the Department of Social & Health Services First Steps services (maternity and infant support); develop and implement strategies to improve AI/AN access and Tribal Health program ability to provide these services .

Objective 2.3: Identify options and opportunities for tribes/urban Indian health programs to ensure access for all AI/AN women to high quality obstetrical care and develop methods to successfully engage them in healthy lifestyles.

¹ American Indian Health Commission for Washington State and the Washington State Department of Health, American Indian Health Care Delivery Plan for 2010-2013, Opportunities for Change: Improving the Health of American Indians/Alaska Natives in WA State, August 2009, p. 37.

² Ibid, p. 39.

In carrying out Objectives 2.1, 2.2, and 2.3 in “Opportunities for Change: Improving the Health of American Indians/Alaska Natives in WA State,” this Maternal and Infant Health (MIH) Strategic Plan sets new goals and objectives that are more specific and measurable, and identifies accepted strategies to accomplish those objectives. It also suggests model programs and promising practices that may be implemented to carry out the strategies. Furthermore, it makes recommendations to improve established program and initiate new ones.

Methods Used to Develop the Maternal and Infant Health Strategic Plan

The MIH Workgroup was established in April 2008 and provided oversight for the development of this strategic plan. Five consultants assisted the MIH Workgroup in the development of this plan:

Mim Dixon, Ph.D, Mim Dixon & Associates, Albuquerque, NM

Lorie Chesnut, MPH, Department of Epidemiology, College of Public Health, University of Kentucky

Bridjette P. March, MA, Mukilteo, Washington

Kris Locke, RN, Tribal Health Consultant, Sequim, Washington

Anna Kidder, RN, PhD. Candidate, University of Washington

Methods used to gather information, identify promising practice models, develop strategies and formulate recommendations are described below.

1. Review of Literature and Data

Anna Kidder summarized the published literature and nursing perspectives on best practices in MIH. DOH provided reports and data summaries that were reviewed by Mim Dixon. Lorie Chesnut reviewed national data bases on maternal and child health programs funded by Title V of the Social Security Act to identify best practices and model programs.

Laurie Cawthon, MD, MPH, Manager of the First Steps Data Base in the Washington State Department of Social and Health Services, provided requested data and reviewed the analysis prepared by Mim Dixon. Because infant deaths are relatively infrequent, data on AI infant deaths was combined for 8 years, from 2000 to 2007, and categories of causes of deaths were combined to seek patterns that would be useful for designing

interventions. Dr. Cawthon calculated levels of confidence for statistical significance. Kristen Sasseen in the Department of Health provided data for the WIC Program.

2. Interviews with Key Informants

Kris Locke conducted preliminary interviews with key informants, including tribal health directors and state DOH personnel, in 2009. Additional interviews were conducted by Mim Dixon and Sheryl Lowe in February 2010. Lorie Chesnut conducted telephone interviews with Coordinators of State MCH Block Grants (Title V, SSA) and others in 8 states to obtain information about models of states working with tribes and urban Indian clinics to improve maternal and child health. Meetings were held with professional staff at tribal and urban Indian programs in September 2010 in conjunction with focus groups at Lummi Nation, N.A.T.I.V.E. in Spokane, and the Quinault Nation.

3. Survey of Tribal and Urban Indian Clinic Health Directors

In April 2010, AIHC conducted a survey of tribal and urban Indian clinics to identify current practices and perceived needs. Lisa Rey Thomas, Ph.D., Research Scientist, Alcohol and Drug Abuse Institute, University of Washington, assisted in distributing the survey via the internet and analyzing data. Mim Dixon served as a consultant in designing the survey, analyzing results and writing the report that is included as Appendix 2.

4. Interviews with Award Winning Tribal WIC Programs

The U.S. Department of Agriculture (USDA) announced awards to WIC programs for highest breastfeeding rates and most improved breastfeeding rates in 2010. Washington State received a large state award for highest breastfeeding rates. Several tribal programs contract directly with USDA and are considered as state WIC agencies (also called “Indian Tribal Organizations”). The Navajo Nation received a large state award for highest rate of breastfeeding. Three tribes and tribal organizations in New Mexico received small state awards for highest breastfeeding rates.³ Mim Dixon made site visits to these tribes to learn what made their tribal breastfeeding programs effective.

³ Five Sandoval (which includes Cochiti Pueblo, Jemez Pueblo, Sandia Pueblo, Santa Ana Pueblo and Zia Pueblo), Kewa Pueblo (formerly Santo Domingo Tribe), and Pueblo of Zuni.

5. Discussion of Strategies and Recommendations

Preliminary findings and recommendations were reviewed by the MIH Workgroup at 6 teleconferences and 3 face-to-face meetings.

6. Focus Groups

Focus groups were held with teenage girls, and with women who were currently or recently pregnant. Two focus groups were held in each of three locations: Lummi Nation, Quinault Nation, and N.A.T.I.V.E. in Spokane. The purpose of these focus groups was to test some of the preliminary recommendations that had been developed to see if they were acceptable to the target audience and to obtain additional perspectives and recommendations that should be incorporated into the strategic plan. Local Indian health programs worked with Bridjette March to organize the focus groups. Tam Lutz, Northwest Portland Area Indian Health Board, served as moderator for 4 of the focus groups. Carmen Bland, Youth Engagement Specialist for Lummi Systems of Care, and Bridjette March each moderated one focus group. Mim Dixon provided technical support and analysis.

7. Commission Review

The American Indian Health Commission for Washington State (AIHC) reviewed portions of the report during their meetings in July, August and October, 2010. At their meeting on October 8, the AIHC passed a resolution accepting the MIH Strategic Plan for presentation, review and discussion at the Tribal Leaders Health Summit, November 9-10, 2010.

Concepts and Guiding Principles

There are 8 underlying concepts and guiding principles used in developing, organizing and presenting the MIH Strategic Plan.

1. Identify the most significant problems where interventions can make the greatest difference in outcomes in the next 5 years.

For the purposes of this plan, maternal and infant health covers the period from conception through the baby's first year of life, recognizing that pre-conception health influences the outcomes during this period. To improve maternal and infant health, it is important to first identify the problems that need to be addressed. While the underlying problems of poverty, racism, education, housing, and employment must be acknowledged, they are not within the scope of this MIH Strategic Plan, except insofar as the delivery of programs can be done in a way that strengthens tribes and empowers communities.

There are insufficient resources, including both leadership focus and funding, to tackle every problem. So, this MIH Strategic Plan focuses on the issues that affect the most people in the most serious ways. Data were analyzed with clear criteria to prioritize problems; however, tribes and urban Indian programs are expected to prioritize the solutions.

For this strategic plan, the most significant problems are: 1) those identified by tribal communities as priority needs; 2) causes of infant mortality that have the greatest prevalence among AI and the greatest disparity between AI and the total population in Washington State; and 3) risk factors for poor pregnancy outcomes that have the highest prevalence, the greatest disparity as compared to the total population, and the most severity.

2. Create measurable goals to eliminate disparities between American Indians and the population as a whole.

It has been argued that some infant mortality and poor birth outcomes are unavoidable. However, if an outcome can be achieved in the total population, then it should be possible to achieve that same outcome in the American Indian population.

The intermediate (5-year) goal is to reduce the disparities for American Indians so that the AI infant mortality and pregnancy outcomes occur at the same rates as the total

population. The more long term goal is to reduce the risk factors for the total population, including AI.

Objectives that are measurable allow us to know if new programs and policies are working. If not, there is an opportunity to make changes that would either make programs more effective or try other approaches.

3. Adopt strategies using approaches proven to be effective.

This MIH Strategic Plan is organized to identify objectives, strategies to achieve those objectives, and programs to carry out the strategies. Research findings are used to select objectives and strategies that have been shown to be valid. For most MIH problems, research has documented causes, risk factors, and effective interventions. Strategies are the intermediate step in the plan that focuses on what needs to be done. Here is one example:

Objective: Reduce AI infant mortality from SIDS by 54 percent

- Strategies:
- 1) Smoking prevention and cessation
 - 2) Parent education on “back to sleep” and SIDS risk factors
 - 3) Increase breastfeeding through parent education, hospital practices, community support, and workplace practices
 - 4) Provide equipment for a safer sleep environment
 - 5) Abstinence from alcohol during pregnancy

The strategies are the strategic direction that is needed to design and/or select programs that are most likely to meet the objectives. Strategies are the *what* is to be done, while programs are the *how* to do it. Strategies to reduce disparities should be based on the best available evidence.

4. Tribes and urban Indian programs can deliver the most culturally appropriate and most geographically accessible programs to American Indians.

Program evaluation is difficult in small populations, such as tribes. When programs have been evaluated in larger populations and found to be effective, it does not necessarily mean that they will also be effective in the tribal context. Adaptations may

be needed to make the program more culturally appropriate and/or more workable in a small scale, rural context.

Interventions should be designed to be delivered at the local level wherever possible. Tribes should be encouraged to design interventions that would work best for their tribal members. A “one size fits all” approach creates barriers to participation by tribes and by individuals who need their services. The types of interventions designed by a small tribe may involve creating linkages to services outside the tribe, offering counseling and providing community support. Larger tribes and urban Indian programs may be able to provide the full range of medical and social services. Diversity among tribes should be recognized. And, cooperation between tribes should be encouraged, such as the South Puget Intertribal Planning Agency (SPIPA), a tribal-chartered intergovernmental agency (a consortium of 5 western Washington tribes).

Data suggest that American Indian women are using some of the services that are currently available either through their tribe or at the county level, including Medicaid, First Steps (Maternity Support Services and Infant Case Management), and the Federal Special Supplemental Nutrition Program for Women, Infants and Children (WIC). However, many who are eligible are not enrolled. Researchers have observed that for those who are already enrolled, there may be a self-selection process that leads to better outcomes.⁴ There may be a group of women who are hard to enroll who would show the most benefit from these types of programs. The challenge is to understand the barriers and incentives that could be addressed to enroll those who are at highest risk for poor pregnancy outcomes. After people are enrolled, the program’s effectiveness is dependent upon their participation in program activities.

Tribes and urban Indian programs are more likely to understand the families that they serve, to approach people in non-judgmental ways that reduce the perceptions of racism on the part of clients, to motivate people through values that are inherent in their cultures, and to create programs that are inclusive and community based. Tribal and urban Indian programs are more likely to be trusted and to gain entry for home visits, as compared to government employees and people representing non-Indian organizations.

Many of the problems identified in this strategic plan require community approaches to support women to make healthy choices. Community empowerment models are especially relevant to tribal governments. Designing effective prevention programs and

⁴ Amira Y. el-Bastawissi, R. Peters, K. Sasseen, T. Bell, R. Manolopoulos, Effect of the Washington Special Supplemental Nutrition Program for Women, Infants and Children (WIC) on Pregnancy Outcomes. *Journal of Maternal and Child Health* 11:611-621, 2007.

interventions to address known risk factors requires community involvement and local knowledge of cultural beliefs and practices.⁵

5. While problems are prioritized at a statewide level, each tribe and urban Indian clinic must prioritize the actions that they will take to implement strategies that have been identified.

This MIH Strategic Plan provides a menu of options for tribes and urban Indian clinics. It is anticipated that planning grants would allow tribes and urban Indian clinics to review the plan, conduct community meetings and other organizing activities, and select a few objectives, strategies and programs to implement that will have a high chance for success due to community priorities, readiness and resources. As long as each tribe and urban Indian clinic uses strategies that have been shown to be effective in achieving the objectives in this plan, there will be a reduction in American Indian infant mortality and an improvement in pregnancy outcomes statewide.

6. Look for solutions that are cost effective, even if it means challenging existing rules and regulations for established programs.

There should be accountability for expenditure of funds and quality assurance without having to use a disproportionate amount of resources for enrollment, data gathering, tracking, accounting and billing. Complexity of systems and paperwork are a barrier for patients to enroll in programs, and it diverts tribes from doing what they do best. One of the ways to reduce administrative costs is to use the federally-approved encounter rate for services delivered in tribal and IHS facilities.

Because tribes are often located in remote rural areas, it is often difficult to recruit and retain health professionals. Over the years, the Indian Health Service has pioneered the use of a variety of types of paraprofessionals and midlevel professionals to deliver services under the supervision of health professionals. This model has proven to be cost effective, as well as providing employment for tribal members. Other programs offered by the state and federal government should have the flexibility to use indigenous people in paraprofessional roles, rather than requiring professional credentials for positions that may be costly and difficult to fill in tribal areas. Another approach to

⁵ Kay M. Tomashek, C. Qin, J. Hsia, S. Iyasu, W.D. Barfield, L.M. Flowers, Infant Mortality Trends and Differences Between American Indian/Alaska Native Infants and White Infants in the United States, 1989-1991 and 1998-2000, American Journal of Public Health, December 2006, Vol 96, No. 12.

reduce costs and provide access to professional expertise is telemedicine and telehealth.

7. State investment in maternal and infant health services for American Indians should help the State of Washington reduce their Medicaid expenditures in the short term and the long term.

Federal laws require the State of Washington to cover prenatal care, deliveries and infant care under the Medicaid program for people who meet the eligibility requirements. Risk factors lead to higher costs of prenatal care and deliveries, and poor pregnancy outcomes lead to more expensive care for infants. By reducing risk factors and improving pregnancy outcomes, the Medicaid program can save money.

For the State of Washington, the most cost effective way to deliver MIH services to tribal members is through Medicaid-funded tribal programs, because they receive a 100 percent federal match. To do this, the State of Washington must make it attractive for tribes and the IHS to deliver those programs. At minimum, tribes and the IHS must receive enough funding to cover the cost of delivering the services. State and federal programs should pay both indirect costs and direct costs for tribes to deliver services.

8. Integrate state-funded and federally-funded programs with existing tribal, urban Indian clinic, and Indian Health Service programs.

Most tribes already have some programs to promote healthier lifestyles, provide nutrition education, offer mental health services, transport people to medical appointments, visit homes to assess needs and offer assistance. Particularly for small tribes, it makes more sense to enhance existing services to meet the needs for improving maternal and infant health, rather than creating entirely new programs with separate funding streams. It should be possible to combine funding from different sources, provide additional training to existing staff, and offer new or expanded services that can meet the specific needs of pregnant women and infants. For example, tribes should be able to offer the same types of services for all pregnant women, regardless of whether they are enrolled in Medicaid; however, they should receive Medicaid funding to cover the costs of serving the women who are enrolled in Medicaid. To make this integration work requires flexibility, respect for tribal ways of doing things, and a commitment to build on the strengths of existing programs.

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RESEARCH FINDINGS ON OUTCOMES AND RISK FACTORS



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Research Findings on Causes of Poor Health Status and Birth Outcomes among American Indian Women

Research using existing databases is complicated to interpret for a number of reasons. First, the definition of American Indian can vary to include: a) enrolled members of federally-recognized tribes; b) people who self-identify as Native American, which may include those who identify with tribes from Canada, Mexico, Central and South America; c) people who self-identify as Native American and another ethnic or racial group. Depending on the definition that is used, the numbers and ratios of people living in urban and rural/tribal areas can vary. Due to differences in eligibility for Indian health services, it may be appropriate to use the most restrictive definitions when analyzing tribal health patterns and problems, and to use the most encompassing definitions when considering urban Indian health issues. This may mean that urban and rural data are not comparable.

Objective 2.1: Establish a Maternal-Infant Health Workgroup to: a) research causes of poor health status and birth outcomes among Indian women; b) identify promising practice models from tribal and urban delivery of MIH services nationally and in WA State.

— American Indian Health Care Delivery Plan
for 2010-2013

The Maternal-Infant Health (MIH) Workgroup was established in April 2008 and they have provided oversight for this strategic plan.

A second problem with research and data is that numbers are often too low to allow for statistical analysis unless several years of data are combined. Combining data is also important for protecting the confidentiality of individuals and communities, so data usually cannot be presented at the tribal level for small tribes. Researchers have used 3-year averages⁶, 6-year averages⁷ and 8-year averages⁸, and other combinations. By using existing databases and the most restrictive definition (Native American only, U.S.

⁶ James A. Gaudino (2008) Progress Towards narrowing Health Disparities: First Steps in Sorting Out Infant Mortality Trend Improvements Among American Indians and Alaska Natives (AI/AN) in the Pacific North West, 1984-1997. *Journal of Maternal and Child Health* 12:S12-S24.

⁷ Mei Castor, M. Smyser, M. Taualii, A. Park, S. Lawson, R. Forquera, A Nationwide Population-Based Study Identifying Health Disparities Between American Indians/Alaska Natives and the General Populations Living in Select Urban Counties, *American Journal of Public Health*, May 2006, Vol 96, No. 5.

⁸ Laurie Cawthon, MD, MPH, Infant Mortality by Race/Ethnicity for Washington State 2000-2007, Number of Deaths by Grouped Cause, March 5, 2010.

citizenship, and not Spanish speaking), the numbers of pregnancies, births, and infant deaths is very low, so more years of data are needed to reach valid conclusions.

Another way to combine data so that there are numbers large enough for analysis is to group causes of infant mortality or low birth weight. Different researchers may decide to group things in different ways. For example, diseases and disorders that relate to a part of the body could be grouped together (such as respiratory system, or digestive system). Another way to group data is to combine causes that have the same underlying risk factors. For example, diseases and disorders that result from smoking and secondhand smoke may be grouped together to look at the impact of that risk factor and to estimate the benefit of an intervention strategy. Another approach is to group data around the time periods in the sequence of care to identify the time at which interventions could be made most effectively. This approach is called Perinatal Periods of Risk (PPOR).

Third, when comparing AI data to others, the magnitude of disparities will be different depending upon whether AI are compared to the best case scenario or to the total population, which is essentially an average. In one study, the comparison group was white non-Hispanic women, older than 20 years old with at least 13 years of education.⁹ The total population could either include AI or exclude AI, but the AI population is relatively small so that the comparisons are not generally affected by the decision to include/exclude AI in the total population.

A fourth problem is misclassification of data related to race and ethnicity.¹⁰ This happens primarily because data are derived from forms that are either filled out by someone who guesses the person's identity, or people self-identify without having clear and consistent guidelines for their responses.

This MIH Strategic Plan draws on a lot of sources, both published and unpublished. The data do not match due to the issues of definition of AI, years selected for data, and decisions about the population that is used as a standard for comparison. However, the patterns that emerge from nearly all studies and databases are very similar.

⁹ Urban Indian Health Institute, Eliminating Disparities in Birth Outcomes of American Indian and Alaska Native Infants: Washington State. Powerpoint presented to the American Indian Health Commission for Washington State, December 11, 2009.

¹⁰ Mei Castor, M. Smyser, M. Tualii, A. Park, S. Lawson, R. Forquera, A Nationwide Population-Based Study Identifying Health Disparities Between American Indians/Alaska Natives and the General Populations Living in Select Urban Counties, American Journal of Public Health, May 2006, Vol 96, No. 5.

There are alarming disparities in American Indian infant death rates and causes of death, and many of these are preventable.

Infant mortality is a relatively rare occurrence. In Washington State, on average 82,036 babies are born each year and 428 die in the first year of life, an infant mortality rate of 5.2 per 1,000.¹¹ Among American Indians, there is an average of 1,555 births per year and 17 infant deaths per year, for a rate of 11.1 per 1,000.¹² Thus, the infant mortality rate is more than twice as high for American Indians than for the population as a whole.^{13,14}

By combining 8 years of data and grouping together causes of death, some very disturbing patterns emerge in AI infant mortality. Over 85 percent of infant mortality can be attributed to the following 8 causes of death that are listed in order of frequency (see Table 1 in Appendix A for more details):

- 1. Sudden Infant Death Syndrome (SIDS).** The SIDS rate is 3 times higher among American Indians than the population as a whole in Washington State.¹⁵
- 2. Birth Defects.** The rate is 30 percent higher among American Indians.¹⁶
- 3. Injuries.** Causes of death that are related to behavior occur at a rate that is 5 times higher among AI compared to the total population of infants in Washington State.¹⁷ These include hanging, strangulation and suffocation (nearly 4 times higher among AI), homicide (7 times higher among AI), poisoning (7 times higher among AI), transportation fatalities (6.5 times higher among AI), and other injuries (4 times higher among AI).

¹¹ Average based on 8 years of data from Laurie Cawthon, MD, MPH, Infant Mortality by Race/Ethnicity for Washington State 2000-2007, Number of Deaths by Grouped Cause, March 5, 2010.

¹² Ibid

¹³ This difference is statistically significant.

¹⁴ To put these infant mortality rates into an international perspective, if Washington State were a country, it would rank 29th in infant mortality, ahead of the United States which ranked 33 according to the United Nations World Population Prospects, 2006 revision. However, the American Indian infant mortality rate would rank 60th in the world, behind such countries as Poland, Slovakia, Estonia, Malaysia, Thailand, and Sri Lanka.

¹⁵ This difference is statistically significant.

¹⁶ Because the numbers are so low, the rate of birth defects in the AI population is not statistically significantly different from the WA State population total.

¹⁷ This difference is statistically significant.

4. Complications of Pregnancy and Delivery. The infant mortality rate from complications of pregnancy and delivery is 50 percent greater among AI babies compared to all babies in Washington State.¹⁸ This includes maternal complications (30 percent higher), intrauterine hypoxia and birth asphyxia (80 percent higher), and respiratory distress of newborn (2.4 times higher).

5. Prematurity and Low Birth Weight. American Indian babies die from being born prematurely and at a low birth weight at a rate that is 60 percent higher than the rate for all babies born in Washington State.¹⁹

6. Infectious Disease. Infectious diseases account for nearly 10 percent of the AI infant mortality and these occur at rates more than 3 times that of the population as a whole.²⁰ The rates are especially high for infant deaths due to influenza and pneumonia (7 times higher) and perinatal infection (nearly 3 times higher).

7. Digestive System Problems. Among AI babies, deaths from digestive system problems occur at 3 times the rate of the total for Washington State babies.²¹ This includes digestive system disorders of the fetus and/or newborn (4.6 times higher) and diseases of the digestive system (60 percent higher).

8. Unknown causes. About 5 percent of AI infant deaths are from unknown or ill-defined causes. On average, one AI infant death per year is from an unknown cause. This is 4.5 times the rate of unknown causes for all infants who die in Washington State.²²

The other 13 percent of AI infant deaths, about 2 per year, come from disorders that are usually very rare in both the AI and the non-AI population.

Infant deaths represent the worst case outcomes, and they also serve as indicators of problem areas that deserve attention. While the numbers of infant deaths are relatively small, it should be feasible to reduce those numbers so that the death rates for AI infants are similar to those for the Washington State population as a whole. In addition

¹⁸ Because the numbers are so low, the rate of complications during pregnancy and delivery is not statistically significantly different from the WA State population as a whole.

¹⁹ Ibid.

²⁰ This difference is statistically significant.

²¹ Statistically, this difference is borderline in significance.

²² This difference is statistically significant.

to the total infant mortality rate, the differences in rates are statistically significant for deaths due to SIDS, injuries, infectious diseases, and ill-defined and unknown causes.

Furthermore, for every death due to the causes listed, there are likely many cases that do not result in death, but can result in disability, pain and suffering, and costly health care. For example, low birth weight is associated with increased risk of neuro-developmental conditions, learning disorders, and respiratory tract infections.²³ In Washington State, an average hospital cost for a preterm birth is over \$50,000, while it costs approximately \$1,500 for a low-risk normal weight birth.²⁴

Risk factors for poor pregnancy outcomes suggest strategies for intervention.

Because infant mortality is a relatively uncommon occurrence, pregnancy outcomes are measured using other indicators. The most common indicators are preterm delivery and low birth weight (LBW). These two outcomes are interrelated. About 66 percent of LBW babies were also born prematurely.²⁵ Overall, AI pregnant women on Medicaid have a rate of LBW babies 30 percent higher than all women on Medicaid (6.9 percent of AI singleton births compared to 5.4 percent of singleton births for all Medicaid recipients).²⁶ In general, babies weighing less than 5.5 pounds (2500 grams) are considered LBW.

There are also negative outcomes associated with high birth weight (HBW) babies, including higher rates of Cesarean section births, preterm births, childhood obesity, and higher risk of chronic diseases for both mother and infant.²⁷ New research also suggests that women whose weight puts them in the category of obese when they become pregnant are more likely to have babies with birth defects, including congenital

²³ Laurie Cawthon, E. Kohlenberg, D. Mancuso, B. Felver, H. Axelsson, Employment and Health among DSHS Clients, by Race and Ethnicity and Region. Presented to the Indian Policy Advisory Committee, January 14, 2010.

²⁴ Amira Y. el-Bastawissi, R. Peters, K. Sasseen, T. Bell, R. Manolopoulos, Effect of the Washington Special Supplemental Nutrition Program for Women, Infants and Children (WIC) on Pregnancy Outcomes. *Journal of Maternal and Child Health* 11:611-621, 2007.

²⁵ Ibid.

²⁶ Laurie Cawthon, MD, MPH, Risk Factors for Low Birth Weight Among Washington Medicaid Women with Births in 2008, DSHS Research and Data Analysis, March 23, 2010.

²⁷ The Institute of Medicine Committee to Reexamine IOM Pregnancy Weight Guidelines considered the additional risks of pregnancy-induced hypertension or preeclampsia and gestational diabetes mellitus and decided there was insufficient evidence that these were caused by weight gain during pregnancy. Kathleen M. Rasmussen and Ann L. Yaktine, Editors, *Weight Gain During Pregnancy: Reexamining the Guidelines*, The National Academies Press, 2009,

heart defects and serious neural malformations of the spine.²⁸ There is no single definition of HBW, as it is usually related to gestational age. For full term births, babies larger than 8.8 pounds (4000 grams) are considered HBW.

The risk factors for poor pregnancy outcomes have been studied extensively in large populations of women, and it is an accepted strategy to reduce those risk factors in order to improve pregnancy outcomes.

As part of the intake process for Maternity Support Services, a number of risk factors are assessed.²⁹ For the purposes of this MIH Strategic Plan, those risk factors were selected for analysis if there were more than 100 AI births in 2008 with the risk factor, or if there was a disparity for AI births in comparison to total Medicaid births (see Table 2 in Appendix 1). This resulted in a list of 16 risk factors for that were ranked by disparity, by prevalence, and by severity.³⁰ These rankings were averaged to highlight the most important risk factors in the AI population.³¹ Using this methodology, the six risk factors that should be addressed to produce the greatest improvements in maternal and infant health were selected.

1. Mental Health. In 2008, there were 720 pregnant AI women with a mental health diagnosis during pregnancy or up to 1 year postpartum, over a third the AI pregnant women on Medicaid. This is 2.7 times the rate for all pregnant women on Medicaid. This is the risk factor for LBW that affects more AI pregnant women than any other risk factor, and nearly 9 percent of these women have LBW babies.

2. Alcohol and/or Substance Abuse. The disparity in LBW risk factors was greatest for alcohol and/or substance abuse during pregnancy or 1 year postpartum. AI births had 3.3 times the rate compared to all Medicaid births. Among the 366 AI pregnant women having this risk factor (18 percent of AI pregnant women), nearly 11 percent had LBW babies in 2008.

²⁸ Risk of Newborn Heart Defects Increases with Maternal Obesity, National Institutes of Health, NIH News, April 7, 2010.

²⁹ MSS Prenatal Eligibility Tool, form DSHS 13-874. Being a Native American is considered a risk factor and the highest level of Maternity Support Services is authorized under the Washington State First Steps program. While this is used to justify higher level of services, it was not considered one of the risk factors that could be changed in the analysis and prioritization in this MIH Strategic Plan.

³⁰ Disparity was ranked from 1 to 16 with 1 being the greatest disparity. Prevalence was ranked from 1 to 16 with 1 being the highest prevalence. Severity was ranked on a scale of 1 to 3 using the A,B,C categories identified in the MSS Prenatal Eligibility Tool with 1 being the most severe.

³¹ This is an unweighted average, with 1 being the highest score possible

3. Smoking. Nearly 28 percent of AI pregnant women reported that they smoked during their pregnancy, compared to 17 percent of all pregnant women on Medicaid, a rate that is 70 percent higher. Among the 575 AI women who smoked during their pregnancy, nearly 8 percent had LBW babies.

4. Threatened Pre-Term Labor. The rate for symptoms of preterm labor was 2 times higher for AI births than for all births on Medicaid. In 2008, there were 309 AI women (15 percent) with this condition which requires medical intervention. Over 10 percent of these AI women gave birth to LBW babies.

5. History of Prior LBW Baby, Preterm Delivery, or Fetal Death. People who have a history of a LBW baby are more likely to have another LBW baby. There were 329 AI women in this high risk category in 2008, which is 16 percent of the AI pregnant women. The rate of this risk factor for LBW is 50 percent greater for AI than for the total Medicaid population. Nearly 12 percent of AI births with this risk factor are LBW.

6. Nutrition and Weight. If a person meets the criteria for obesity prior to pregnancy (defined as greater than or equal to a body mass index of 30) and their weight gain during pregnancy is outside of the guidelines established by the Institute of Medicine, then there is a higher risk of complications in pregnancy and childbirth from a high birth weight (HBW) baby, as well as preterm birth. About a quarter of AI births have this risk factor, a rate 30 percent higher than the Medicaid population as a whole. In 2008, there were 492 pregnant women with this risk factor.

This list of the top six risk factors that should be addressed to improve pregnancy outcomes points to the need for greater behavioral health and nutrition services, as well as increased access to specialty medical care.

American Indian women need greater access to alcohol, substance abuse and mental health services.

Substance abuse and mental health problems are associated with overall infant mortality rates. Babies of women who use alcohol and other drugs during their pregnancy have a rate of infant mortality 50 percent greater the first month of life, and more than twice as high in the remainder of the first year of life, compared to babies of women for whom there is no identified substance abuse.³² Similarly, if mothers have mental health problems, their babies are at higher risk for infant mortality. The infant

³² The neonatal death rate is 6.0 per 1,000 for babies born to maternal substance abusers compared to 4.0 per 1,000 where there is not identified substance abuse. For the postneonatal period (1 month to 1 year) the rates are 6.6 per 1,000 compared to 3.1 per 1,000. Source: Laurie Cawthon, MD, MPH.

mortality rate during the first month of life is 3.8 per 1,000 births for mothers who have no identified mental health problem, 6.7 per 1,000 births for mothers who have intermediate mental health problems, and 10 per 1,000 births for mothers who have severe mental health problems.³³ Often, women have dual diagnoses, experiencing mental illness and self-medicating with alcohol or other drugs.

In the Seattle-King County area, the perception is that Medicaid provides adequate compensation to assure access to obstetricians. However, a significant number of AI/AN pregnant women have mental health, alcohol and drug abuse problems. So, when the State of Washington cuts funding for treatment programs, it affects pregnant women and their infants, according to Dr. Peter Talbot, a pediatrician and Medical Director at the Seattle Indian Health Board.

Research has shown that Chemical Dependency (CD) treatment during pregnancy can reduce the low birth weight rate by 33 percent; and if CD treatment is combined with other wraparound services, the rate of low birth weight can be reduced by 66 percent.³⁴ Furthermore, CD treatment during pregnancy can reduce accepted referrals³⁵ to Child Protective Services (CPS) by 27 percent during the child's first year of life; and if CD treatment is combined with other wraparound services during pregnancy, the reduction in accepted CPS referrals can be 36 percent.³⁶ CD treatment also reduces arrest rates among moms two years after entry into a program by as much as 58 percent compared to their arrest rates in the two years prior to entry for such drug-related crimes as possession, theft, fraud, and prostitution.³⁷

In 2008, CD treatment was provided to 45 percent of pregnant Medicaid women who were identified as substance abusing. However, only 30 percent of AI pregnant women on Medicaid with substance abuse problems received CD treatment (a total of 210 women). An additional 43 AI women who gave birth in 2008 received CD treatment immediately after their child was born.³⁸

DSHS data show that 18 percent of American Indian women on Medicaid used alcohol and other substances during their pregnancy and/or during the first year post partum,

³³ Source: Laurie Cathon, MD, MPH.

³⁴ Laurie Cawthon, MD, MPH, Safe Babies, Safe Moms, Fact Sheet Number 4.36f, January 2004.

³⁵ If a report of suspected child abuse or neglect warrants further investigation by Child Protective Services, then it is considered an "accepted referral."

³⁶ Ibid

³⁷ Ibid

³⁸ Laurie Cawthon, MD, MPH, personal communication, April 1, 2010.

compared to 5 percent of the total Medicaid population of pregnant women.³⁹ Another way of looking at this is that 16 percent of the pregnant women on Medicaid with alcohol and substance abuse treatment needs are American Indian, far in excess of their 5 percent representation within the total Medicaid population of pregnant women. At the same time, only 73 percent of AI pregnant women with alcohol and substance abuse use on Medicaid received Maternity Support Services.⁴⁰ In one tribe that was visited to discuss recommendations in this plan, health care professionals estimated that 30 percent of pregnant women were on methadone. At another tribe, health care professionals also expressed concern about heroin use and reported that Swedish Hospital in Seattle has a unit that provides methadone during pregnancy at a cost of approximately \$78,000 for 2 months.

Women who do not know that they are pregnant may be exposing a fetus to the harmful effects of alcohol and other drugs (AOD). In addition to the well-known problems of Fetal Alcohol Spectrum Disorders (FASD)⁴¹, research suggests that drinking during pregnancy may affect the development of the brainstem. This provides one explanatory model for SIDS, with evidence suggesting that alcohol and/or smoking induced brainstem abnormality deprives the infant of the capability of protective responses to life-threatening respiratory challenges during sleep.⁴²

Pre-conception treatment of alcohol and other drugs would have the greatest impact on maternal and child health. American Indian youth age 12 to 17 have a much higher rate of need for AOD treatment than all other ethnic groups. An estimated 14 percent of AI youth who received Medicaid in fiscal year 2008 needed AOD treatment, compared to 4 percent of Asian /Pacific Islander, 5 percent of Hispanic, 6 percent of white, and 7 percent of African American youth.⁴³ The need for AOD treatment for AI youth varies by region from 12 percent to 17 percent.⁴⁴ Among working age adults (18 to 64 years old)

³⁹ Laurie Cawthon, MD, MPH, Risk Factors for Low Birth Weight Among Washington Medicaid Women with Births in 2008, DSHS Research and Data Analysis, March 23, 2010.

⁴⁰ Ibid

⁴¹ This includes Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE).

⁴² Hannah C. Kinney, et al, Serotonergic Brainstem Abnormalities in Northern Plains Indians with the Sudden Infant Death Syndrome. *Journal of Neuropathology and Experimental Neurology*, Vol 62, No. 11, November, 2003.

⁴³ Laurie Cawthon, E. Kohlenberg, D. Mancuso, B. Felver, H. Axelsson, Employment and Health among DSHS Clients, by Race and Ethnicity and Region. Presented to the Indian Policy Advisory Committee, January 14, 2010.

⁴⁴ Ibid

who are receiving medical assistance from the State of Washington, the need for alcohol and other drug treatment is also higher among American Indians compared to every other group, with 39 percent of American Indian men and women need AOD treatment.⁴⁵ This rate varies by region and is highest in the Seattle area at 46 percent.⁴⁶

The proportion of pregnant American Indian women on Medicaid with a mental health diagnosis (36 percent) is much higher than that for all pregnant Medicaid women (13 percent).⁴⁷ Mental illness diagnoses are 2.7 time higher among AI pregnant women. Among the total Medicaid population of pregnant women with mental health problems, 75 percent were receiving MSS in 2008, compared to 64 percent of the AI women.⁴⁸

Also, a disproportionate number of American Indian pregnant women have developmental disabilities. It is possible that this is part of a continuing cycle of untreated alcoholism that results in fetal alcohol spectrum disorders, but there are insufficient data to substantiate this. Among AI pregnant women on Medicaid, 2.7 percent have a developmental disability, compared to 0.8 percent of the total Medicaid pregnant population – 3.4 times greater among AI.⁴⁹ Among pregnant women who have a developmental disability, a lower percentage of AI are enrolled in MSS compared to the total (64 percent and 78 percent, respectively).

Untreated alcohol and substance abuse is tragic and costly for infants and for society to take care of them. Not only is it a risk factor for low birth weight babies and disabilities, but it is highly likely that many of the infant deaths due to injuries are related to parents with untreated alcoholism, substance abuse, and mental illnesses. Because the American Indian population is relatively small in Washington State, the unmet need for treatment is numerically low. In 2007, the number of pregnant AI women on Medicaid who were not enrolled in Maternity Support Services was 714, including an estimated 142 in need of alcohol and substance abuse services and 238 with a mental health diagnosis.

It is possible that some of these AI pregnant women were receiving mental health and outpatient substance abuse services from their tribes or the Indian Health Service

⁴⁵ Ibid

⁴⁶ Ibid

⁴⁷ Laurie Cawthon, MD, MPH, Risk Factors for Low Birth Weight Among Washington Medicaid Women with Births in 2008, DSHS Research and Data Analysis, March 23, 2010.

⁴⁸ Ibid

⁴⁹ Ibid

without being enrolled in First Steps, particularly if the Indian health clinic was not a First Steps provider or did not receive significant income from First Steps to provide these services. However, the Indian health system is funded below the level of need and depends on Medicaid for the additional resources to provide necessary services to all Indian health beneficiaries.

Cigarette smoking prevention and cessation programs are needed in American Indian communities to reduce infant mortality and improve health outcomes.

Traditional American Indian uses of tobacco as part of a spiritual practice are different from the abuse of tobacco by smoking cigarettes. Smoking cigarettes during pregnancy is one cause of low birth weight (LBW). Maternal smoking during pregnancy and second-hand smoke are risk factors for preterm births and Sudden Infant Death Syndrome (SIDS).^{50,51} In addition, new information suggests that exposure to smoke during pregnancy, either because the mother is smoking or because the mother is exposed to secondhand smoke, causes a genetic mutation in the baby that is associated with cancer later in life.⁵²

Among Native American women on Medicaid with births in 2008 in Washington State, nearly 28 percent reported smoking during pregnancy and another 4 percent smoked within 3 months of their pregnancy.⁵³ Compared to all women on Medicaid in Washington State, the AI rate of smoking during or within 3 months pregnancy was 70

⁵⁰ According to the Center for Disease Control and Prevention (CDC) website (<http://www.cdc.gov/reproductivehealth/TobaccoUsePregnancy/index.htm>) on 3-11-10, babies born to women who smoke during pregnancy are 30 percent more likely to be born prematurely and 1.4-3.0 times more likely to die from SIDS. Exposure to secondhand smoke increases the odds of low birth weight babies by 20 percent. Children exposed to secondhand smoke are at increased risk for bronchitis, pneumonia, ear infections, more severe asthma, respiratory symptoms and slowed lung growth.

⁵¹ Hannah C. Kinney, et al, Serotonergic Brainstem Abnormalities in Northern Plains Indians with the Sudden Infant Death Syndrome. *Journal of Neuropathology and Experimental Neurology*, Vol 62, No. 11, November, 2003.

⁵² HHS HealthBeat, August 9, 2010, reporting on research by Stephen Grant of the University of Pittsburgh, <http://www.hhs.gov/newss/healthbeat/2010/08/20100809a.html>

⁵³ Laurie Cawthon, MD, MPH, Risk Factors for Low Birth Weight Among Washington Medicaid Women with Births in 2008, DSHS Research and Data Analysis, March 23, 2010.

percent higher.⁵⁴ A report based on earlier data suggested that 20 percent of AI women in Seattle reported smoking during their pregnancy.⁵⁵

Strategies to improve maternal and infant health must involve youth.

One-third of the American Indian population is younger than 18 years old, compared to less than a quarter of the White population.⁵⁶ Many of the most significant risk factors for low birth weight babies and infant mortality among AI begin in youth.

In the Youth Risk Behavior Survey (YRBS) analysis of urban Indian youth, 33 percent of AI began smoking cigarettes before age 13, while 41 percent reported having drunk alcohol before age 13, and 18 percent first used marijuana before age 13.⁵⁷ By the end of high school, 7 percent of AI urban youth had used heroin, compared to 3 percent of Whites.⁵⁸

Risk factors for high birth weight babies also begin in increasingly younger years. Thus, preventing childhood obesity is a key strategy for reducing the risk of high birth weight babies, and improving maternal and infant health.

Patterns of domestic violence also begin in youth. The YRBS analysis shows that 17 percent of AI urban youth reported being physically hurt by a boy/girlfriend, compared to 8 percent of Whites.⁵⁹ The study reports that 16 percent of AI urban youth were physically forced to have unwanted sex, compared to 7 percent of White youth.⁶⁰

⁵⁴ Ibid.

⁵⁵ Urban Indian Health Institute, Community Health Profile 2009, Seattle Indian Health Board, Seattle, Washington.

⁵⁶ Shira Rutman, A. Park, M. Castor, M. Tualii, R. Forquera, Urban American Indian and Alaska Native Youth: Youth Risk Behavior Survey 1997-2003, Journal of Maternal and Child Health, 2008, 12:S76-S81.

⁵⁷ Ibid

⁵⁸ Ibid

⁵⁹ Shira Rutman, A. Park, M. Castor, M. Tualii, R. Forquera, Urban American Indian and Alaska Native Youth: Youth Risk Behavior Survey 1997-2003, Journal of Maternal and Child Health, 2008, 12:S76-S81.

⁶⁰ Ibid

Immunizations can protect infants from influenza and pneumonia.

The Centers for Disease Control and Prevention (CDC) recommends that infants be given a pneumococcal vaccine at 2 months and 4 months of age. Annual influenza vaccines are recommended starting at 6 months of age.

There is a high infant mortality rate among Native Americans due to influenza and pneumonia, more than 7 times higher than the population as a whole (see Table 1 in Appendix A). It should be noted that the infant mortality rates used in this strategic plan are based on the period from 2000 to 2007, prior to the H1N1 epidemic of 2009-2010. These high infant mortality rates call into question the percentage of AI infants receiving the recommended pneumococcal and influenza vaccines. These data are not readily available from the Washington State Department of Health.

Protective effects of breastfeeding can improve infant and maternal health both short term and long term.

The many health benefits of breastfeeding and human milk are well documented in over 150 research papers.^{61,62} For purposes of this MIH Strategic Plan, it is most significant that breastfeeding and human milk have been shown to reduce infant deaths from all causes other than birth defects and cancer.⁶³ Breastfed infants are 80 percent less likely to die in the first year of life compared to those never breastfed.⁶⁴ Receiving breast milk is associated with a 36 percent reduction in SIDS compared to infants who never breastfed.⁶⁵ Mothers who breastfeed have lower rates of symptoms of depression and there is research to suggest that breastfeeding may also help protect against child abuse and neglect.⁶⁶ It can also be part of a long term strategy to lower

⁶¹ American Academy of Family Practice Breastfeeding Advisory Committee, Breastfeeding, Family Physicians Supporting (Position Paper) published on the internet at www.aafp.org, as available on 3/30/10.

⁶² American Academy of Pediatrics Work Group on Breastfeeding, Breastfeeding and the Use of Human Milk, Pediatrics Vol 100, No 6, December 1997.

⁶³ American Dietetic Association, Position of the American Dietetic Association: Promoting and Supporting Breastfeeding, Journal of the American Dietetic Association, November, 2009.

⁶⁴ 2005 WIC Annual Report, citing Forste R, Weiss J, Lippincott E, The Decision to Breastfeed in the United States: Does Race Matter?, Pediatrics 2001, 1:295-7.

⁶⁵ American Dietetic Association, Position of the American Dietetic Association: Promoting and Supporting Breastfeeding, Journal of the American Dietetic Association, November, 2009.

⁶⁶ Ibid

the risks of associated with high birth weight babies because infants who are breastfed are less likely to become overweight or obese as adults.⁶⁷ In addition, breastfeeding improves the effectiveness of immunizations.⁶⁸ Breastfeeding also lowers the rates of infections, asthma, diabetes, and allergies.⁶⁹

The Healthy People 2010 objectives for breastfeeding are: a) 75 percent of mothers initiating breastfeeding, b) 50 percent of mothers breastfeeding at 6 months, c) 25 percent of mothers breastfeeding at 12 months, d) 40 percent of infants exclusively breastfed for 3 months, and e) 17 percent of infants exclusively breastfed for 6 months.⁷⁰ In 2005, in the United States as a whole, the rates for these objectives were a) 74 percent, b) 43 percent, c) 21 percent, d) 32 percent, and e) 12 percent.⁷¹

PRAMS data suggest that 86 percent of postpartum AI women initiate breastfeeding, compared to 92 percent of all women in Washington State for the period from 2004-2007.⁷² Between 2 and 6 months postpartum, the rate of breastfeeding had dropped to 50 percent for AI and 67 percent for the population as a whole.⁷³ Data from the Washington State WIC Nutrition Program show that 51 percent of American Indian women on WIC were breastfeeding in Washington State in 2009 (see Table 3 in Appendix A). The rate was 60 percent for AI women served by the Seattle Indian Health Board.

In general, older mothers have higher rates of initiating and sustaining breastfeeding as compared to younger mothers.⁷⁴ Less than 20 percent of teenage mothers are breastfeeding by the time an infant is 6 months old.⁷⁵ In research studies, adolescent

⁶⁷ Ibid

⁶⁸ 2005 WIC Annual Report, citing Pabst, HF, et al, "Effect of Breast-feeding on Immune Response to BCG Vaccination," *Lancet*. 1989;1:295-7.

⁶⁹ 2005 WIC Annual Report

⁷⁰ American Dietetic Association, Position of the American Dietetic Association: Promoting and Supporting Breastfeeding, *Journal of the American Dietetic Association*, November, 2009.

⁷¹ Ibid

⁷² Laurie Cawthon, MD, MPH, Breastfeeding by Race/Ethnicity for PRAMS Respondents, 2004-2007, May 4, 2010.

⁷³ Ibid

⁷⁴ American Dietetic Association, Position of the American Dietetic Association: Promoting and Supporting Breastfeeding, *Journal of the American Dietetic Association*, November, 2009.

⁷⁵ Ibid

mothers say that physicians and nurses do not tell them about the benefits of breastfeeding.⁷⁶ Low rates of breastfeeding are associated with low income, low educational levels, obesity, and postpartum depression.⁷⁷

Access to medical care is problematic in some counties in Washington State.

Pregnant women in rural areas of Washington State may have to travel to neighboring counties for prenatal care and deliveries.⁷⁸ In recent years, five community hospitals closed their labor and delivery services, including one in Lincoln County adjacent to the Colville and Spokane tribes. In Washington State, 9 counties have no hospital with obstetric services. Eight of the 39 counties in Washington State have hospitals that serve as regional referral centers that are able to provide a higher level of care for high risk deliveries and neonatal intensive care. These regional hospitals are located in the Contract Health Service Delivery Areas or in relatively close proximity for a few tribes, including Pierce County (Puyallup), Skagit County (Samish, Swinomish, Upper Skagit). Since many AI women are considered high risk, they may have to travel further than the closest hospital to go to a regional center for their deliveries.

The number of obstetric providers in Washington State decreased by 13 percent from 2000 to 2008, while the number of births increased by 12 percent during that same time. The workload for remaining providers has increased to a point where some physicians are retiring or restricting the number of obstetrical patients they will see. While the number of obstetricians increased by 6 percent during this time period, the number of family practice physicians attending deliveries decreased by 26 percent, certified nurse midwives decreased by 8 percent, and licensed midwives decreased by 4 percent.

As a result, there has been an increase in the number of women who are getting late or no prenatal care. Overall, 77 percent of pregnant women begin prenatal care in their first trimester, while 6 percent have no prenatal care or begin their prenatal care in their third trimester. For women on Medicaid, the statewide rate of first trimester care is 67 percent, while late or no prenatal care is 8 percent. Among American Indian women with births in 2008 on Medicaid, 63 percent of urban women and 65 percent of rural women started their prenatal care in the first trimester. At the same time, 13 percent of

⁷⁶ Ibid

⁷⁷ Ibid

⁷⁸ Unless otherwise noted, information in this section is from Laurie Cawthon, MD, MPH and Peter Woodcox, County Profiles: Birth Statistics and Maternity Care Access 2000 to 2008, WA State Department of Social and Health Services, April 2010.

urban AI women had late or no prenatal care. For rural women, the rate for late or no prenatal care was 7 percent in 2008, but it was almost 12 percent the previous year.

Qualitative research by the Department of Health suggests that some private obstetricians limit the number of Medicaid patients that they accept due to reimbursement rates.⁷⁹ Some private physicians do not want to treat high risk patients with mental health and substance abuse problems because they are not prepared to provide the intensive case management that is needed.⁸⁰ Distance to care, access to transportation, and other factors lead to missed appointments which further discourage private physicians from accepting high risk AI patients. At a focus group with pregnant women and women who had delivered babies in the past year at a tribe where obstetrical services are more than an hour away, women reported that bus service is limited to two trips per day, so women have to spend more than 7 hours waiting in town before they can return home and if they are 15 minutes late for their appointment, they have to reschedule.

A recent study suggests that some women who are using illegal drugs may avoid prenatal care because they are afraid of the consequences of universal screening for drug use through urine tests without their consent.⁸¹ They expected that there would be adverse psychological, social and legal consequences if they were identified as drug users and that they would be reported to Child Protective Services. Their attempts to stop drug and/or alcohol use before seeking prenatal care may affect the timing of their first visit to a provider.

Another aspect of access to care is the availability of services for medically fragile infants that are discharged and go home to a family who may have many challenges and may be far away from high-risk pediatric care. Medical advances have led to more preterm babies surviving in neonatal intensive care units; however, this can lead to higher levels of postneonatal mortality.

The survey of tribes and urban Indian clinics conducted as part of the MIH Strategic Plan process suggests that the area of greatest concern for tribes is access to alcohol and substance abuse services (see Appendix 2). In a meeting with tribal health providers to discuss this MIH Strategic Plan, access to dental care was raised as an issue, particularly since dental decay leads to infection which is dangerous for pregnant women and can impact the health of infants.

⁷⁹ Kathy Chapman, verbal report at MIH Workgroup teleconference, April 30, 2010.

⁸⁰ Ibid

⁸¹ Sarah C.M. Roberts and Amani Nuru-Jeter, Women's Perspectives on Screening for Alcohol and Drug Use in Prenatal Care, Women's Health Issues, Vol 20, 2010.

Domestic violence affects both pregnant women and infants.

Domestic violence is “a pattern of assaultive and coercive behaviors, including physical, sexual and psychological attacks, as well as economic coercion, that adults and/or adolescents use against their intimate partners to gain or maintain power and control.”⁸² It affects people from all ages, cultures, socioeconomic levels, religions, and educational levels. A national survey conducted by the Centers for Disease Control and Prevention (CDC) in 2008 found that 39 percent of Native American women experienced intimate partner violence sometime in their life, a rate higher than any other ethnic group surveyed.⁸³ In Washington State in 2005, one in four women reported that they had experienced a physical injury from an intimate partner during their lifetime.⁸⁴ Women who experience domestic violence are at increased risk for other health problems during pregnancy, including delivering a LBW baby.⁸⁵ Child abuse occurs in 33 to 77 percent of families where there is abuse of adults.⁸⁶

For all women in a statewide sample, 5 percent reported physical violence by a husband or partner in the 12 months before pregnancy or during pregnancy.⁸⁷ The Pregnancy Risk Assessment Monitoring System (PRAMS) data show that 9.6 percent of AI women in Washington State experienced partner abuse before or during pregnancy. A disproportionate number of AI babies are at risk of child abuse and neglect. Among AI babies born in 2006, 12 percent were accepted for Child Protective Services (CPS) referrals and 9 percent were placed out of home during their first year of life.⁸⁸ This is 4 times greater than White infants for accepted referrals to CPS and nearly 6 times greater for out-of-home placements.⁸⁹

⁸² Maria Pena, Editor, Domestic Violence and Pregnancy: Guidelines for Screening and Referral, Washington State Department of Health, revised, August 2008 P. 2

⁸³ Family Violence Prevention Fund, Building Domestic Violence Health Care Responses in Indian Country: A Promising Practices Report, 2010. Available on-line at www.endabuse.com.

⁸⁴ Ibid

⁸⁵ Ibid

⁸⁶ Ibid

⁸⁷ Ibid, citing the Washington State Behavioral Risk Factor Surveillance System (BRFSS).

⁸⁸ Laurie Cawthon, MD, MPH, A Conversation Around Native American Pregnant Women and Infants, Powerpoint presented to the American Indian Health Commission, November 6, 2008.

⁸⁹ Ibid

In meetings with providers of Indian health services in conjunction with this MIH Strategic Plan, there was a discussion of cultural approaches to prevention and treatment of domestic violence. For American Indians, historical and intergenerational trauma plays a significant role in domestic violence and attachment disorders. Some behavioral health counselors believe that it is detrimental to use a victim/abuser framework and that the Western model of criminalizing domestic violence leads to the destruction of AI families. While counselors must adhere to state reporting requirements, they are careful to engage people without judgment and want to establish trust to allow them to work with families to improve the family dynamics.

Teen pregnancy prevention is a priority for some tribes.

Among those who answered the AIHC survey of tribes and urban Indian programs in 2010, 75 percent thought that teen pregnancy was an important issue and 50 percent thought it was one of the three top risk factors that could be changed to make the biggest difference in maternal and infant health outcomes for their tribe/clients (see Appendix 2).

In 2008, there were 137 babies born to AI mothers on Medicaid in Washington State who were 16 years old or younger at age of conception, about 7 percent of all AI pregnancies.⁹⁰ This percentage seems to be similar for AI living in urban and rural areas.⁹¹ Age 16 at conception is considered a risk factor for low birth weight babies, and this occurs at a rate that is 70 percent higher among AI than for the Medicaid population as a whole.⁹² It is an even greater risk factor for conception to occur under age 15, and this represents 3 percent of AI mothers on Medicaid, 70 percent greater than the total pregnant Medicaid population.⁹³ While infant mortality rates have improved for the overall population in Washington State during the past 12 years in

⁹⁰ Laurie Cawthon, MD, MPH, Risk Factors for Low Birth Weight Among Washington Medicaid Women with Births in 2008, DSHS Research and Data Analysis, March 23, 2010.

⁹¹ In the Seattle area, 6.3 percent of AI births were to teens during the period of 2001-2005 according to the Urban Indian Health Institute, Community Health Profile 2009, Seattle Indian Health Board, Seattle, Washington.

⁹² Laurie Cawthon, MD, MPH, Risk Factors for Low Birth Weight Among Washington Medicaid Women with Births in 2008, DSHS Research and Data Analysis, March 23, 2010.

⁹³ *ibid*

nearly every age group, the infant mortality rate has increased for those who are less than 15 years old by over 37 percent.⁹⁴

The national Youth Risk Behavior Survey (YRBS) for 1997 to 2003 was analyzed for urban Indian youth and the results showed that 12 percent of urban Indian youth had first sexual intercourse before the age of 13, compared to 4 percent of Whites.⁹⁵ It is not known how much of this sexual activity is a result of child sexual abuse, incest and sexual assault. By the end of high school, 61 percent of AI were sexually experienced (compared to 43 percent of Whites), 47 percent were sexually active (compared to 31 percent of Whites), and 11 percent had been pregnant or gotten some one pregnant (compared to 4 percent of Whites).⁹⁶

While there are fewer health risks for pregnant women who are older than 16 years old, there may be social and economic consequences, including lower levels of education, employment, income over the course of their lifetimes. In 2008, the teen birth rate for all Washington State residents 15 to 19 years old was 31.8 per 1,000.⁹⁷ A closer look shows that the overall teen birth rate is an average of extremely high rates for Hispanics (92.6) and fairly low rate for Whites (21.9).⁹⁸ For all minorities, the teen birth rate was 54.5 per 1,000 and this is very similar to the birth rate for American Indians and Alaska Natives teens.⁹⁹ In 2008, there were 239 births to AI/AN who were 15 to 19 years old in Washington State, which is a rate of 55.8 per 1,000.¹⁰⁰

While the survey of tribal health programs conducted for this MIH Strategic Plan identified teen pregnancy as a priority, the meetings and focus groups with tribes to discuss issues and recommendations in the plan pointed to a number of areas where tribes are not making teen pregnancy a priority. At one tribe, teens reported that health and sex education classes had been discontinued years ago. At another tribe, teens

⁹⁴ State of Washington, First Steps Data Base, Infant Mortality Rates for Washington Births by Year of Birth, March 4, 2010.

⁹⁵ Shira Rutman, A. Park, M. Castor, M. Tualii, R. Forquera, Urban American Indian and Alaska Native Youth: Youth Risk Behavior Survey 1997-2003, *Journal of Maternal and Child Health*, 2008, 12:S76-S81.

⁹⁶ Ibid

⁹⁷ Laurie Cawthon, E. Kohlenberg, D. Mancuso, B. Felver, H. Axelsson, Employment and Health among DSHS Clients, by Race and Ethnicity and Region. Presented to the Indian Policy Advisory Committee, January 14, 2010.

⁹⁸ Ibid

⁹⁹ Ibid

¹⁰⁰ Ibid

said that they wanted condoms to be available in the school, but that idea was rejected by the Tribal Council. Teens said that they did not want to seek birth control or pregnancy tests at their tribal clinic because they were worried about confidentiality. Health care professionals said that annual exams for women were not recommended or provided until the woman was 23 years old.

Social support is related to maternal and infant health.

Many pregnant AI women have no family or friends who can help them. The Pregnancy Risk Assessment Monitoring System (PRAMS) measurements of social support during pregnancy in King County from 1999-2001 found that 24 percent of AI pregnant women said that they had no one to loan them \$50, 17 percent had no one to help if they were sick and in bed, 15 percent had no one to talk with about problems, and 11 percent had no one to provide a ride to the doctor.¹⁰¹

A nationwide study of AI living in counties served by urban Indian health clinics from 1995 to 2000 found that unmarried status was associated with 70 percent of infant deaths.¹⁰² In Washington State, nearly 70 percent of AI women giving birth were unmarried¹⁰³, so this could account for the correlation with infant deaths found nationally. Pregnant teens may find themselves without a partner and without the support of a disapproving family, as well as rejection by the community.

PRAMS data show that 13.5 percent of AI women in Washington State experienced postpartum depression between 2004 and 2006.¹⁰⁴ In addition, the five-year maternal mortality for AI women with deliveries in Washington State between 1998 and 2002 was 64.7 per 10,000, a rate nearly 4 times that of Whites.¹⁰⁵

¹⁰¹ Urban Indian Health Institute, Eliminating Disparities in Birth Outcomes of American Indian and Alaska Native Infants: Washington State. Powerpoint presented to the American Indian Health Commission for Washington State, December 11, 2009.

¹⁰² Mei Castor, M. Smyser, M. Taulii, A. Park, S. Lawson, R. Forquera, A Nationwide Population-Based Study Identifying health Disparities Between American Indians/Alaska Natives and the General Populations Living in Select Urban Counties, American Journal of Public Health, May 2006, Vol 96, No. 5.

¹⁰³ Laurie Cawthon, MD, MPH, A Conversation Around Native American Pregnant Women and Infants, Powerpoint presented to the American Indian Health Commission, November 6, 2008.

¹⁰⁴ Laurie Cawthon, MD, MPH, A Conversation Around Native American Pregnant Women and Infants, Powerpoint presented to the American Indian Health Commission, November 6, 2008.

¹⁰⁵ Ibid

Lack of social support, in combination with historical trauma and intergenerational trauma, is seen as a contributing factor to alcohol and drug use, as well as smoking and domestic violence. Social support may be a key ingredient to protect infants from injury. In the absence of family and community support, tribal and urban Indian health programs can create professional and peer support for pregnant women. Prevention research in the community is a growing area in the evidence base, extending beyond risk to established assets including mentor relationships, spiritual connection, and good health of family members as protective factors against substance use for AI/AN adolescents living in urban areas.¹⁰⁶

Focus groups conducted as part of this MIH Strategic Plan identified the problem of homelessness among pregnant teenagers. Sometimes they are rejected by their families and sometimes they reject their families. Usually, they do not have a job and cannot afford to pay rent. They may move from house to house during their pregnancy and after the baby is born, creating an unstable social environment, and making it difficult to provide case management and follow up services. The combination of pregnancy, homelessness, drug and alcohol use, and other factors often lead to dropping out of high school.

Even when social support is available, family members do not always have current knowledge to help reduce risks of poor pregnancy outcomes. In American Indian communities, often grandparents are raising their grandchildren. The National Indian Women's Health Resource Center (NIWHRC) has developed a program to teach mothers, grandmothers, aunts or caretakers how to communicate sexual health to the younger females in their families. NIWHRC found that "most of the women had not been told the sexual facts by their parent and did not follow traditional puberty ceremonies of their tribe, so they were unfamiliar with human sexuality terms and did not have all the knowledge or confidence to share with their daughters."¹⁰⁷

According to people interviewed for this plan and discussions in focus groups, there is a need to inform tribal elders and parents of pregnant women about ways that they can contribute to maternal and infant health. For example, older adults who are smoking inside the home increase the risks to pregnant women and infants from secondhand smoke. Also, some new mothers have reported that they are discouraged from breastfeeding by their mothers and grandmothers.

¹⁰⁶ L.A. Beebe, SK Vesely, RF Oman, et al. Protective assets for non-use of alcohol, tobacco, and other drugs among urban American Indian youth in Oklahoma. *Journal of Maternal and Child Health*, 2008, 12(4), S82-S90.

¹⁰⁷ Pamela E. Iron, Executive Director, National Indian Women's Health Resource Center, personal communications, May 17, 2010.

Nutrition and physical activity before and during pregnancy can improve the health of mothers and reduce the risks of high birth weight babies.

Obesity is a risk to the health of the pregnant woman as well as her baby. The body mass index (BMI) is used to measure obesity. An Institute of Medicine report states:

Evidence from the scientific literature is remarkably clear that prepregnancy BMI is an independent predictor of many adverse outcomes of pregnancy. As a result women should enter pregnancy with a BMI in the normal weight category.¹⁰⁸

Twenty percent of women in Washington State are considered overweight or obese before they become pregnant with their first child, and this risk factor grows with each successive pregnancy.¹⁰⁹ Among Native American women giving birth in 2008, 37 percent were considered obese.

The risk of complications of pregnancy for women giving birth in Washington State in 2008 was higher for women classified as obese compared to non-obese women for hypertension (12 percent compared to 4.5 percent), diabetes (12 percent compared to 4 percent), and Cesarean section (39 percent compared to 25 percent).¹¹⁰ Obesity also affects maternal health by increasing the risks of heart disease, high blood pressure, cancer, stroke, and respiratory problems. Risks to the baby include still birth, prematurity, neural tube defects, and higher rates of childhood obesity.¹¹¹

Researchers have classified obesity into categories based on body mass index (BMI) and compared outcomes for pregnant women in the different groups. In the United States as a whole, the number of women in childbearing ages in class 3 (BMI \geq 40), the most severe class of obesity, has tripled in the past 30 years and is growing faster than lower levels of obesity, with an estimated 6.5 percent currently affected.¹¹² Compared to women with class 1 obesity, women with class 3 obesity at conception have substantially higher risks of infant mortality, still birth, maternal mortality, hypertensive disorders of pregnancy, congenital malformations, gestation diabetes, large-for-

¹⁰⁸ Kathleen M. Rasmussen and Ann L. Yaktine, Editors, *Weight Gain During Pregnancy: Reexamining the Guidelines*, The National Academies Press, 2009, p. S-6.

¹⁰⁹ Laurie Cawthon, MD, MPH, *Obesity and Pregnancy*, DSHS report number 9.99.

¹¹⁰ Ibid

¹¹¹ Ibid

¹¹² Lisa M. Bodnar, AM Siega-Riz, HN Simhan, KP Himes, B Abrams. Severe obesity, gestational weight gain, and adverse birth outcomes. *American Journal of Clinical Nutrition*, March 31, 2010.

gestational age (LGA) infants, and cesarean delivery.¹¹³ For these women, losing weight during pregnancy could have negative effects on the development of their babies.¹¹⁴ Therefore, the risk reduction through weight loss must occur prior to conception.

The epidemic of Type 2 Diabetes in Indian Country has led to a greater awareness of the risks of childhood and adult obesity, and a greater focus on programs to provide nutritional information and physical activity. However, AI women may not be aware of the increased risks to their babies and themselves if they become pregnant while overweight and continue to gain weight during their pregnancy. A high percentage of American Indian women have gestational diabetes when they are pregnant, followed by Type 2 diabetes after their pregnancy. If diabetes is not controlled before and during pregnancy, it can lead to multiple complications for both fetus and mother.¹¹⁵

The Institute of Medicine recommends preconception counseling, prenatal counseling, and counseling after a woman's baby is born and before she conceives again to make women aware of risks of obesity for themselves and their babies.¹¹⁶

In most cases, exercise has been shown to be beneficial for pregnant and postpartum women, not only helping them maintain a healthy weight, but also easing physical discomforts associated with pregnancy and improving mood.¹¹⁷

Trends in infant mortality suggest that effective interventions should be extended to better serve American Indians in Washington State.

A national study of infant mortality trends from 1989 to 2000 by the Centers for Disease Control and Prevention (CDC) suggests that significant improvements were made in AI

¹¹³ Ibid

¹¹⁴ Ibid

¹¹⁵ Indian Health Service, Division of Diabetes Treatment and Prevention, "Indian Health Diabetes Best Practice: Diabetes and Pregnancy," revised December 2009 at http://www.diabetes.ihs.gov/HomeDocs/Tools/BestPractices/2009_BP_Diabetes_Pregnancy.pdf.

¹¹⁶ Kathleen M. Rasmussen and Ann L. Yaktine, Editors, *Weight Gain During Pregnancy: Reexamining the Guidelines*, The National Academies Press, 2009,

¹¹⁷ Laurie Cawthon, MD, MPH, *Obesity and Pregnancy*, DSHS report number 9.99.

infant mortality, as well as rates of SIDS and congenital malformations.¹¹⁸ These improvements are attributed to greater access to quality obstetric and neonatal care, campaigns to promote safe infant sleep environments and home safety, and use of folic acid supplements. The authors conclude that “current successful systems and strategies need to be identified and emulated” and “new culturally appropriate interventions are needed to assure that all high-risk AI/AN pregnancies are identified early and delivered in appropriate health care settings.”¹¹⁹

For rural American Indians and Alaska Natives nationally, research has suggested that adequate prenatal care and rate of post-neonatal deaths have improved over the past ten years, but these outcomes have also improved for the total population, so the disparity has increased significantly.¹²⁰ Other studies done in the Pacific Northwest have indicated some improvements for the AI population that were not sustained.^{121,122,123}

However, data from Washington State for the period from 1996 to 2007 suggests a very different pattern from the national and regional trends reported for AI. In Washington State there have been improvements for the total population in the past 12 years, but the situation for American Indians has gotten worse and the disparity has grown over time.¹²⁴ In Washington State, infant mortality has declined overall and in every category

¹¹⁸ Kay M. Tomashek, C. Qin, J. Hsia, S. Iyasu, W.D. Barfield, L.M. Flowers, Infant Mortality Trends and Differences Between American Indian/Alaska Native Infants and White Infants in the United States, 1989-1991 and 1998-2000, American Journal of Public Health, December 2006, Vol 96, No. 12.

¹¹⁹ Ibid. P.2225

¹²⁰ L.M. Baldwin, D.C. Grossman, E. Murowchick, et al. (2009). Trends in perinatal and infant health disparities between rural American Indians and Alaskan Natives and rural whites. American Journal of Public Health, 99(4), 638-646.

¹²¹ James A. Gaudino (2008) Progress Towards narrowing Health Disparities: First Steps in Sorting Out Infant Mortality Trend Improvements Among American Indians and Alaska Natives (AI/AN) in the Pacific North West, 1984-1997. Journal of Maternal and Child Health 12:S12-S24.

¹²² Joe Campo, Assessing disparities: Washington State Vital Statistics Report, 2006. Data review and evaluation presented to American Indian Health Commission for Washington State, Tacoma, WA, 10 October 2009.

¹²³ Urban Indian Health Institute, Eliminating Disparities in Birth Outcomes of American Indian and Alaska Native Infants: Washington State. Powerpoint presented to the American Indian Health Commission for Washington State, December 11, 2009.

¹²⁴ State of Washington, First Steps Data Base, Infant Mortality Rates for Washington Births by Year of Birth, March 4, 2010.

of ethnicity¹²⁵, except for American Indians, who have experienced increases. Much of the improvement in infant mortality for non-AI has been in rates of SIDS and in deaths during the first month of life. However, for the AI population in Washington State, there have been increases in SIDS deaths and neonatal mortality. In Washington State, there has been an increase in infant mortality after the first month of life excluding SIDS for all groups except Whites, but the greatest increase was among Native Americans.

Survey of Health Directors

During April 2010, the American Indian Health Commission for Washington State (AIHC) sent e-mails to health directors of all 29 tribes and 2 urban Indian programs in Washington State with a link to an on-line survey using the Survey Monkey program. The survey sample includes 16 responses from 13 tribes and one urban Indian program. In addition to the Seattle Indian Health Board (SIHB), 45 percent of the tribes in Washington State responded to the survey and the sample is fairly representative geographically and by size of tribe, with a slight skewing toward smaller tribes.

A complete report from the survey is attached in Appendix 2. Here are the conclusions of the survey:

- About one-fourth of AI health programs have fewer than 10 pregnant women each year, which makes it difficult to provide staffing for a full-range of services. The design of prenatal services for the 25 percent of tribal programs that are very small must be different from the 25 percent that serve more than 50 pregnant women and infants each year.
- For individual tribes, infant mortality is a rare occurrence. Based on this first-hand experience alone, reducing infant mortality may not seem like a priority for health care. Sharing statistical data showing the disparities in infant mortality may raise awareness that this is a largely preventable problem that requires the attention of tribal leadership.
- The most important issues related to maternal and infant health perceived by survey respondents are alcohol and substance abuse, smoking, teen pregnancy, and mental health.

¹²⁵ For Pacific Islanders the trends are inconclusive due to insufficient data.

- Access to care for pregnant women and infants is not perceived as a significant problem, except for alcohol and substance abuse treatment for about a third of respondents.
- Mental health, substance abuse, and domestic violence are not only risk factors, but they also keep women from seeking services that might help to address these risk factors, such as WIC and First Steps.
- Most pregnant women and parents of infants do not receive transportation assistance to access medical care.
- About a third of tribes have not addressed domestic violence.
- Half the AI health programs do not offer breastfeeding programs or home visiting programs. Fewer than 20 percent of the AI health programs are utilizing Bedtime Basics for Babies, a free SIDS risk reduction program.
- Significant problems contributing to low AI participation in WIC and First Steps include lack of transportation and personal/family issues with mental health, substance abuse and/or domestic violence.
- Half of the tribal health programs that do not deliver WIC or First Steps services cite burdensome billing and reporting requirements as a barrier to their participation.
- Most WIC programs that are tribally-operated would prefer to have the state provide training in their tribal offices.
- Most tribes grade their relationships with county health departments and public health jurisdictions as “B” (acceptable communication and cooperation).



STRATEGIC PLAN GOALS, OBJECTIVES, AND STRATEGIES FOR INTERVENTION



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Strategic Plan Goals, Objectives and Strategies for Intervention

Data presented in the previous sections allow us to construct goals and objectives that are specific, actionable and measurable to bring American Indians to parity with the total population in Washington State for maternal and infant health.

Some infant mortality and preterm deliveries are not preventable; however, the average for the total population is a benchmark that has been achieved already and provides the basis for constructing measurable interim goals for American Indian maternal and infant health (see Table 4 in Appendix 1).

To achieve parity with the total population of pregnant women and infants on Medicaid, these are the goals and objectives for the American Indian population:

- Reduce overall AI infant mortality by 38 percent.
 - Reduce AI SIDS deaths by 54 percent.
 - Reduce AI infant deaths due to injuries by 69 percent.
 - Reduce AI infant deaths due to infectious disease by 68 percent.
 - Reduce AI infant deaths from unknown causes by 74 percent.
- Reduce low birth weight births for AI by 22 percent.
 - Reduce the number of AI pregnant women with an untreated mental health diagnosis by 63 percent.¹²⁶
 - Reduce the number of AI pregnant women who are consuming alcohol and other nonprescription drugs by 70 percent.
 - Reduce smoking among AI pregnant women by 40 percent.
 - Reduce the number of AI women who threaten pre-term labor by 50 percent.
 - Reduce the incidence of low birth weight, preterm labor and fetal death in first pregnancies of AI women by 35 percent.
- Reduce number of AI pregnant women with BMI >30 who gain weight outside IOM guidelines by 25 percent.

¹²⁶ Mental health diagnosis is a risk factor that is too complicated to address in this MIH Strategic Plan, so the statement of goal has been altered to reduce untreated mental health diagnoses.

- Reduce the number of births to AI women between 15 and 19 years old by 43 percent.
- Increase breastfeeding among AI mothers and infants
 - Increase the initiation of breastfeeding by AI women by 7 percent.
 - Increase the percentage of AI women breastfeeding at 6 months by 34 percent.
- Increase AI enrollment in First Steps/Maternity Support Services by 17 percent
- Increase chemical dependency treatment for AI pregnant women with substance abuse problems by 50 percent.

These objectives are interrelated. For example, a reduction in smoking will reduce SIDS deaths, overall infant mortality, hypertension during pregnancy, and the incidence of low birth weight, preterm labor and fetal death in first pregnancies. Similarly, any reductions in any of the risk factors for low birth weight will reduce the risk factor of a LBW baby/preterm labor/fetal death in previous pregnancies, as well as reducing overall infant mortality.

The following table shows strategies to achieve these goals and objectives. Looking across a row gives an idea of the number of strategies that could be implemented to address a given objective. For example, there are five different strategies to reduce infant mortality from injuries. Looking down a column suggest the number of objectives a single strategy can impact. For example, smoking prevention and cessation programs can impact six different objectives to reduce infant mortality and low birth weight.

Figure 1. Strategies for Achieving Maternal and Infant Health Objectives

GOALS & OBJECTIVES		STRATEGIES													
		Smoking Prevention & Cessation	Parent / Patient Education	Breastfeeding – Hospital Policies	Breastfeeding – Community Support	Breastfeeding – Workplace Policies	Equipment	CD Prevention, Treatment	Mental Health Screening & Treatment	Domestic Violence Prevention	Access to Care	Statewide AI Infant Death Review	Immunizations	Involve Youth	Nutrition & Physical Activity
Reduce Infant Mortality															
SIDS	↓54%														
Injury	↓69%														
Infectious Disease	↓68%														
Unknown Causes	↓74%														
Total Infant Mortality	↓38%														
Reduce LBW															
MH Diagnoses	↓63%														
Alcohol, Drugs Use	↓70%														
Smoking	↓40%														
Threaten PT Labor	↓50%														
LBW First Pregnancies	↓35%														
Total LBW	↓22%														
Reduce HBW															
>30 BMI, Weight Gain	↓25%														
Reduce Teen Births															
Increase Breastfeeding															
Initiation	↑ 7%														
BF at 6 mos	↑34%														

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PROGRAMS FOR STRATEGIC INTERVENTIONS



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Programs for Strategic Interventions

Introduction

Programs are the way to implement the strategies identified in Figure 1 to achieve the goals and objectives of this MIH Strategic Plan. Just as the strategies were selected using the best available data, data can also help guide the selection of programs to implement those strategies. Ideally, program evaluations should report outcomes so that we can know what programs have demonstrated ability to achieve the objectives.

The State of Washington has evaluated many programs that are described this strategic plan. Federal agencies, such as the Centers for Disease Control and Prevention (CDC) have relied on extensive research and evaluation before making program and policy recommendations. In addition, there are some websites that summarize evaluations of programs for improving maternal and infant health that have been implemented in various communities across the nation, and some of these are listed as *Additional Resources* at the end of this plan.

Most of the evaluation research is for population groups that are primarily urban and not AI/AN. Evaluation research is often inconclusive, and sometimes the benefits of programs do not seem to justify the costs. It is often difficult to measure outcomes in programs designed specifically for American Indians because the number of participants is too small to design evaluation research that is statistically significant. Because infant mortality is such a rare occurrence, it is not a good measure of outcomes for small populations. Outcome measures are more likely to focus on low birth weight as an indicator and/or the reduction of risk factors.

Some good ideas have been used in demonstration projects. When those projects are implemented in AI communities, the evaluation is often anecdotal or uses qualitative methods that are appropriate for the small numbers of participants.

Measuring outcomes allows us to know whether a program provides effective interventions. Programs to improve maternal and infant health have demonstrated that wrap around services can be effective. These are the services that provide education, social and emotional support, and help in navigating systems and getting linked to a wider array of services. While access to medical care is necessary for improving health outcomes, having quality obstetrical care is not sufficient to improve the health outcomes of high risk individuals.

Established Programs

State and federal government have extensive experience with several programs to improve pregnancy outcomes and infant health, including the Federal Special Supplemental Nutrition Program for Women, Infants and Children (WIC), First Steps, Maternal and Child Health Block Grants, and Healthy Start grants. Over the years, there have been quantitative evaluations of these programs and research on their effectiveness on a national and state basis.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is funded primarily by the U.S. Department of Agriculture (USDA). WIC is an integral part of the public health system and is designed to reach families most in need of preventive health and social services. The program is cost effective in protecting or improving the health and nutritional status of lower income women, infants and children. The WIC Program augments the Basic Food program¹²⁷ by providing additional resources for pregnant women, infants and children.¹²⁸ The WIC program in Washington State spends 78 percent of its funding on food, 14 percent on nutrition and breastfeeding services, and 8 percent on administration of more than 210 sites that are located in all 39 counties.¹²⁹ In 2006, WIC received an “effective” rating from the U.S. Office of Management and Budget (OMB) which found that it had efficient use of program funds, as well as positive impact on birth outcomes, childhood immunization rates, children’s nutrition, and Medicaid savings.¹³⁰

Research has shown that WIC reduces adverse pregnancy outcomes, including preterm delivery (PTD) and low birth weight babies, especially for high risk women.¹³¹ Women

¹²⁷ Formerly known as Food Stamps. On October 1, 2008, the new name of the program became “Supplemental Nutrition Assistance Program (SNAP).”

¹²⁸ People are income-eligible for WIC if they are receiving SNAP, but they are not eligible if they are receiving benefits from the Supplemental Food Commodities Program. However, the Food Distribution Program on Indian Reservations (FDPIR) does make a person income-eligible for WIC.

¹²⁹ Washington State Department of Health, 2007 Annual Report, Washington WIC Nutrition Program.

¹³⁰ Ibid

¹³¹ Amira Y. el-Bastawissi, R. Peters, K. Sasseen, T. Bell, R. Manolopoulos, Effect of the Washington Special Supplemental Nutrition Program for Women, Infants and Children (WIC) on Pregnancy Outcomes. *Journal of Maternal and Child Health* 11:611-621, 2007.

served by WIC during pregnancy were 40 percent less likely to have a preterm delivery, 20 percent less likely to have a low birth weight baby, and 50 percent less likely to have a very low birth weight baby.¹³² A study suggests the most important value of WIC is linking high risk women to other services¹³³:

Although there seems to be little evidence in the clinical literature to suggest that provision of healthy food prenatally could reduce the incidence of PTD¹³⁴, it should be noted that the WIC Program offers a number of services other than food that may impact birth outcomes. In addition to healthy foods, Washington WIC provides pregnant women with education on prenatal nutrition, assistance in accessing early prenatal care, connections to Medicaid, including their First Steps program, through referral and co-location of services, and referrals to other services like dental care and smoking cessation.

In order for WIC to provide these kinds of linkages, there must be programs available locally for such things as smoking cessation.

For AI women, it appears that there is a need for nutrition education to prevent high birth weight babies, as well as preventing low birth weight babies. The Institute of Medicine recommends preconception counseling to help women achieve a normal weight, but women are not eligible for WIC until after they are pregnant.

On a national basis, historically WIC has had limited success in encouraging women to breastfeed their babies. Compared to women who were eligible but not receiving WIC, women on WIC with children born in 2005 had lower rates for initiating breastfeeding, breastfeeding at 6 months, breastfeeding as 12 months, and exclusively breastfeeding at 3 and 6 months.¹³⁵ WIC has added incentives and support for breastfeeding, including providing breast pumps, organizing peer counseling, and paying for lactation specialists and a lactation consultant. However, the American Academy of Family

¹³² Ibid

¹³³ Ibid, p. 619

¹³⁴ The el-Bastawissi et al study cites Gennaro, S. (2005), Overview of current state of research on pregnancy outcomes in minority populations, *American Journal of Obstetrics and Gynecology*, 192, S3-S10.

¹³⁵ American Dietetic Association, Position of the American Dietetic Association: Promoting and Supporting Breastfeeding, *Journal of the American Dietetic Association*, November, 2009.

Practice concludes that provision of formula through WIC “may make bottle-feeding an attractive alternative, despite concordant attempts to encourage breastfeeding.”¹³⁶

In Washington State, there are 22 tribes and 1 urban Indian health program providing WIC services to their members/community – 14 tribes through direct intergovernmental agreements with the Department of Health, one through another tribe’s intergovernmental agreement, one through local health jurisdiction, and six tribes through the South Puget Intertribal Planning Agency (SPIPA), a tribally-chartered intergovernmental agency (see Table 5 in Appendix 1). In 2009, these programs served 1,123 AI pregnant women, as well as 493 AI women who had given birth in the previous 12 months, and 2,410 AI infants. On average, 70 percent of the WIC clients served by these programs are American Indian, compared to 2 percent of clients in the 187 other local WIC clinic sites in the state. In 2009 statewide in all the local WIC agencies, services were provided to 14,195 women, infants and children who self-identified as American Indian.¹³⁷

The dollar value of food provided to American Indian and Alaska Native people in Washington State through the WIC program in 2009 was \$4,736,633 (see Table 6 in Appendix 1). About 43 percent of that amount went to people enrolled in tribal and urban Indian programs: \$2,040,976. People were eligible to receive more food; however, on average AI WIC recipients only redeemed 80 percent of the checks that were issued.¹³⁸ The redemption rate was 76 percent for Native Americans enrolled in WIC programs operated by tribes, tribal organizations, and urban Indian clinics.¹³⁹

Women who participated in focus groups conducted in conjunction with this MIH Strategic Plan said that one reason they did not use all the WIC checks that had been issued to them is that the local grocery store at the tribe had very limited and poor quality foods. At one tribe the closest grocery store that carried all the WIC approved food was more than an hour away from tribal housing and public transportation was limited to one bus each way each day, requiring a 7 hour wait in town before returning with groceries. Some women said that they did not pay attention to the expiration dates

¹³⁶ American Academy of Family Practice Breastfeeding Advisory Committee, Breastfeeding, Family Physicians Supporting (Position Paper) published on the internet at www.aafp.org , as available on 3/30/10.

¹³⁷ The definition of American Indian in WIC data differs from the Medicaid definitions so the data for pregnant women and infants do not match.

¹³⁸ Data provided by Kristen Sasseen, WIC Program, Washington State.

¹³⁹ Ibid

on WIC checks. Another problem is that grandparents give children food that is not on the WIC list of approved foods and then the children do not want to eat the WIC foods. One participant said she was lactose intolerant and that her county WIC program would not allow her to use WIC checks for lactose free milk. Health care professionals working for tribes said that they would like the WIC food list to include healthier options, such as goat's milk and organic milk.

First Steps Maternity Support Services (MSS)

First Steps is the Washington State program to carry out the Maternity Care Access Act enacted in 1989 to improve birth outcomes through increased access to prenatal care and support services for women below 185 percent of the federal poverty level. First Steps includes Medicaid, as well as Maternity Support Services (MSS) and Infant Case Management (ICM). For MSS, core services are defined as “interdisciplinary, client-centered” services to include screening, basic health messages, basic linkages, and minimum interventions. The program provides funding for MSS for:

Preventive health services for pregnant/postpregnant women including:
Professional observation, assessment, education, intervention and counseling.
MSS services are provided by an interdisciplinary team consisting of at minimum, a community health nurse, a nutritionist, and a behavioral health specialist.
Additional MSS services may be provided by community health workers.
(WAC 388-533-0315)

An evaluation in 2006 showed that there was a reduction in low birth weight (LBW) after the First Steps program was started; however, for the American Indian population, the rate of LBW began to climb again in 2003-2004.¹⁴⁰

One study suggests that First Steps is most effective in the rural Hispanic population who are served by Community and Migrant Health Centers (CMHC) that use community outreach workers to conduct health education programs and link women to culturally-appropriate services that improve patient satisfaction and utilization of prenatal care.¹⁴¹ Other research suggests that the greatest benefit has been among African American

¹⁴⁰ Laurie Cawthon, MD, MPH, First Steps Database, The First Steps Program: 1989-2004, Fact Sheet Number 9.82, WA Department of Social and Health Services, May 2006. This pattern also occurred in the statewide population.

¹⁴¹ Yuzo Arima, BL Guthrie, IC Rhew, AJ De Roos, The impact of the First Steps prenatal care program on birth outcomes among women receiving Medicaid in Washington State, Health Policy, 2009.

women with no identified risk factors, while for Hispanic women the greatest improvement in birth outcomes has been for those with hypertension and prior low birth weight babies.¹⁴²

Current data for AI women show that MSS did not have a statistically significant impact on LBW in 2007, prior to program changes that prioritized high risk women, effective July 2009.¹⁴³ Currently, all AI women are deemed to be in the highest category for risk, and therefore eligible for 40 units of MSS.¹⁴⁴ In 2008, on average AI only received 19.2 units.¹⁴⁵ This is comparable to the White population, which averaged 19.4 units.¹⁴⁶ The Hispanic population had the highest utilization of MSS in 2008 with an average of 28.1 units¹⁴⁷, which was 46 percent greater than the AI average.

In 2008, there were 1,268 AI women enrolled in MSS, which is 62 percent of AI pregnant women enrolled in Medicaid. To achieve parity with the total Washington State population of pregnant women using Medicaid, there would need to be a 17 percent increase in MSS enrollment by AI (see Table 4 in Appendix 1)

Only six tribes in Washington State and the Seattle Urban Indian Clinic are participating in the MSS program. Since tribes generally do not hire obstetricians, AI pregnant women receive their medical care and some of the intended MSS support services from providers outside the tribe who may not have the cultural competency skills needed to be effective in influencing birth outcomes.

¹⁴² Laurie Cawthon, MD, MPH, First Steps: Looking to the Future, WA State DSHS Research and Data Analysis, Powerpoint, May 2009, and personal communication April 14, 2010.

¹⁴³ Ibid

¹⁴⁴ A unit is 15 minutes of service. Fee for service payment for a unit of service varies depending upon the type of service provided, but it averages about \$25 per unit.

¹⁴⁵ In 2008, the most recent year for which data are available, the maximum number of units of service for MSS was 60. This maximum was lowered to 40 units of service in 2009, and a new system of prioritization put AI into the highest risk category eligible for 40 units.

¹⁴⁶ Laurie Cawthon, MD, MPH, personal communication via e-mail April 14, 2010.

¹⁴⁷ Ibid

Maternal and Child Health Block Grant, Title V of the Social Security Act

Title V of the Social Security Act provides Maternal and Child Health (MCH) block grants to states with funding allocations based on the number of children below the federal poverty level. States must match the funding with \$3 for every \$4 in federal funds. In Washington State in 2008, the program had \$41 million, including about \$8.3 million in federal funding and \$32 million in state funding.¹⁴⁸ Federal funding for MCH Block Grants nationwide was \$662 million in 2010, the lowest level of appropriations since 1993.¹⁴⁹

Authorization levels and spending plans may vary from year to year. In 2008, nearly 68 percent of the Washington State MCH Block Grant was spent on population-based services (such as childhood immunizations), 23 percent on infrastructure-building services (such as data systems, evaluation and planning), and 8 percent on enabling services (such as enrollment outreach). Block grant funding is passed through from the state to 35 local health jurisdictions and other agencies to carry out the population-based and enabling services, as well as some direct health care services (which comprise only 1 percent of the budget). The Washington State MCH Block Grant also has discretionary funding which is used for grants that range from \$15,000 to \$940,000, primarily for training and research through the University of Washington, and targeted services provided by nonprofit organizations and state agencies. The State receives \$3.8 million in funding from other Maternal and Child Health Bureau grant programs.

Under the Government Performance Results Act (GPRA), states are required to track MCH health data and outcomes annually and upload this information to a national data base.¹⁵⁰ There are 6 standardized national outcome measures and 18 performance measures that every state must report. In addition, states may select 7 other performance measures to report. States have 5-year plans and set annual goals for each of these measures.

Some of the outcome and performance measures are aligned well with this AI MIH Strategic Plan, while others are not. On the website currently, goals are set for 2013 and results are reported for 2008. One of the state-selected performance measures is: “Identify health disparities, develop and implement interventions to address disparities,

¹⁴⁸ Details available on-line at <http://mchb.hrsa.gov/programs/default.htm>

¹⁴⁹ This includes both state allocations of \$536 million and discretionary grant funds. Source: Association of Maternal and Child Health: Advocacy: “Friends of Title V”.
<http://www.amchp.org/Advocacy/TitleV/Pages/default.aspx>

¹⁵⁰ Ibid

and evaluate the effectiveness of interventions in achieving health equity.” Currently, no funding goes directly to tribes under the MCH Block Grant for Washington State. Other states have used MCH Block Grant funding for tribal services.

Healthy Start

Healthy Start is a federally-funded program to reduce disparities in infant mortality and improve perinatal outcomes. Since 1991, funding for Healthy Start has been provided through the federal Health Resources and Services Administration (HRSA), starting with 15 sites in a 5-year demonstration project. Today there are 100 Healthy Start Programs nationwide, including several American Indian Healthy Start Programs. To be eligible, the target population must have an infant mortality rate at least 1.5 times the national average.

The Northern Plains Healthy Start program administered by the Aberdeen Area Tribal Chairmen’s Health Board started in 2002 and has an annual budget of \$1,250,000. It reaches 16 reservations in North Dakota, South Dakota, Nebraska and Iowa and has demonstrated success in reducing preterm labor and low birth weight through a targeted case management program.

In 2009, the Inter-Tribal Council of Michigan (ITCM) was awarded \$4.5 million over a 5 year period which is subcontracted to 6 tribes and 2 urban Indian programs. The Michigan Healthy Start Program provides case management through monthly home visits through the child’s second birthday, group activities that involve teaching and cultural components (such as making moccasins), and Outreach Workers who provide referrals, follow-up, and transportation. The ITCM considers the Healthy Start model to be more flexible and culturally appropriate than the Nurse Family Partnership.

Honoring Our Children (HOC), the Wisconsin tribal project described as a model program in this MIH Strategic Plan, is funded through Healthy Start. When it began in 2001, the Great Lakes Inter-Tribal Council (GLITC) received \$1.4 million that was divided among nine tribes. Now GLITC receives \$900,000 per year from HRSA to serve 8 tribes. An additional \$500,000 in funding is required to maintain the 20 positions needed to conduct the HOC project.

Two other Healthy Start programs serve American Indians. The City of Minneapolis administers the Twin Cities Healthy Start, which has outreach programs for American Indians and African Americans. The University of North Carolina at Pembroke is the grantee for the Healthy Start CORPS, which serves American Indians in that area. A

sixth program serving indigenous people is the State of Hawai'i Department of Health Malama A Ho'opili Pono Healthy Start Project.

The six Healthy Start programs that serve indigenous people met in 2003 to form the Healthy Start Native Peoples Council. In 2005 they issued a series of position papers on maternal and child health called, "Speaking with One Voice." Their report states, "Healthy Start's vision is to create the best community-based, community-driven approach to infant mortality reduction. Healthy Start's key strategies are case management and interventions that are specifically tailored to each distinct community."¹⁵¹ One of the issues that they identified is that federal data and reporting components for Healthy Start grants make it difficult for tribes to participate. All the Healthy Start grants are provided to regional tribal organizations (or local and state governments) that have staff who perform the required reporting and documentation, and funding is subcontracted to tribes and urban Indian clinics to provide programs.

Model Programs that Have Been Evaluated and Found Effective

The following programs have been found to be effective using statistical measures. When programs are tested in larger populations, it is difficult to know whether they would be equally effective if they were implemented in tribal settings.

Safe Babies, Safe Moms

Safe Babies, Safe Moms (SBSM) started in Washington State in 2000 as the Comprehensive Program Evaluation Project (CPEP). The pilot program was started at three sites where it is on-going. The sites are located in Benton-Franklin Counties, Snohomish County and Whatcom County.¹⁵² A similar program with funding from DSHS started by the University of Washington (called "Birth To Three" initially) added a prenatal component and became the Parent Child Assistance Program (PCAP). It provides advocacy services annual to an estimated 675 high-risk substance-abusing

¹⁵¹ Healthy Start Native Peoples Council, *Speaking with One Voice: Position Papers on Maternal and Child Health Among American Indians and Native Hawaiians*, March 2005.

¹⁵² Laurie Cawthon and Karen Westra, *Safe Babies, Safe Moms Program Evaluation*, Research and Data Analysis Division, Department of Social and Health Services, Olympia, WA, October 2003.

pregnant and parenting women on the Spokane Reservation and in 9 counties (King, Pierce, Spokane, Grant, Cowlitz, Skagit, Kitsap, Clallam, and Yakima).¹⁵³

Safe Babies, Safe Moms offers comprehensive services to substance abusing pregnant women and women parenting children under age 3, including Targeted Intensive Case Management (TICM), Residential/Outpatient Chemical Dependency (CD) Treatment, Housing Support Services for Transitional Housing, Parenting Education, and Child Development Assessment and Referrals. All of the sites offer some of the same services, such as individual therapy and Dialectical Behavioral Therapy (DBT); while each site has some unique behavioral services, such as acupuncture or yoga.

An evaluation of 445 substance abusing women and their children enrolled in three pilot sites from 2000 to 2003 showed significant improvements in pregnancy outcomes, including a drop in low birth weight rates for infants born after program entry, decreasing by 66 percent.¹⁵⁴ This reduction in low birth weight rates was significantly greater for those enrolled in Safe Babies, Safe Moms than for those who received CD Treatment alone.¹⁵⁵ In addition, women who enrolled in Safe Babies, Safe Moms prior to delivery were much less likely to need the intervention of Child Protective Services to protect their babies from child abuse and neglect. However, the rate of CPS involvement for women enrolled in Safe Babies, Safe Moms prior to delivery was still significantly higher than women on Medicaid with no history of substance abuse (33.6 percent compared to 4.5 percent).¹⁵⁶

Pacific Treatment Alternatives (PTA) is the provider of the Safe Babies, Safe Moms program in Snohomish County and it has augmented the program with groups and classes to provide additional support to pregnant women. On-site child care is provided during the classes, which feature such topics as parenting, child development, life skills, domestic violence, safety, assertiveness, education, housing communication, relationships, interpersonal development, yoga and walking for exercise.¹⁵⁷

¹⁵³ Parent Child Assistance Program (PCAP) Profile, Division of Behavioral Health and Recover, January 2010.

¹⁵⁴ Laurie Cawthon, MD, MPH, Safe Babies, Safe Moms, Fact Sheet Number 4.36f, January 2004.

¹⁵⁵ Ibid

¹⁵⁶ Ibid

¹⁵⁷ Laurie Cawthon, C. Du, T. Keenan-Wilke, K. Rust, D. Tornatore, Group Services for Pregnant and Parenting women: An Exploratory Study. Research and Data Analysis Division, Department of Social and Health Services, Olympia, Washington, October 2006

California Smokers' Helpline

In 1992, the State of California adopted a statewide telephone counseling program, The California Smokers' Helpline, after a research project at the University of California, San Diego (UCSD) demonstrated the effectiveness of the model program.¹⁵⁸ Elements of the model include television advertising, a toll-free telephone number, intake screening, a customized packet of information sent to callers, a "pre-quit" counseling session that usually takes 40-45 minutes, motivational interviewing strategies, drugs to aid in smoking cessation, follow up calls from a counselor that usually last 10-15 minutes, and an evaluation. Many of the counselors are bilingual and bicultural, and the services are offered in English, Spanish, Mandarin, Cantonese, Vietnamese, and Korean, as well as other languages. The model has been so effective that other states and countries have used it, including Washington State.

The prevailing opinion among tribal health providers in California was that American Indians would not use a telephone counseling service for smoking cessation. Initially only about 100 callers per year were AI. However, the California Rural Indian Health Board (CRIHB), which represents most tribes in Northern California and had a tobacco cessation program, began a dialogue with the UCSD researchers that led to collaborative relationship. CRIHB designed culturally appropriate materials for the packets to be sent to AI enrolled in the program and provided cultural training to the counselors.

Prior to the Helpline, CRIHB had tried to train volunteers and health care professionals to lead smoking cessation programs, but they found this model difficult to sustain. The CRIHB cultural awareness trainer for the Helpline observed these advantages for tribal members:

Some people prefer the privacy and confidentiality of a telephone conversation, she says. While shy people may be reluctant to speak in groups, the telephone counseling assures that they are being heard and their individual needs are being met. Furthermore, she believes the telephone counseling takes away the barriers of transportation, babysitters, and starting times. She says one person may be ready to quit smoking, but there may not be enough other people to provide a class or group support in small rural communities.¹⁵⁹

¹⁵⁸ Mim Dixon and Pamela E. Iron, *Strategies for Cultural Competency in Indian Health Care*, Washington, DC: American Public Health Association, 2006. Information on the California Smoker's Helpline was taken from Chapter 6, California Rural Indian Health Board (CRIHB): Cultural Training for the California Smokers' Helpline, p 79-95.

¹⁵⁹ Ibid p. 89

When CRIHB was convinced that the Helpline could assist tribal members in a culturally competent way, they began to promote the Helpline program. The number of AI callers increased to over 1,400 per year in 2001.

Parent Education for Breastfeeding

The Centers for Disease Control and Prevention (CDC) has reviewed all the research and produced The CDC Guide to Breastfeeding Interventions¹⁶⁰, which describes model programs and suggests action steps to implement them. Education on breastfeeding was deemed the “most effective single intervention for increasing breastfeeding initiation and short-term duration.”¹⁶¹ Education as part of prenatal care not only increases knowledge about the benefits of breastfeeding, but it also influences attitudes. In the United States, new mothers often cannot look to their own mothers for experience and advice on breastfeeding. Written materials alone have not proven effective.¹⁶²

The CDC encourages childbirth educators to routinely incorporate breastfeeding education as part of their courses. They have also found that support from health professionals is important: “Mothers often identify support received from health care providers as the single most important intervention the health care system could have offered to help them breastfeed.”¹⁶³

After a short duration in the hospital, women often need more help from health care professionals, but they are reluctant to ask for the help they need. Giving new mothers a telephone number to call if they have breastfeeding questions when they are discharged from the hospital is not as effective as in-person intervention in significantly increasing breastfeed duration.¹⁶⁴

The American Academy of Family Physicians (AAFP) has found that the role of the baby’s father is one of the most powerful influences on a mother’s decision to

¹⁶⁰ Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM. The CDC Guide to Breastfeeding Interventions. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005. Available on-line at <http://www.cdc.gov/breastfeeding>.

¹⁶¹ Ibid, p. 19

¹⁶² Ibid

¹⁶³ Ibid, p. 23

¹⁶⁴ Ibid

breastfeed.¹⁶⁵ Family physicians seek to include fathers in “the protection and support of breastfeeding.”¹⁶⁶ Therefore, parent education should foster the father’s knowledge, opinion and attitude of breastfeeding. In addition, the American Dietetic Association recommends that mothers and grandmothers of pregnant adolescents should be included in breastfeeding education and counseling sessions.¹⁶⁷

Encouragement to breastfeed from physicians and other health professionals may be undermined by utilizing materials that bear the logos or sponsorship of infant formula companies, including free samples of infant formula. Therefore, the AAFP and other organizations endorse the WHO/UNICEF Code of Marketing of Breast Milk Substitutes adopted in 1981.

Baby Friendly Hospital Initiative (BFHI) and Can Do 5

Most AI babies in Washington State are born in hospitals, and the time immediately after birth is critical for establishing successful breastfeeding. Hospital practices are key to initiating and sustaining breastfeeding. The Baby Friendly Hospital Initiative (BFHI) has been established by the World Health Organization (WHO/UNICEF) to designate hospitals and other birth facilities that are committed to implementing 10 steps that have been shown to be effective in encouraging women to initiate and sustain breastfeeding. The Ten Steps to Successful Breastfeeding are:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.

¹⁶⁵ American Academy of Family Practice Breastfeeding Advisory Committee, Breastfeeding, Family Physicians Supporting (Position Paper) published on the internet at www.aafp.org , as available on 3/30/10.

¹⁶⁶ Ibid, p. 7.

¹⁶⁷ American Dietetic Association, Position of the American Dietetic Association: Promoting and Supporting Breastfeeding, Journal of the American Dietetic Association, November, 2009.

5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in – allow mothers and infants to remain together – 24 hours a day.
8. Encourage breastfeeding on demand.
9. Do not give pacifiers to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

In addition to the 10 steps, the CDC and the American Dietetic Association (ADA) recommend that hospitals do not include infant formula in discharge packs given to breastfeeding mother, because this gives mixed messages about the value of exclusive breastfeeding.¹⁶⁸

In 2010, only three hospitals in Washington State had BFHI designation: Evergreen Hospital Medical Center (Kirkland), Tacoma General Hospital, and University of Washington Medical Center.¹⁶⁹ However, hospital accreditation requirements are changing to eliminate in other hospitals the common practice of supplementing newborn feeding with formula. In April 2010, the Joint Commission adopted a core measure for perinatal care quality for exclusive breast milk feeding during the newborn's entire hospitalization.¹⁷⁰

Some hospitals are reluctant to pursue BFHI accreditation due to the cost of the accreditation process. Based on a study of maternity practices in hospitals in Colorado, 5 of the 10 steps that have been shown to be effective are called "The Colorado Five" or the "Can Do 5."¹⁷¹ The Can Do 5 include: breastfeeding within the first hour after birth, breast milk only, infant rooming-in, not using pacifiers, and giving the mother a

¹⁶⁸ American Dietetic Association, Position of the American Dietetic Association: Promoting and Supporting Breastfeeding, *Journal of the American Dietetic Association*, November, 2009.

¹⁶⁹ According to the website: www.babyfriendlyusa.org.

¹⁷⁰ For details, see <http://manual.jointcommission.org/releases/TJC2010A/MIF0170.html>

¹⁷¹ Erin Murray, Sue Ricketts, and Jennifer Dellaport. Hospital Practices that Increase Breastfeeding Duration: Results from a Population-Based Study. *BIRTH* 2007; 34 (3):202-211 (September)

telephone number to call for help after being discharged from the hospital. Research has shown that if none of the 10 steps are implemented, women are 8 times more likely to stop breastfeeding before 6 weeks compared to women who deliver in hospitals where 5 of the 10 steps are implemented.¹⁷²

Breastfeeding Community Support and Peer Counseling Programs

Peer support includes both individual counseling and support groups for breastfeeding mothers. Peer support has been shown to be effective in many different population groups by utilizing mothers who have similar sociocultural characteristics to provide social and emotional support, encouragement, education about breastfeeding, and help with solving problems.¹⁷³ Evidence has suggested that paid peer counselors are more effective than volunteers.¹⁷⁴ Ideally, peer counselors are trained on basic breastfeeding management, nutrition, infant growth and development, counseling techniques, and criteria for making referrals. They are supervised by health care professionals and/or lactation specialists.

The four tribally operated WIC programs that won awards for the highest rates of breastfeeding (Zuni, Navajo, Five Sandoval, and Kewa) were interviewed about their peer counseling programs and offered advice for other tribes based on their experience. Most peer counselors are young women who have recently breastfed their own babies. In general, tribal WIC directors have found that it is easier to supervise peer counselors if it is a full-time job and the person is hired directly by the tribe (instead of being hired on contract). Kewa Pueblo has developed a home visit form that improves accountability. Peer counselors seem most effective if their caseload is about 30 pregnant women and new moms.

Getting clients to answer telephone calls and return telephone calls can be a challenge for peer counselors. The WIC program at Zuni has learned that many pregnant women and young mothers have cell phones, but they try to conserve the minutes on their cell phone plans by using texting instead of answering phone calls. At Five Sandoval, the WIC program is exploring the use of texting to make appointments and let people know

¹⁷² Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM. The CDC Guide to Breastfeeding Interventions. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005. Available on-line at <http://www.cdc.gov/breastfeeding>.

¹⁷³ Ibid

¹⁷⁴ Ibid

when WIC personnel are schedule to be at various sites. At Kewa Pueblo, the WIC program has found that nursing mothers often prefer to ask questions and have them answered via text messages because it is more private than a telephone conversation.

Washington State WIC Nutrition Program has had a Breastfeeding Peer Counseling (BFPC) Program grant from USDA since 2004. The program requires implementation of the “Loving Support” peer counseling model, which is evidence-based but has not been evaluated for use with Native American populations. All local WIC programs are eligible to apply and participating local WIC programs are allotted specific funds to support this work, including pay for the peer counselors.¹⁷⁵

In focus groups conducted with pregnant women and new mothers in conjunction with this MIH Strategic Plan, women whose income is too high to qualify for WIC said that they do not have access to breastfeeding support services, such as a lactation specialist.

The Breastfeeding: Heritage and Pride¹⁷⁶ peer counseling program in Hartford, CT, offers a model program that calls for at least one home visit before the baby is born, daily visits during the hospital stay, a contact within 24 hours after hospital discharge, and 2 subsequent contacts. The peer counselors have at least 6 months of breastfeeding experience, complete 30 hours for classroom instruction, 3-6 months of supervised work experience, biweekly case reviews, and continuing education.

Another aspect of community support is social marketing campaigns that strengthen the positive perception of breastfeeding. The CDC found that television commercials have resulted in higher initiation rates for breastfeeding.¹⁷⁷ Two social marketing campaigns that have been successful are the *Babies Were Born to Be Breastfed* campaign by the Office on Women’s Health at the U.S. Department of Health and Human Services, and *Loving Support Makes Breastfeeding Work*, the WIC National Breastfeeding Promotion Program.

¹⁷⁵ Currently Puyallup Tribal Health Authority and Colville Confederated Tribes WIC programs are participating in BFPC. The state recently received a significant increase in funding for the Breastfeeding Peer Counseling Program, and once again all WIC agencies have been encouraged to apply and participate. Tribal WIC programs joining BFPC this year are: Swinomish Indian, Spokane Tribe of Indians, Seattle Indian Health Board, Quinault Indian Nation, Port Gamble S'Klallam Tribe, Makah Tribal Council, and Lower Elwha Tribe.

¹⁷⁶ Ibid

¹⁷⁷ Ibid

Workplace Breastfeeding Policies

Women often stop breastfeeding when they return to work. About 70 percent of women work fulltime, and one-third of them return to work 3 months after the birth of a baby, while two-thirds return to work within 6 months.¹⁷⁸ Workplace breastfeeding policies can make the difference between meeting the Healthy People 2010 goals of breastfeeding exclusively for 6 months and breastfeeding for 12 months.

A Nursing Mother Room is essential in the workplace. Ideally, it should have privacy, comfortable seating, a sink, an electrical outlet, and refrigerator. Other elements essential to workplace support for breastfeeding include flexible break schedules for nursing women, and on-site or near-site child care. Furthermore, women need to know that they have the support of their supervisors and their co-workers. The U.S. Health Resources and Services Administration Maternal and Child Health Bureau created a resource kit for employers, “The Business Case for Breastfeeding,” which is available on-line.

There are 14 states with legislation to support breastfeeding in the workplace.¹⁷⁹ Several tribes have adopted breastfeeding support policies for their tribal employees, including Tohono O’Odham Nation, Gila River, the Pueblo of Isleta, and Salt River Pima-Maricopa. Several Area Health Boards have also adopted workplace breastfeeding policies, such as the Northwest Portland Area Indian Health Board and the Intertribal Council of Arizona.¹⁸⁰

Pueblo of Zuni Breastfeeding Program

In 2010, the Pueblo of Zuni received an award from USDA for being a WIC State Agency with one of the highest rates of breastfeeding in the country. Some months 100 percent of new mothers at Zuni Pueblo enrolled in WIC are breastfeeding.¹⁸¹ It wasn’t

¹⁷⁸ Ibid

¹⁷⁹ According to the CDC website, the following states have employer mandates for breastfeeding support: Arkansas, California, Colorado, Connecticut, District of Columbia, Illinois, Indiana, Maine, Minnesota, Montana, New Mexico, New York, Oregon, Tennessee, and Vermont.

¹⁸⁰ The source of information in this paragraph is a Resolution of the White Rock Chapter of the Navajo Nation to Support and Endorse Breastfeeding in the Workplace for All Employees on the Navajo Nation.

¹⁸¹ Ruby Wolf, Director, Zuni WIC Program, and her staff provided information for this section. Zuni has about 11,000 tribal members and about 10,000 live on the reservation. There are about 850 people enrolled in WIC each month, and about 10,000 contacts per year. Zuni Pueblo is an Indian State Agency

always like this. According to Ruby Wolf, WIC Program Director at Zuni Pueblo, in the 1960's the Indian Health Service adopted a policy to prohibit women from breastfeeding. They told women that breastfeeding was unsanitary, they gave hormone injections to women after they gave birth to stop milk production, and they instructed women to mix evaporated milk with corn syrup to feed babies with bottles. In the 1970s, the IHS entered into promotional agreements with formula manufacturers that have continued until today. When Ms. Wolf started working for the Zuni WIC program at its inception in 1979, she became an advocate for breastfeeding. She went to the Tribal Council and the Governor of Zuni Pueblo and told them that replacing human milk with cow's milk goes against tribal tradition. They wholeheartedly agreed and supported her efforts, which began with breastfeeding classes in 1979 and a decision to never accept formula products, advertising or promotional items.

As WIC Program Director at Zuni, Ruby Wolf only hires people "who support breastfeeding, are comfortable with breastfeeding, and promote breastfeeding." She expects her staff to know the latest information about breastfeeding and to have the best technology available to assist breastfeeding mothers. Zuni WIC staff attends national training on breastfeeding, where they are also able to learn about new products, such as breast pumps. They have joined the New Mexico Breastfeeding Task Force which hosts an annual meeting that brings to the state the "the finest presenters and the latest information," including information about advanced medical issues related to breastfeeding.

About 95 percent of pregnant women on the Zuni reservation enroll in WIC and breastfeeding counseling begins immediately with their orientation session. They are given a sling bag that contains a DVD about breastfeeding, a brochure for dads, a brochure for grandparents, a burp cloth and other helpful items. Every time they come to the WIC office, they receive additional materials and counseling to promote breastfeeding. Fathers, grandparents, and other family members are included in counseling sessions. They do not treat teenage parents any differently than others. According to Ms. Wolf, "Young moms are very capable with maternal responsibility." They respond well to the message that breastfeeding is the best way to get to know your baby and to bond with your baby.

All of the materials used by the Zuni WIC program are screened for cultural appropriateness, including the photographs of people used in pamphlets. Ms. Wolf

in the Southwest Region of WIC with regional offices in Dallas. The annual budget for the Zuni WIC program is about \$1,048,000, including both food and administration.

says they are able to use materials developed in Texas for Hispanics because the people in the photographs look similar to Zuni people.

The tribe has 5 different kinds of breast pumps available for women. They assess the individual's needs and match them to the breast pump that is right for them. They also listen to feedback from nursing mothers about which pumps they like the best. Breast pumps and other breastfeeding supplies are purchased from WIC food funding.

Two full-time paid Breastfeeding Peer Counselors at Zuni are very young women who are tribal members that have recently breastfed their own babies and have had training for their positions. Each has a caseload of about 30 women. A computer program helps them track the due dates and delivery dates of pregnant women so that they can make home visits as early as possible after the baby is born and follow up at intervals that are considered critical for continuation of breastfeeding, such as 4 months after birth when the infant goes through a growth spurt and may be fussy.

As a State WIC agency in the Southwest Region with offices in Dallas, Zuni Pueblo has an excellent working relationship and receives consistently strong support from the FNS/USDA Southwest Region. Ruby Wolf's leadership is recognized nationally, as she is the only American Indian on the USDA National Advisory Council.

It took about 10 years for the Zuni nation to make breastfeeding the norm again. Ms. Wolf advises other tribes to rely on their elders and traditions. She says that change must come from within the tribe – it doesn't work when it comes from outside. She encourages tribes to use epidemiological data to guide how to create change and measure outcomes. The dedicated Zuni WIC staff continues to inspire families to promote breastfeeding.

Navajo Nation Breastfeeding Coalition, Workplace Legislation, and Peer Support

In 2010, the Navajo Nation (NN) was recognized by the U.S. Department of Agriculture (USDA) for having the highest breastfeeding rate among larger WIC agencies, and given a \$50,000 award for their outcomes. People who work in the Navajo Nation WIC program attribute the high rate of breastfeeding to two factors: traditional values and the local economy.¹⁸² They say that grandmothers are very supportive of breastfeeding and elders influence decisions of younger people. With a 56 percent unemployment

¹⁸² Adele King, Program Director, The Navajo Nation WIC Program, and Amanda Singer, Navajo Nation WIC Peer Counselor, provided most of the information in this summary, with assistance from other WIC staff.

rate and a high level of poverty, the cost of formula at \$23 per can is too expensive for most families to afford. The WIC program only pays for 7 cans of formula for the first 6 months after a baby is born, so there is a strong economic incentive for women to breastfeed. At the same time, the Navajo Nation has taken steps to increase the duration of breastfeeding by passing a law that governs workplaces, including tribal offices, organizations that are located on the reservation, and those that do business with the tribe.

The strategies that NN used to increase initiation and duration of breastfeeding are the proven strategies in “The CDC Guide to Breastfeeding Interventions.” The implementation of these strategies started by building regional and community coalitions of breastfeeding advocates from health care, tribal government, Head Start and other interested people in the communities. They decided to prioritize items from the CDC guide that were possible to implement without money. The coalitions formed teams to work on different aspects of implementation. They also worked in partnership with other organizations, including the Indian Health Service, US Breastfeeding Committee, the WIC program, the CDC Breastfeeding Work Group¹⁸³, the Maternal & Child Health Bureau at Health Resources & Service Administration (HRSA) in the U.S. DHHS, and the National Institutes of Health.¹⁸⁴ In 2009, they formalized the group and officially became the Navajo Nation Breastfeeding Coalition.

The Navajo Nation Healthy Start Act of 2008 was passed by the Navajo Nation Council and signed into law by the Navajo Nation President. It requires all employers within the territorial jurisdiction of the Navajo Nation or having any contracts with the tribe to provide “a clean and private area or other enclosure near the employee’s workspace, and not a bathroom, to allow a working mother to engage in breast-feeding or use of a breast pump” and “a sufficient number of unpaid and flexible breaks.”¹⁸⁵ Employers are required to submit a compliance plan with the Office of Navajo Labor Relations which is charged with enforcing the act. The Navajo Nation Labor Commission is authorized to conduct hearings if violations of the act are alleged and to order remedial action. The WIC Program gives women cards informing them of the law and telling them to call the Office of Navajo Labor Relations if they feel discriminated by their employer for their

¹⁸³ Lorraine Whitehair, Public Health Nutritionist, CDC Division of Nutrition, Physical Activity, and Obesity, and a member of the Navajo Nation, served as a consultant and provided some of the information in this section of the report. She is available to work with other tribes and breastfeeding coalitions.

¹⁸⁴ National Institute of Diabetes and Digestive and Kidney Diseases

¹⁸⁵ An Act Relating to Health, Human Services, and Judiciary; enacting the Navajo Nation Healthy Start Act of 2008.

choice to breastfeed. In collaboration with the Arizona Breastfeeding Coalition, the Navajo Nation Breastfeeding Coalition received an \$8,000 grant from HRSA to implement the Business Case for Breastfeeding. They advise businesses on the Navajo reservation about how to implement the Navajo Nation Healthy Start Act of 2008, and they held a conference on this subject.

As they built support for the workplace breastfeeding tribal legislation, the Breastfeeding Coalition developed materials that present the issues in a cultural context. For example, one flyer with a photo of a Navajo mother and child states: “Breastfeeding is a Navajo Tradition which creates a special bond between a mother and her newborn baby. The close relationship offers the infant the knowledge of kinship and traditional values of living in harmony with the world.” Culturally appropriate information was also developed for new mothers including, “An Easy Guide to Breastfeeding for American Indian and Alaska Native Families,” which has 27 pages of information and a toll free number to call for assistance.¹⁸⁶ Billboards have been placed throughout the Navajo Nation encouraging breastfeeding. One has a photo of mother and child and the message: “Breastfeeding is sharing wisdom, love and health.”

The NN has a Peer Counselor program to encourage breastfeeding. However, there are only 3 WIC positions for Peer Counselors for the entire Navajo Nation, one of the largest tribes in the country with a reservation that extends into three states and 12 tribal WIC clinics serving about 850 breastfeeding clients. The Peer Counselors work on breastfeeding promotion at a systems and community level, as well as doing individual counseling. The role of counseling on breastfeeding is shared by all WIC staff, with 85 percent of the WIC staff trained in breastfeeding. The Loving Support curriculum is available on-line and this is how most WIC employees receive their training. All of the WIC nutritionists are Certified Lactation Counselors.¹⁸⁷ Each of the 12 WIC clinics operated by the Navajo Nation has a lead person trained in breastfeeding. The Phoenix Indian Medical Center provided a nurse who is an International Board Certified Lactation Consultant (IBCLC)¹⁸⁸ to train 24 people including Health Promotion staff, LPNs, Dietitians, RNs, and WIC employees. The 6-day training was a 3-credit course through Central Arizona College. These Certified

¹⁸⁶ Office on Women’s Health, U.S. Department of Health and Human Services, “Easy Guide to Breastfeeding for American Indian and Alaska Native Families,” Washington, DC. No date. Available on-line.

¹⁸⁷ There are 6 nutritionist positions.

¹⁸⁸ Sue Murphy, RD, MPH, CDE, IBCLC, Diabetes Center of Excellence, Phoenix Indian Medical Center, provided the training and is available to consult with tribes in Washington State.

Breastfeeding Counselors work in both diabetes prevention programs and maternal and child health programs.

Teams from the NN Breastfeeding Coalition are working with hospitals to adopt the Baby Friendly Hospital Initiative (BFHI). Three hospitals have submitted a letter of intent to become BFHI certified.¹⁸⁹ The biggest obstacle is the requirement that physicians and nurses receive 18 hours of training on breastfeeding. Many health care professionals are overwhelmed by an underfunded system and not aware of the research on the benefits of breastfeeding, so this is regarded as a large commitment of time and funding for training.

Home Visiting Programs

Home visiting programs for low income, high risk, first time mothers during pregnancy and the first two years of an infant's life have been implemented in a variety of populations. Research suggests that parenting skills learned through the home visits could improve preconception health for the next generation. For example, children whose mothers received home visiting services are less likely to initiate smoking and other drug use before they are 12 years old, and may be at less risk for depression.¹⁹⁰ In general, home visiting during pregnancy has not resulted in better pregnancy outcomes, such as lower rates of preterm delivery or low birth weight.¹⁹¹ Home visiting programs have gained popularity because research shows that the investment in these programs pays off in the life course of mothers who are more likely to return to work earlier and have longer spacing between pregnancies compared those who have not had the benefits of a home visiting program.¹⁹²

¹⁸⁹ The IHS hospitals at Chinle and Shiprock, and the 638 hospital in Ft. Defiance have submitted letters of intent. The nurses at Ft. Defiance are especially supportive, and they have been trying to get BFHI certification for more than a decade.

¹⁹⁰ Harriet J. Kitzman, DL Olds, RE Cole, CA Hanks, EA Anson, KJ Arcoleo, DW Luckey, MD Knudtson, CR Henderson, JR Holmberg, Enduring Effects of Prenatal and Infancy Home Visiting by Nurses on Children: Follow-up of a Randomized Trial Among Children at Age 12 Years. *Archives of Pediatric and Adolescent Medicine*, Vol 164, No 5, May 2010.

¹⁹¹ Harriet Kitzman, DL Olds, CR Henderson, C Hanks, R Cole, R Tatelbaum, KM McConnochie, K Sidora, DW Luckey, D Shaver, K Engelhardt, D James, K Barnard, Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing. *JAMA*, Vol 278, No 8, August 27, 1997.

¹⁹² NFP website (nursefamilypartnership.org) on May 14, 2010

The home visiting program that has received the most attention and research is the Nurse-Family Partnership (NFP) program. Research suggests that nurses with BSN degrees are more effective than paraprofessionals with a high school education as home visitors.¹⁹³ In Washington State, the first NFP program started in 1999 and now 10 counties have NFP programs.¹⁹⁴ The consortium of agencies that provides NFP services meets quarterly and all of the programs adhere to a structured model based on three principles: 1) parents need to set realistic goals and have confidence that they can achieve those goals (self-efficacy theory); 2) parents need to negotiate and regulate their social environments that includes relationships with family, friends, neighborhoods, communities and cultures (human ecology theory); and 3) children are more likely to become sensitive and responsive parents if that is how they were parented (attachment theory).¹⁹⁵

Participation is voluntary for pregnant women, but the model requires that visits begin early in pregnancy, no later than the 28th week. This eliminates high risk women who seek late prenatal care and selects for those who are most motivated to improve the outcomes of their pregnancy. There is a fairly high rate of discontinuation on the parts of both the pregnant/parenting women and the nurse visitors during research trials that have been reported. This complicates the research findings about program outcomes.

Depending upon the ethnic group served, the program may reduce smoking among pregnant women, but very few other reductions in pregnancy risk factors have been demonstrated.¹⁹⁶ For teen mothers, home visitation showed improved parenting attitudes and school continuation, but it did not change outcomes related to depression

¹⁹³ David L. Olds, J Robinson, R O'Brien, DW Luckey, LM Pettitt, CR Henderson, RK NG, KL Sheff, J Korfmacher, S Hiatt, A Talmi. Home Visiting by Paraprofessionals and by Nurses: A Randomized, Controlled Trial. *Pediatrics*, Vol 110, No. 3, September 2002.

¹⁹⁴ Clark, Jefferson, King, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston and Yakima counties. Source: NFP website (nursefamilypartnership.org) on May 14, 2010.

¹⁹⁵ NFP website (nursefamilypartnership.org) on May 14, 2010.

¹⁹⁶ Harriet Kitzman, DL Olds, CR Henderson, C Hanks, R Cole, R Tatelbaum, KM McConnochie, K Sidora, DW Luckey, D Shaver, K Engelhardt, D James, K Barnard, Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing. *JAMA*, Vol 278, No 8, August 27, 1997.

and repeat pregnancy.¹⁹⁷ A review of the literature is inconclusive about whether home visitation changes patterns of drug and alcohol use.¹⁹⁸

Overall, research suggests that the program reduces childhood injuries, child abuse and neglect.¹⁹⁹ One finding is that “in contrast to comparison-group counterparts, nurse-visited women held fewer beliefs about child-rearing associated with child abuse and neglect – lack of empathy, believe in physical punishment, unrealistic expectations for infants.”²⁰⁰ However, the NFP is not as effective in decreasing child abuse and neglect in households with intimate partner violence, and trials are underway for another program with additional training for nurse visitors called Domestic Violence Enhanced Home Visitation (DOVE).²⁰¹

Funding sources vary among agencies and may include First Steps, federal grants, local government, foundations and non-profits, and other sources. The Patient Protection and Affordable Care Act of 2010 (health care reform) included a Home Visitation Grant Program as part of Title V of the Social Security Act with federal funding through formula grants to states building from \$100 million in 2010 to \$400 million in 2014, with a 3 percent set aside for tribes and urban Indian programs.²⁰²

¹⁹⁷ Beth Barnet, J Liu, M DeVoe, K Alperovitz-Bichell, AK Duggan, Home Visiting for Adolescent Mothers: Effects on Parenting, Maternal Life Course, and Primary Care Linkage, *Annals of Family Medicine*, Vol 5, No. 3, May/June 2007.

¹⁹⁸ Catherine Doggett, SL Burrett, DA Osborn, Home visits during pregnancy and after birth for women with an alcohol or drug problems (Review) in *The Cochrane Collaboration*. The Chochrane Library, Issue 1, John Wiley & Sons, 2009./

¹⁹⁹ Harriet Kitzman, DL Olds, CR Henderson, C Hanks, R Cole, R Tatelbaum, KM McConnochie, K Sidora, DW Luckey, D Shaver, K Engelhardt, D James, K Barnard, Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing. *JAMA*, Vol 278, No 8, August 27, 1997.

²⁰⁰ Ibid

²⁰¹ Phyllis W. Sharps, J Campbell, ML Baty, K Walker, MH Bair-Merritt. Current Evidence on Perinatal Home Visiting and Intimate Partner Violence, *JOGNN*, Vol 37, Issue 4, 2008.

²⁰² On September 28, 2010, the U.S. Department of Health and Human Services announced that \$3 million in Affordable Care Act funds was awarded to 13 tribes, tribal organizations, and urban Indian organizations through the Tribal Maternal, Infant, and Early Childhood Home Visiting Grant Program. The awards included \$261,000 for Port Gamble S’Klallam Tribe, and \$194,000 for SPIPA.

In focus groups with pregnant women and new mothers in conjunction with this MIH Strategic Plan, women who were enrolled in First Steps and received home visits were very happy with having a nurse in their home to answer questions. However, American Indian women whose income is too high to qualify for Medicaid felt that they would also like to have visiting nurses and other services related to First Steps.

Honoring Our Children Project (Wisconsin)

Honoring Our Children (HOC) provides funding and support to 8 tribes in Wisconsin²⁰³ through the Great Lakes Inter-tribal Council, Inc (GLITC) to reduce infant morbidity and mortality rates and eliminate perinatal health disparities through outreach, education, case management, maternal depression screening and referral, interconceptional care and consortia building.

Each tribe develops their own program, and these are showcased with personal testimonials from program participants in a document available on the web at <http://www.glitc.org/HOC/pdf/leave-behind%202009.pdf>. All of the programs have some common elements, including:

- Home visiting, which may include breastfeeding support, in-home immunizations, screening for depression, safety improvements and parenting education and support.
- Case management services, including risk assessment, referral, monitoring, facilitation, and follow-up.
- Group activities that bring families together for social support and provide information. Some examples of group activities are pumpkin painting, no-sew blanket making, and Christmas portraits.
- Car seats and installation, along with information for parents about how to properly secure their children in the car seat.

²⁰³ Tribes served include: Lake Superior Chippewa (Bad River Band, Lac Courte Oreilles Band, Lac de Flambeau Band, Red Cliff Band, Sokaogon Band, St. Croix Band), Forest County Potawatomi Tribe and Stockbridge-Munsee Band of Mohican Indians.

- “NEST” incentives store: parents earn points for attending physician visits, breastfeeding, participating in classes and activities, enrolling in WIC, and other behaviors that are likely to improve infant health. Points are converted to dollars that can be used at the NEST store for items such as diapers, child clothing, baby equipment (like high chairs and cribs), household supplies (like laundry detergent and paper towels), safety items (like gates and outlet plugs), toys, seasonal items, cameras and photo albums.

Both participants and staff believe that the NEST incentives are the most effective way of enrolling and retaining families, as well as other caregivers.

The program design, implementation and evaluation have involved the GLITC, the Wisconsin Tribal Health Directors Association, families and tribal communities. Funding has been provided through the HRSA Healthy Start Initiative.

Risk Reduction Program for Teens Engaging in Sexual Activity (NIWHRC)

The National Indian Women’s Health Resource Center (NIWHRC) has developed an intergenerational program for risk reduction in American Indian teens, including preventing pregnancy, HIV/AIDS and other sexually transmitted infections. The program has been replicated in the Ponca Tribe, with the name “WellSpeak.” Funding for the program in various locations with various names at different times since 2008 has been provided by the federal government through the Office of Women’s Health, the Indian Health Service (IHS), and the Administration for Native Americans (ANA).²⁰⁴ This case study reports on one of the programs held in 2008 that was evaluated by an independent evaluator.

Weekend workshops were held in 8 communities throughout Oklahoma with participation by 202 members of 14 tribes. Community advisory boards were convened prior to the workshops and community members assisted in participant recruitment and meeting logistics. The modules included in the workshop were: Parent/Teen Communication; Puberty Rites of Passage; The Body- Reproduction Process; Building Condom Use Skills; Building Negotiation and Refusal Skills; and two sessions on HIV/AIDS.

Family members participated together with pairs of adolescent women (age 12 to 18) and their mothers, grandmothers or aunties. Each participant was paid \$50 if they

²⁰⁴ Pamela E. Iron, Executive Director, National Indian Women’s Health Resource Center, personal communications, May 17, 2010.

attended all the sessions and filled out evaluation questionnaires before and after the event.²⁰⁵ Free, voluntary HIV testing was provided during the workshop and about half the participants elected to be tested. A psychologist was available during the workshop to assist people for whom the issues discussed created emotional responses.

The workshops were delivered to a high risk group of adolescents. Teens over 15 years old were asked questions about their sexual activity. Among this group (n=54), 53 percent were sexually active, and their number of sexual partners ever ranged from 1 to 16 with an average of 4-5, and age at first intercourse ranged from 12 to 17 with a peak at 14 years old. Most partners were age appropriate, while 3 percent reported non-consensual sex. At first sexual activity 92 percent used condoms, while only 54 percent reported current condom use.

While 78 percent of the adults in the group said that they had talked with the teen participating about preventing unplanned pregnancies, the adolescents said they had learned how to prevent pregnancies from their teachers (31 percent) and medical personnel (23 percent). Outcome measures showed that 79 percent of adults and 51 percent of teen thought that the workshop would make it easier for them to communicate with one another. Teens showed a statistically significant increase in knowledge about how to access medical care, particularly for sexual health.

Traditionally, many tribes had puberty ceremonies, but only 18 percent of the adults participating in the workshops said that they had given their daughter this rite of passage. Even though they had not experienced such a ceremony themselves, the majority of adults thought it would be of value, "viewing it as a way of affirming the transition into womanhood, countering fear and shame, and showing of self-respect." In contrast, the majority of adolescents did not want this type of acknowledgement of their development, which they considered a private matter.

All adults who participated and 83 percent of the adolescents said they would recommend the workshop to others. The evaluation found that "it helps to ease difficult conversations by preparing parents with correct terminology and skills for addressing difficult or embarrassing questions and creates awareness about an important topic that impacts the entire community."

²⁰⁵ All of the evaluation information in the section is from Sage Associates, Inc, Final Evaluation Report, 2008 Intergenerational Approaches to HIV/AIDS Prevention Education with Women Across the Lifespan, unpublished report prepared for NIWHRC, September, 2009

Tribal Teen Pregnancy Prevention Programs (Arizona)

The State of Arizona uses state lottery funds for teen pregnancy prevention and education programs in 14 counties. A total of \$408,000 is provided annually for tribal programs, and the funding is split between the Navajo Nation and the Inter-tribal Council of Arizona (ITCA). ITCA subcontracts with three tribes to conduct the programs. In 2009, there were 11,600 children and 200 adults participating in the tribal programs.

Three different curricula are being used by the tribal programs. The pregnancy prevention program that is preferred by the Arizona Department of Health Services is Teen Outreach Program (TOP) and this is being used by the Navajo Nation. TOP is designed for 12 to 17 year old youth and includes classroom/group instruction, community service, and service learning. It is a program that has been conducted in more than 400 locations since 1976 and evaluated extensively, but the outcome measures are not conclusive.²⁰⁶ It is often conducted in community settings by youth organizations.

The ITCA tribes requested that funding for teen pregnancy prevention utilize a program called Reducing the Risk (RTR) for high school students, and another program for middle school students called Making A Difference. Because both of these were evidence-based programs, the State approved this request.

For the younger students, Making a Difference has 8 modules of 60 minutes each that can be delivered in a weekend format or within the school curriculum. It focuses on abstinence, building negotiation and refusal skills, and knowledge about pregnancy and sexually transmitted disease. The curriculum is interactive and asks youth to think about their goals and dreams, as well as the consequences of their choices. One of the themes that may make it attractive for tribal use is “to be proud of themselves, their family, and their community, and to behave responsibly for the sake of themselves, their families and their communities.”²⁰⁷

The RTR curriculum for high school students has 16 lessons designed for 45 minute periods that can be incorporated into school-based health education classes. It provides information about preventing HIV and other STDs and pregnancy through both

²⁰⁶ More about TOP is available at: <http://www.promisingpractices.net/program.asp?programid=14>

²⁰⁷ <http://www.etr.org/recapp/index.cfm?fuseaction=pages.home>

abstinence and protection. It also focuses on behaviors to use refusal skills, delaying tactics, and avoid high risk situations.²⁰⁸

Cultural Approach to Nutrition Intervention

Registered Dietitian Kibbe Conti, RD, MA, CDE, is a member of the Oglala Lakota tribe from Pine Ridge, South Dakota. She drew upon her tribe's wisdom, traditional foods, and spiritual beliefs to develop the Four Winds Model for Healthy Eating. Research using the model with the Cheyenne River Sioux Tribe showed that the culturally rich approach was more effective than usual dietary education.²⁰⁹ This culturally competent approach to nutrition education resulted in statistically significant weight loss and decrease in BMI.²¹⁰ In private practice as a Dietitian, Kibbe Conti used this approach to help tribes develop their own models before joining the Indian Health Service. While this approach was used primarily for diabetes prevention education, the principle of using cultural approaches to nutrition education can also apply to pregnant women and new mothers.

Michigan AI/AN Statewide Infant Death Review

There are about 10-20 American Indian infant deaths in Michigan each year. The Inter-Tribal Council of Michigan (ITCM) conducts infant death reviews for American Indians statewide. This effort is funded primarily from the ITCM Healthy Start grant, which serves 6 tribes and 2 urban Indian clinics, and covers the cost of staff and travel for the infant death reviews. Coordination, data management and reporting requires about 20 percent of a full-time equivalent position within the ITCM. The State uses Healthy Michigan Funds to provide an additional \$1,080 that is used primarily to contract for data abstraction, which costs about \$270 per case.

Cases are referred to ITCM from two sources. One is death certificates that identify the child as American Indian, which are flagged by the State Fetal and Infant Mortality

²⁰⁸ More about RTR is available at [More about RTR and Making a Difference is available at http://www.etr.org/recapp/index.cfm?fuseaction=pages.home](http://www.etr.org/recapp/index.cfm?fuseaction=pages.home)

²⁰⁹ Kendra K. Kattelman, Kibbe Conti, Cuirong Ren, The Medicine Wheel Nutrition Intervention: A Diabetes Education Study with the Cheyenne River Sioux Tribe, *Journal of the American Dietetic Association*, Volume 109, Issue 9, 2009.

²¹⁰ Ibid

Review (FIMR) coordinator and sent to the ITCM. However, there is often misclassification of ethnicity on death certificates. On birth certificates, babies are classified the same as their mothers. Doctors or coroners do the classification on death certificates and these are often not consistent with birth certificates. So the State FIMR Coordinator uses a method called, “Any mention case definition,” where any mention of AI/AN in any field on the birth or death certificate leads to classification of the infant death as AI/AN and flags it for potential FIMR review. ITCM decides which deaths merit additional review. Priority is given to Sudden Unexplained Infant Deaths (SUID) deaths, deaths to Healthy Start enrollees, and deaths in the 14 counties where Healthy Start services are provided under the ITCM grant.

The ITCM uses the Fetal Infant Mortality Review (FIMR) model developed by the American Congress of Obstetricians and Gynecologists (ACOG).²¹¹ The process starts with a case abstraction, including review of medical records and public records. This information often comes to ITCM from Child Fatality Review teams at the county level. If this has not been done, ITCM contracts with someone to do case abstraction. While the ACOG model calls for interviewing the mother of the infant who died, the ITCM has conducted very few mother interviews due to concerns about cultural appropriateness.

A Case Review Team of experts from the medical, social services, and public health fields from the Healthy Start program sites meets twice a year to review individual cases and consider policy changes and other interventions that may be needed to prevent similar types of deaths in the future. These recommendations are shared with the Healthy Start Project Consortium at their regular meetings.

One example of an outcome of this process was the identification of a high rate of postneonatal SUIDs where infants were sleeping with their parents. Rather than recommending against co-sleeping, they took a more culturally appropriate approach of making recommendations for risk reduction for co-sleeping, and noted that this message needs to be delivered early and often, not only to the mother but also to her extended family.

CenteringPregnancy

CenteringPregnancy is a trademark name for a program developed in 1994 at the Yale University School of Nursing and offered at more than 100 sites across the U.S. and

²¹¹ <http://www.acog.org/>

Canada. Three sites in Washington State are registered as offering the program.²¹² The CenteringPregnancy group consists of people at the same stage of pregnancy who meet monthly for 90 to 120 minutes until the fifth month of pregnancy and then biweekly through the early postpartum period. The model includes having clients check their own blood pressure, weight and urine and record results in their medical records. Group sessions involve patient education, socializing and group support. The Centering Healthcare Institute provides materials for both providers and patients to use during sessions.

The CenteringPregnancy program has been evaluated in various parts of the country and it is shown to be cost effective and well-accepted by clients, while having birth outcomes similar to that of traditional care.²¹³ Women who participate in CenteringPregnancy have been shown to breastfeed longer. A study of a high risk group of primarily African Americans showed that perinatal outcomes were equivalent to traditional standard maternity care at no added cost.²¹⁴

Another study concluded that adolescents participating in CenteringPregnancy programs had “excellent health care compliance, satisfaction with prenatal care, and low rates of preterm birth and low birth weight infants.”²¹⁵ The model evaluated for teens used groups that self-selected for participation. The program included Peer Assistants, program graduates who served as an expert within the groups. The teen pregnancy model also involved fathers, family members, friends, and grandparents in their own support groups for education and discussion. Another element was “Baby Bucks” as an incentive for participating and positive health behaviors that could be used to purchase donated items, such as car seats and baby clothes. The teen pregnancy

²¹² Swedish Midwifery and Women’s Health in Seattle, Midwives at Valley Medical Center in Renton, and Madigan Army Medical Center in Tacoma are listed on the Centering Healthcare Institute website (www.centeringhealthcare.org) on May 11, 2010. In 2003, the March of Dimes provided a \$10,000 grant to Family Planning of Chelan and Douglas Counties (FPCD) to offer the CenteringPregnancy program in Wenatchee, Washington.

²¹³ Laurie Cawthon, C. Du, T. Keenan-Wilke, K. Rust, D. Tornatore, Appendix A. Detailed Literature Review. Group Services for Pregnant and Parenting women: An Exploratory Study. Research and Data Analysis Division, Department of Social and Health Services, Olympia, Washington, October 2006

²¹⁴ Jeanette R. Ickovics, TS Kershaw, C Westdahl, U Magriples, Z Massey, H Reynolds, SS Rising, Group Prenatal Care and Perinatal Outcomes: A Randomized Controlled Trial, *Obstetrics & Gynecology*, Vol 110, No. 2, Part 1, August 2007.

²¹⁵ Mary Alice Grady and Kathaleen C. Bloom, Pregnancy Outcomes of Adolescents Enrolled in a CenteringPregnancy Program, *Journal of Midwifery & Women’s Health*, Vol 49, No 5, September/October 2004.

center where the evaluation was conducted also offered group support after delivery for new moms.

CenteringPregnancy has not been evaluated in a tribal context. Many tribes are too small to have 8-10 women for a group at the same stage of pregnancy at the same time.

Promising Programs

The promising programs that are identified here do not yet have outcome measures. Some have been used in small scale settings at tribes and urban Indian clinics, where it may not be possible to have quantitative evaluation that would demonstrate their effectiveness in changing pregnancy outcomes.

Seattle Indian Health Board Prenatal Care Program

The Seattle Indian Health Board has a successful model that has been used for 12 years with funding from Public Health Seattle-King County, approximately \$75,000 per year in addition to Medicaid payment for direct services. SIHB serves about 200 pregnant women per year, and their doctors deliver about 80-90 babies per year.

The model is designed to promote early and timely entry into prenatal care for AI/AN women and promote optimal birth outcomes. The model is based on three components: 1) a multidisciplinary team, 2) a dedicated “Prenatal Day” and 3) incentives. A multidisciplinary prenatal team provides comprehensive coordinated care. Free pregnancy tests are provided at the SIHB medical clinic. A woman with a positive pregnancy test meets with a dedicated prenatal nurse for a comprehensive intake and scheduling prenatal appointments. Two community outreach staff work with pregnant women to follow-up on missed appointments and assist with Medicaid enrollment. A Case Manager with a Masters in Social Work (MSW) provides maternity support services case management. A nutritionist provides nutrition counseling and enrollment in the Women Infant and Children’s (WIC) program, available on site at SIHB. Home visits are also made to pregnant women who miss prenatal appointments and to new mothers a few days after they are discharged from the hospital. Care conferences are held after weekly prenatal clinics where cases are reviewed by the prenatal team.

A dedicated “Prenatal Day” is held every Thursday. On that day, SIHB provides luncheons for pregnant women and new moms that include informal programming, such as nutrition education, crafts, and cradleboard projects. The luncheon provides an

opportunity for networking and social support, as well as discussions and demonstrations about nutrition. It also gives health professionals, such as childbirth educators, community health nurses and outreach workers, an opportunity to develop more trusting relations. Approximately 10-20 women attend the weekly luncheons.

Incentives, funded by the monies from Public Health Seattle & King County, are given along the course of prenatal care to promote visits. Diaper bags filled with clothes, bibs, and essential items are also provided to women who complete their pregnancy under the care of the SIHB prenatal team. As a result of this model, patients feel well cared for and have essential items that they otherwise may not be able to afford.

Designed to meet the individual needs of the patient using a comprehensive, coordinated model of care, the SIHB has been able to realize consistent positive birth outcomes year after year: over 90% of pregnant women enter care in the first and second trimester and 98% of all babies delivered by SIHB physicians are of normal birth weight.

Washington State Bedtime Basics for Babies Program

The Washington State Bedtime Basics for Babies Program is a program coordinated by Seattle Children's Hospital and First Candle with funding through 2014 from the Bill & Melinda Gates Foundation. The goal is to reduce SIDS deaths by providing free portable cribs, SleepSack wearable blankets, and pacifiers to families with infants. The educational component of Bedtime Basics for Babies includes sleep position, sleep surface, cigarette smoke, breastfeeding, pacifier use, alcohol use, and healthy temperature during sleep. Evaluation of this and similar programs located in Indiana and Washington, DC, is on-going and results are not yet available.

Families are eligible to enroll in Bedtime Basics for Babies if they are on Medicaid, SCHIP, WIC or below 150 percent federal poverty level. Nearly 80 percent of American Indian newborns in Washington State would meet the family income criteria to qualify for this program; however, there is a need to link pregnant women to the program. To participate, families need to enroll in the research component of the project. Tribes can facilitate this through review by their Institutional Review Boards (IRBs) for research or other research protocols, and tribal resolutions to endorse participations and assist in enrollment.

Shoalwater Bay Contract Health Services Program for Pregnant Women

For the past decade, the Contract Health Services (CHS) department at the Shoalwater Bay Wellness Center has taken a leadership role in providing support services for pregnant women.²¹⁶ The tribe is small (323 enrolled tribal members) and has a history of high rates miscarriages, stillbirths and infant mortality that was investigated by the Centers for Disease Control (CDC) without conclusive results about the cause of these problems. CDC recommended that all tribal members who are pregnant receive specialty medical care, Congress created a special appropriation to enhance CHS at Shoalwater Bay for this purpose, and the tribal council adopted a policy that would allow CHS to authorize all parents to take their children to private sector pediatricians.

The tribal clinic provides primary care, including a physician and a physician assistant, as well as dental, mental health, and chemical dependency services. Tribal members are adept at utilizing both tribal and private sector services, and electronic medical records in both systems facilitate coordination of care. The closest hospital to the tribe discontinued their labor and delivery services, so tribal members have to travel 35-40 minutes for prenatal services and a hospital, or 1.5 hours to a larger community offering more specialized services for high risk patients.

After women receive a positive pregnancy test in the Shoalwater Bay Wellness Center, they are referred to the CHS Department. CHS not only assists them with enrolling in Medicaid and obtaining appointments with obstetricians, but they also offer patient education materials and become part of the community support. They believe that most doctor's offices do not provide educational materials and tribal members cannot afford to purchase the books that may be available in bookstores. CHS provides newly pregnant women with booklets, pamphlets and their choice of a week-by-week guide to pregnancy or a journal that allows women to chart their progress day-by-day. They also receive a poster explaining fetal development called, "How Big is My Baby Now."

A poster in the CHS office informs women that they may be eligible for gifts during their pregnancy to encourage them to return to the CHS office where there is informal case management. If there are missed appointments, CHS works with the Community Health Representative (CHR) and medical records to flag charts and follow up to see that women get the care that they need.

At the end of the second trimester, pregnant women who return to the CHS office receive a backpack filled with newborn items such as diapers, wipes, bath products,

²¹⁶ Information in this case study is from Kim Zillyett-Harris, CHS Director, Shoalwater Bay Wellness Center, personal communications, May 19, 2010.

thermometer, fingernail clippers, a bath towel, a blanket, a bottle, and a toy. They also receive information about child care and child development, including the Guide from Birth to the First Year.

Near the time of delivery, women return to the CHS office to receive a car seat. CHS employees have been trained and certified to demonstrate the car seat installation and use. As the child grows larger, parents can return to the CHS office to obtain larger car seats. The CHS office measures the child's height and weight to determine the right car seat for a child and offers three sizes: infant, convertible, and booster. Occasionally, CHS staff have driven to the hospital to deliver a car seat to a mom who goes into labor early.

About 6-7 pregnant women are served each year by this program. The program costs \$200-250 per pregnant woman. Some of the car seats are purchased by the tribe and some are donated. In addition to providing education and support services, CHS collects data and interfaces with epidemiologists and others who are studying maternal and infant health at the tribe.

Young Women's Group at Port Gamble S'Klallam Tribe

In 2003, the Port Gamble S'Klallam Tribe Community Health Department started a Young Women's Group with a \$2,400 grant from the March of Dimes.²¹⁷ The Community Health Department already provided a range of services including First Steps, WIC, health education, car seat training, transportation, immunizations, outreach, and a Fetal Alcohol Syndrome (FAS) prevention program. The Young Women's Group was started by the Health Educator to provide peer support for women ages 16-25. The group was limited to 10 participants, including pregnant women, women trying to get pregnant, mothers, and women trying to develop new relationships to support their efforts to abstain from alcohol or drugs. Half of the participants were single mothers.

The initial group met for two hours in the evenings, every two weeks for six months. Dinner was provided and the women participated in a 5-month project of making a traditional button blanket. In the beginning, the women signed a confidentiality agreement and selected health and wellness topics to be presented and discussed during the meetings. The Health Educator and MCH Nurse served as facilitators, and

²¹⁷ Information was abstracted from Laurie Cawthon, C. Du, T. Keenan-Wilke, K. Rust, D. Tornatore, Group Services for Pregnant and Parenting women: An Exploratory Study. Research and Data Analysis Division, Department of Social and Health Services, Olympia, Washington, October 2006

also made presentations, as did invited guest speakers. Reminder calls were made on the days of the meetings and transportation was provided if needed.

Akimel O'odham/Pee Posh Council, Gila River Indian Community

The Gila River Indian Community is a federally-recognized tribe in Arizona. The people call themselves Akimel O'odham and Pee Posh, but the Spanish gave them the names Pima and Maricopa. The Akimel O'odham/Pee Posh Council was organized by youth on the Gila River reservation in 1987.²¹⁸ The 20 members of the council are elected by their peers to serve staggered 2-year terms. Members range in age from 14 to 21. In the Gila River Indian Community, more than half the 17,000 tribal members are under 21 years old.

Akimel O'odham/Pee Posh Council members receive training in conflict resolution, communications, ethics and how to conduct meetings using parliamentary procedures. They represent youth issues to the tribal government and represent the tribe at meetings on a state and national level. The Council has also coordinated 15 leadership conferences. Over the years, more than 300 youth have served on the Akimel O'odham/Pee Posh Council and more than 8,000 people have participated in their activities.

The Youth Council was responsible for starting Boys and Girls Clubs on the reservation and recently received a grant to develop a youth court.²¹⁹ They maintain a website (http://www.gricyouthcouncil.org/gryc/index.php?option=com_frontpage&Itemid=1) where they report that the intent of the Akimel O'odham/Pee Posh Council is to be a grassroots organization that re-defines youth and adult relationships and establishes a voice for youth inside the tribal structure.

United Indian Tribal Youth, Inc (UNITY)

UNITY is a national organization headquartered in Oklahoma City that connects tribal youth councils and helps to organize American Indian youth on a national basis to deal with issues related primarily to leadership, education and health. Their website

²¹⁸ Amy Besaw et al, *The Context and Meaning of Family Strengthening in Indian America*, A Report to the Annie E. Casey Foundation by The Harvard Project on American Indian Economic Development, John F. Kennedy School of Government, Harvard University, August 2004.

²¹⁹ http://www.gricyouthcouncil.org/gryc/index.php?option=com_frontpage&Itemid=1

[\(http://unityinc.org/\)](http://unityinc.org/) links to dozens of youth councils, including Akimel O’odham/Pee Posh Council, and provides sample documents that help youth councils get organized.

Intergenerational Indian Women’s Health Education Program, Ponca Tribe of Nebraska

Women Educating Women Through the Life Span is a program conducted by the Intergenerational Indian Women’s Health Education Program at the Ponca Tribe of Nebraska.²²⁰ Groups gather every other month with female health providers, educators and elders facilitating discussion of issues. Most of the programs include activities, such as playing bingo, beading, or making cradleboards, diaper bags and shawls. Some of the program titles include:

- Cradleboards: Using Traditional Practices to Promote Baby Safe Sleep and Reducing the Risk of SIDS
- Heal the Spirit: The Dance against Violence
- Protecting Our Nation: Health through Immunization
- Alcohol and Pregnancy: Protecting the Future of Our Nation
- Babies, Blankets, Bathing and Bonding

Nearly 10 percent of the tribe’s members have participated in these programs, ranging in age from 7 to 87. The program draws on resources both within and outside the tribe, including WIC, the March of Dimes, adjacent county health departments, local colleges, and state and federal agencies.

Coming of the Blessing, March of Dimes Prenatal Curriculum

The March of Dimes created a prenatal curriculum intended to be used with American Indian pregnant women called, “Coming of the Blessing.” The materials include a booklet that has an adaptation of the medicine wheel imagery to present information about self care during the preconception period and three trimesters of pregnancy. It was designed under the guidance of an American Indian advisory committee primarily representing Plains tribes, and conveys their spirituality. The 8 educational sessions

²²⁰ National Indian Health Board, Healthy Indian Country Initiative Promising Prevention Practices Resource Guide: Promoting Innovative Tribal Prevention Programs, December 2009.

include topics such as pregnancy, prenatal care, nutrition, stress, labor and delivery, postpartum care, and caring for babies.

In a survey that March of Dimes conducted with 181 women from 40 tribes in 10 states who received the booklet, 90 percent reported changes in behavior to be healthier during pregnancy, most frequently eating and exercise, stress reduction, decision to breastfeed, multi-vitamin use, and smoking and drug use. AIHC will be working with the March of Dimes to make the curriculum and materials more culturally-appropriate for tribes in the Pacific Northwest.

Domestic Violence Health Care Response

With funding from the Indian Health Service (IHS) and the Administration for Children and Families (ACF), and leadership from the Family Violence Prevention Fund, a project was begun in 2002 to improve the health care response to domestic violence within the Indian health system.²²¹ Screening for domestic violence became a required measure under the Government Performance Results Act (GPRA) with tracking through the Resource and Patient Management System (RPMS) used by the IHS and many tribal clinics as an electronic medical record. Screening for domestic violence went from 4 percent in 2004 to 48 percent in 2009 as a result of the project. To help Indian health programs replicate these results the Family Violence Prevention Fund issued a publication, “Building Domestic Violence Health Care Responses in Indian Country: A Promising Practices Report.”

The project identified 10 steps that can be used to address domestic violence as a public health issue²²²:

1. Set up a collaborative working group
2. Develop collaborative relationships with community domestic violence experts
3. Develop a protocol²²³

²²¹ Family Violence Prevention Fund, Building Domestic Violence Health Care Responses in Indian Country: A Promising Practices Report, 2010. Available on-line at www.endabuse.com.

²²² Ibid

²²³ Model protocols are provided on line at www.endabuse.org/health.

4. Develop routine, site-specific assessment and response²²⁴
5. Develop and institutionalize a staff training program
6. Order/adapt resource materials for clinicians and patients²²⁵
7. Increase community awareness
8. Integrate domestic violence prevention into wellness programs
9. Establish quality assurance mechanisms to monitor response
10. Engage youth, boys and men

Materials and examples are available for Indian health programs that want to improve their response to domestic violence and participate in prevention activities.

Alaska Justice Center

The Alaska Justice Center opened in 1993 and does a wide spectrum of services for the Alaska Native population including advocacy, clinics, community involvement, legal oversight in courts, tribal court training, and providing legal representation for the victim. They provide a full domestic violence program, including Safe Harbor, shelter for abused women with children under five years old. They also have a program of prisoner reentry which starts in the prison and ends up with follow-through when they are released.

²²⁴ One model is the National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings, available on-line at www.endabuse.org/health.

²²⁵ Materials are available on-line at www.endabuse.org, www.msh-ta.org, and www.sacred-circle.com.

Best Practices

The best practices described below consist of program elements that appear to be effective, although quantitative measures are not available or have not been reviewed. While these are not stand alone ideas, they could be incorporated in the design of programs to meet the needs of AI women and infants.

State Funding to Tribes

Many states have policies that recognize tribal sovereignty and acknowledge a government-to-government relationship between the state government and tribal governments. In carrying out these policies, some states provide funding directly to tribal governments for public health activities, including maternal and infant health.

California implemented the American Indian Infant Health Initiative Program in five counties with the most severe disparities in maternal and infant health using \$424,000 from Federal Title V MCH Block Grant funding.²²⁶

Nebraska created a tribal set aside for the MCH Block Grant of \$200,000 for 4 tribes. The tribes participated in crafting the formula for distribution of the funds. Tribes have flexibility in using the MCH Block Grant funding, but they are expected to comply with federal rules and regulations. A Native American Liaison employed by the state Office of Health Disparities and Health Equity assists the tribes in meeting the planning and reporting requirements.

Oregon's public health laws were amended to specifically allow tribal governments to receive Title V Block Grant funds on a voluntary basis. Oregon uses its MCH Block Grant to fund tribes on the same basis as counties, using the same funding formula that has been modified slightly to accommodate differences in types of available data. The annual grants range from \$14,000 to \$34,000, with 3 out of 9 tribal governments requesting the funds.²²⁷ Tribes are expected to use the funds to deliver MCH services defined by state public health statutes and rules. Oregon provides MCH Planning Mini-Grants to tribal governments to help them create needs assessment and triennial plans

²²⁶ M. Gustafson and N. Cruz, The American Indian Infant Health Initiative (AIHI), 1996-2001. California Department of Health Services. Posted January 2003 and accessed 07/21/10 at <http://www.dhcs.ca.gov/services/rural/Documents/Final%20Report%20on%20AIHI%201996%20through%202001.pdf>

²²⁷ Molly Emmons, MPA, MCH Policy Analyst, Office of Family Health, Oregon Public Health Division, personal communications, August 2, 2010.

required to participate in the MCH grant program. This one-time funding is \$5,000 for a 6-month period.

In recognition of tribal sovereignty and the government-to-government relationship between the State of Minnesota and tribes, in 2003 there was enabling legislation that allowed local public health grants to go directly to tribes rather than through county health departments, as was the practice previously. Minnesota rolled together into a single block grant to local and tribal governments several funding streams, including Temporary Assistance for Needy Families (TANF), maternal and child health funding from the state's general fund, and the Eliminating Health Disparities Initiative (EHDI).

Most federally-recognized tribes in Minnesota receive these grants based on a formula that includes IHS-user population data. To facilitate this process, the state has a Tribal Health Liaison position and provided training to state employees on tribal sovereignty and cultural competency. Tribes have used these block grants for a variety of purposes including supporting doulas, breastfeeding programs, home visiting, prenatal clinics, Fetal Alcohol Syndrome (FAS) counseling, nutrition education, teen pregnancy prevention and teen parenting. Tribes are adapting programs that are considered evidence based. The grants range from \$100,000 to more than \$800,000 per tribe.²²⁸

Telemedicine and Telehealth

Telemedicine is defined as the use of medical information exchanged from one site to another via electronic communications to improve patients' health status; while telehealth encompasses a broader definition of remote healthcare that does not always involve clinical services.²²⁹ Usually this involves both audio and visual components, including some sophisticated instruments that allow diagnosis. Since 1995, there has been a dramatic increase in telemedicine applications and federal funding to implement telemedicine, particularly in rural areas. Telemedicine and telehealth have been used by federal agencies, including the Indian Health Service, the Veterans Administration, and Department of Defense.²³⁰ The Indian Health Service has established programs in tele-radiology, tele-retinal screening, tele-dermatology, tele-mental health, and tele-

²²⁸ Sharon T. Smith, Minnesota Department of Health, personal communications, August 2, 2010.

²²⁹ American Telemedicine Association website on March 11, 2010, (<http://www.americantelemed.org/i4a/pages/indes.cfm?pageid=333>)

²³⁰ Ibid

cardiology. In 2010, Virginia became the 12th state to pass legislation mandating that health insurers pay for telemedicine services.²³¹

Many telemedicine projects have been evaluated over the years. A meta analysis of those evaluations was conducted by the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) in 2001 and again in 2005.²³² Since 2006, Medicare has paid registered dietitians and other nutrition professionals to deliver individual medical nutrition therapy using telehealth.²³³

Counseling has been one of the earliest and most widespread applications of telemedicine and telehealth because it does not require sophisticated and costly technology. Psychiatry is one of the most prevalent uses of telemedicine in rural and tribal areas where it is nearly impossible to recruit and retain psychiatrists. In Washington State, a telemedicine network of 8 mental health professionals provided mental health, chemical dependency, and HIV counseling to tribal members in a program that involved the Quileute Health Center, Neah Bay Service Unit, and Forks Community Hospital.²³⁴ The National Network to Eliminate Disparities in Behavioral Health (NNED) provides training and resources, such as the Telemental Health Guide, a resource for developing, implementing and using mental health services delivered through videoconferencing, specifically for use with tribal health care.²³⁵

Preconception Counseling

The Institute of Medicine (IOM) has recommended preconception counseling by health care providers to inform women in childbearing ages that they will have healthier babies and that they will be healthier if their weight is within the normal range before they

²³¹ Ibid. The other states are California, Colorado, Georgia, Hawaii, Kentucky, Louisiana, Mine, New Hampshire, Oklahoma, Oregon and Texas.

²³² Carolyn M. Clancy, MD, Director, AHRQ, testimony on Telemedicine Activities at the Department of Health and Human Services before the Subcommittee on Health Committee on Veterans Affairs, U.S. House of Representatives, May 18, 2005, available at (<http://www.hhs.gov/asl/testify/t050518a.html>).

²³³ Centers for Medicare and Medicaid Services, Medlearn Matters: Information for Medicare Providers, Number MM4204, Released December 23, 2006.

²³⁴ Indian Health Service (<http://www.ihs.gov/NonMedicalPrograms/DFEE/telemed>)

²³⁵ Information available at <http://nned.net/>

become pregnant.²³⁶ This discussion could become a standard topic for annual exams for young women, as well as postpartum to assist women in achieving a normal weight before their next pregnancy. In addition to individual counseling, community services are needed to support women in maintaining a healthy diet and exercise. The IOM report states that “special attention should be given to low-income and minority women who are at risk of being overweight or obese at the time of conception, consuming diets of lower nutritional value, and of performing less recreational physical activity.”²³⁷ The report also calls for research on the most effective way to accomplish this.

Group Services

Pregnant women and new mothers participating in focus groups for this MIH Strategic Plan were enthusiastic about the idea of group services for patient education. They said that others often ask questions that they forget to ask or are too embarrassed to ask. They like the idea of social support from their peers. At Quinault Nation, women love the baby showers that the WIC program holds every two months that includes games that teach information about breastfeeding and infant care. Pregnant women and new mothers would like their tribal fitness centers to offer classes such as yoga for pregnant women and exercise classes for babies and moms together. They also want childbirth education (CBE) classes to be provided at their tribe. When tribes do not offer CBE classes, women report that they have difficulty enrolling in CBE classes outside the tribe because people do not return their telephone calls, and the transportation to locations an hour away is difficult.

Some women in the focus groups said they were working outside the home and did not have time to attend meetings. However, they were able to engage with on-line groups that provided answers to their questions and social support. A favorite website is BabyCenter.com²³⁸, which provides week-by-week updates on child development and gives women an opportunity to enroll in groups on line. This is convenient and available anytime of the day or night when a mom has a question about child health and development.

²³⁶ Kathleen M. Rasmussen and Ann L. Yaktine, Editors, *Weight Gain During Pregnancy: Reexamining the Guidelines*, The National Academies Press, 2009,

²³⁷ Ibid, p, S-8

²³⁸ BabyCenter is owned by Johnson & Johnson.

The Centering Healthcare Institute in Cheshire, CT, has expanded the CenteringPregnancy model to apply the group model to pediatric care and diabetes care. This is considered to be an “evidence based redesign of health care delivery that helps to promote: safety, efficiency, effectiveness, timeliness, culturally appropriate patient-centered care, and more equitable care.”²³⁹ Sessions lasting from 90 to 120 minutes include individual assessment by care provider, self-care activities, facilitated discussion about a health topic, and shared experiences. CenteringParenting provides pediatric care through the first year and corresponding well-woman care for participating mothers. This patient empowerment model had demonstrated improved patient outcomes and patient and provider satisfaction.²⁴⁰ Agencies bill for group care the same way they would bill for individual services.²⁴¹

Seven group programs for pregnant women in Washington State, including CenteringPregnancy at Family Planning of Chelan and Douglas Counties (FPCD) and the Young Women’s Group at Port Gamble S’Klallam Tribe, were reviewed by the Department of Social and Health Services (DSHS) in 2006.²⁴² Their review of the literature on group programs found:

In these studies, group care is generally associated with similar or better clinical outcomes, greater patient satisfaction, improved self-efficacy, increased knowledge, the development of support networks and problem-solving skills, a greater sense of trust in one’s provider, and the efficient use of resources.²⁴³

The number of participants in each of the seven group programs was too small to use quantitative methods for evaluation, but surveys and interviews point to the following elements that contribute to the success of these programs: “leaders with a clear vision, effective group facilitators, incentives and recruitment strategies to encourage participation, and community partnerships.”²⁴⁴ The incentives used in the programs reviewed included meals, craft activities, infant car seats, clothes, diapers and other

²³⁹ Centering Healthcare Institute website (www.centeringhealthcare.org)

²⁴⁰ Ibid

²⁴¹ Ibid

²⁴² Laurie Cawthon, C. Du, T. Keenan-Wilke, K. Rust, D. Tornatore, Group Services for Pregnant and Parenting women: An Exploratory Study. Research and Data Analysis Division, Department of Social and Health Services, Olympia, Washington, October 2006

²⁴³ Ibid, p. 3

²⁴⁴ Ibid, p. 39

tangible goods, and WorkFirst credits for women who have Individual Responsibility Plans (IRP). Barriers to participation were reduced by making reminder telephone calls, offering transportation, and providing child care.

Native American Women’s Dialogue on Infant Mortality (NAWDIM) Cradleboard Project

Native American Women’s Dialogue on Infant Mortality (NAWDIM) is a collective of Native American women that began in Seattle in 2000 to address issues related to infant mortality, particularly Sudden Infant Death Syndrome (SIDS). They use a uniquely cultural approach of offering cradleboard making classes to pregnant and parenting women. The cradleboard provides a culturally powerful image of babies sleeping on their backs in a safe place, and the classes offer social support during pregnancy as well as patient education to reduce infant mortality.

The program is offered at the Seattle Indian Health Board on a regular basis and is well accepted by patients and well respected by health professionals, but it has not been formally evaluated. The group has developed a relationship with the Urban Indian Health Institute which may create a more standardized approach for replicating the program. NAWDIM has offered to provide its program to tribes throughout Washington State. Currently, there is no source of funding to help provide the program to AI women.

Hospital Infant Feeding Plan, Kewa Pueblo

Kewa Pueblo, formerly known as Santo Domingo Pueblo, in New Mexico has received an award from the U.S. Department of Agriculture (USDA) as a small tribe with a WIC program with one of the highest rates of breastfeeding in the country. In 6 years, Kewa went from 12 percent of WIC clients breastfeeding to 88 percent breastfeeding. One of the tools that they use is a Hospital/Health Care Infant Feeding Plan, which is a form that pregnant women fill out and take with them to the hospital and ask to have inserted in the medical record when they deliver their babies.

The Hospital/Health Care Infant Feeding Plan allows women to check 11 options that are explained in detail. For example, one option that women can check is:

✓ NO BOTTLES OR PACIFIERS

Please do not give my baby artificial nipples including pacifiers or any type of bottles with formula, water, or glucose water. If there is a medical reason for

supplementation, I would first like to speak with a lactation consultant or pediatrician about using alternate feeding methods with expressed milk.

Other options that women can check are: fully breastfeeding, skin-to-skin, first hour, routine exams, emergency Cesarean (or planned), rooming in, breastfeeding assistance, breast pumps, discharge bags, and breastfeeding support after discharge.

The form was originally developed by the State of Texas WIC Program and adapted by Kewa in 2009. The Peer Counselor reviews the form with pregnant women during a prenatal conversation/education session. Kewa staff say the form “helps our mom’s communicate with their care providers.”²⁴⁵

Tribal Training for Non-Tribal Providers of Perinatal Care, Lower Elwha Klallam Tribe

Pregnant women from the Lower Elwha Klallam Tribe receive their obstetric services from private physicians and midwives and usually deliver their babies at the Olympic Medical Center in Port Angeles, about 6-9 miles from the reservation. The Lower Elwha tribe has collaborated with New Family Services, a subsidiary of the Olympic Medical Center, to provide nurses for home visits under the Maternity Support Services (MSS) program. After visiting families for several months, the non-Native nurses expressed a need for greater cultural understanding. The Lower Elwha tribe provided cultural education to this provider group at the Olympic Medical Center.

The cultural training was provided by Carmen Watson-Charles, who is a Lower Elwha tribal member, speaks some Klallam language, is trained as a doula and a massage therapist, and works as a Community Health Representative (CHR) and Klallam Cultural Educator. She has worked with tribal elders to develop a cultural training program that draws on oral traditions and local history, as well as broader context of American Indian history nationally. Her initial presentation to the visiting nurses was very well received and the hospital has requested additional training for the nursing staff, including labor and delivery nurses.

As a doula who has accompanied many tribal members through their childbirth experiences, Mrs. Watson-Charles has observed some differences between Native Americans and the predominantly non-Native health care providers at the Olympic Medical Center. For example, Native Americans may want as many as 20 people in the birthing room to experience the sacred and emotional event. This is often met by

²⁴⁵ Carole Farina, RD, LD, Consulting Nutritionist, Kewa Pueblo, personal communication, September 2, 2010.

resistance by the hospital staff, who do not understand that Native Americans carry a lot of grief and have experienced a lot of death, and birth is part of the healing process. She says that family members may come to the hospital during labor and that they should be welcomed with coffee or tea and made to feel comfortable, even if they are not in the delivery room. A better understanding of the local culture can also result in the initiation of breastfeeding in the critical time that women are in the hospital and sustaining it through difficult times, such as a mother recovering from surgery.

Mrs. Watson-Charles advises that cultural training has to be honest, positive, collaborative, local and respectful. She received permission from her tribal council to present the training, and she says it would be disrespectful to represent the beliefs and cultures of other tribes without their permission.

Childbirth Educator Training

Bates Technical College in Tacoma provides training for Childbirth Educators (CBE).²⁴⁶ The part-time, two-year training program is open to individuals with a high school diploma. Training covers content areas and teaching skills, as well as providing hands-on practicum. This local resource may offer tribal members the opportunity to become facilitators and coordinators for tribal programs for pregnant women. In addition, there are international associations that provide conferences, continuing education, training and certification, including the International Childbirth Education Association, and Doulas of North America International.

Washington State Guidelines for Providers

Recognizing that health care providers play a significant role in identifying health risks and referring pregnant women to appropriate services, the State of Washington Department of Health has developed several manuals for providers. The manuals provide guidance based on best practices, offering information about the issue and skills for effectively managing the process within the usual constraints of time and resources that affect providers. There are provider scripts that give effective and non-judgmental ways of asking questions and interpreting answers. The manuals also offer

²⁴⁶ Laurie Cawthon, C. Du, T. Keenan-Wilke, K. Rust, D. Tornatore, Group Services for Pregnant and Parenting women: An Exploratory Study. Research and Data Analysis Division, Department of Social and Health Services, Olympia, Washington, October 2006.

resources such as standardized forms, references, and referral information. The manuals are available on-line.

Three manuals that can help providers develop skills to improve maternal and infant health for priority goals and objectives of this MIH Strategic Plan are:

- Smoking Cessation During Pregnancy: Guidelines for Intervention
- Substance Abuse During Pregnancy: Guidelines for Screening
- Domestic Violence and Pregnancy: Guidelines for Screening and Referral

Each suggests specific processes that constitute best practices for providers. For example, the smoking and substance abuse processes are: ask, advise, assess, assist, and arrange. For domestic violence and pregnancy, the process is: ask, acknowledge, assess safety, refer, assure, and document. Washington State provides a link for providers to order referral cards to give to patients at no cost to the provider.

The best practice guide for substance abuse includes screening guidelines, tools and tips, additional information on skill building techniques, testing and consent issues, laboratory testing, basic prenatal management, referral information, and other resources. This document was designed for physicians and other healthcare professionals; it is not intended for the general public, as it contains terms, abbreviations and acronyms that may not be familiar to those outside the field of healthcare.

In meetings with health care professionals in conjunction with this MIH Strategic Plan, some expressed the opinion that the guides could be improved by making them more culturally relevant for American Indians.

Department of Justice Guidelines for Domestic Violence

The Violence Against Women Act was passed in 1994 and reauthorized in 2000 and 2005. The Reauthorization of the Violence Against Women Act of 2005, Title IX, Section 904(a)(1)(2), authorizes the National Institute of Justice, in consultation with the U.S. Department of Justice's Office on Violence Against Women, to conduct research on violence against American Indian and Alaska Native women in Indian Country. The Office of Violence Against Women has created a task force to take testimony from tribes to define the scope of the problem and to suggest ways in which the Department of Justice can assist them in addressing the problem.

Guiding principles include safety for victims and children, reflecting multiculturalism and

diversity, respect for victims and abusers, community collaboration and advocacy, and training for adults and children. Most domestic violence programs for tribes call for a tribal commitment to addressing the subject. Clan Star, Inc. is a National Sexual Violence Resource Center funded by Department of Justice to help tribes address domestic violence.

Summary of Programs for Strategic Interventions

Figure 2 summarizes the types of programs that could be used to carry out the strategic interventions identified to achieve the goals and objectives of this MIH Strategic Plan (Figure 1). The strategies from Figure 1 are in the first column in Figure 2. The second column in Figure 2 lists the model programs that could be implemented to achieve the strategy. The third column suggests best practices that could be applied to accomplish the strategies and/or included in the programs identified.

Figure 2 can be regarded as a menu of programs that could be selected. For many strategies, there are several model programs that have been demonstrated to have outcomes that improve MIH and have been used in tribal settings. For example, programs to improve breastfeeding initiation and continuation rates are well-documented and could be implemented at the tribal level with little additional research and development. However, some strategies will require innovation, such as involving youth in leadership, planning and messaging for preconception health.

This section of the MIH Strategic Plan has considered various programs; however, without coordination, the benefits of individual programs could be diminished considerably. For example, an evaluation of a home visiting program for adolescent mothers found that when visitors identified problems, there was often no way for them to communicate with the physicians for the pregnant women they were visiting.²⁴⁷

While it seems ideal for tribes to provide culturally-appropriate wraparound services, it is difficult to do this effectively when obstetrical services are being delivered through Medicaid and the private sector. One approach that some tribes have used is to provide incentives for pregnant women to continue receiving support services at the tribal clinic during their pregnancy and the first year of their infant's life. Use of

²⁴⁷ Beth Barnett, J Liu, M DeVoe, K Alperovitz-Bichell, AK Duggan, Home Visiting for Adolescent Mothers: Effects on Parenting, Maternal Life Course, and Primary Care Linkage, *Annals of Family Medicine*, Vol 5, No. 3, May/June 2007.

electronic medical records can facilitate care coordination between private providers and Indian health clinics, but this may not be sufficient to assure that private sector physicians make referrals to programs operated by tribes and urban Indian clinics. Further consideration needs to be given to the concept of the Indian health clinic as a medical home. For small tribes this can be a challenge, but it is short sighted to implement programs in isolation without considering structural issues of the health care delivery system.

Figure 2. Summary of Programs and Practices to Implement Strategies

Strategies	Model Programs/Promising Programs	Best Practices
Smoking Prevention & Cessation	First Steps California Smokers Helpline Home Visiting	Telehealth WA State Guidelines for Providers
Parent/Patient Education	WIC First Steps Breastfeeding education by providers, childbirth educators (to include fathers) Young Women’s Group at Port Gamble S’Klallam Tribe Seattle Indian Health Board Prenatal Care Model Washington State Bedtime Basics for Babies (SIDS risk reduction) Intergenerational risk reduction workshop for sexually active teens (NIWHRC) Home Visiting Honoring Our Children (Wisconsin) Intergenerational Indian Women’s Health Education Program (Ponca Tribe of Nebraska) Coming of the Blessing (March of Dimes)	Grants to tribes Preconception counseling Group services Cradleboard Project (SIDS education) Formula marketing guidelines in clinics Childbirth educator training for AI Telehealth
Breastfeeding: Hospitals	Baby Friendly Hospitals Initiative Can Do 5	Formula marketing guidelines in hospitals Cultural Training (Lower Elwha) Hospital Infant Feeding Plan (Kewa Pueblo)
Breastfeeding: Community Support	Pueblo of Zuni Breastfeeding Program Navajo Nation Breastfeeding Coalition WIC Peer Counselors Loving Support Peer Counseling (WIC) Honoring Our Children (Wisconsin)	Group services Social marketing “An Easy Guide to Breastfeeding for AI and AN Families” Formula marketing guidelines in clinics

Strategies	Model Programs/Promising Programs	Best Practices
Breastfeeding: Workplace	Business Case for Breastfeeding Navajo Nation Healthy Start Act of 2008	
Equipment	WIC (breast pumps) Washington State Bedtime Basics for Babies (portable cribs, SIDS risk reduction) Shoalwater Bay CHS program for pregnant women Honoring Our Children (Wisconsin)	Grants to tribes
Chemical Dependency Prevention & Treatment	Safe Babies, Safe Moms	WA State Guidelines for Providers Group services
Mental Health Screening and Treatment	First Steps Honoring Our Children (Wisconsin) Home visiting (screening for prenatal, postpartum depression)	
Domestic Violence Prevention	Domestic Violence Health Care Response Alaska Justice Center	WA State Guidelines for Providers DOJ Principles for Tribal Domestic Violence Programs
Access to Care	First Steps CenteringPregnancy Honoring Our Children (Wisconsin)	Group services Grants to tribes Telehealth
Statewide AI Infant Death Review	Intertribal Council of MI Statewide Review of AI Infant Deaths	
Immunizations		
Involve Youth	Akimel O'odham/Pee-Posh Council (Gila River) UNITY	Preconception counseling
Nutrition Education & Physical Activity	WIC Four Winds Model for Healthy Eating Home Visiting	Preconception counseling Telehealth Group Services



IMPROVE PARTICIPATION IN WIC AND FIRST STEPS



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printing purposes

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

Introduction

Participation in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) under the United States Department of Agriculture (USDA) has been shown to improve birth outcomes, including preterm delivery and low birth weight.²⁴⁸ The State of Washington contracts with 63 WIC agencies for services at 214 sites, including 14 tribal programs operated at 22 tribes. One tribe provides WIC services to a second tribe. Seven other tribes are served

through SPIPA and Public Health Seattle-King County, and there is one WIC program at Seattle Indian Health Board / Urban Indian Health. Tribally-operated programs are conveniently located for serving tribal members and facilitate the enrollment of eligible people who are tribal members. Only 22 of 29 tribes have WIC programs²⁴⁹, some having dropped the program because it was too expensive and/or they could not meet the program requirements, such as hiring a Registered Dietitian (RD).

Nationwide, 34 tribes contract directly with the USDA to administer WIC programs and they are treated like states. However, states provide a match for some of the federal

Objective 2.2: Identify specific barriers to tribal/urban Indian health program participation in the DOH Women-Infants-Children (WIC) Program and the Department of Social & Health Services First Steps services (maternity and infant support); develop and implement strategies to improve AI/AN access and Tribal Health program ability to provide these services.

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²⁴⁸ Amira Y. el-Bastawissi, R. Peters, K. Sasseen, T. Bell, R. Manolopoulos, Effect of the Washington Special Supplemental Nutrition Program for Women, Infants and Children (WIC) on Pregnancy Outcomes. *Journal of Maternal and Child Health* 11:611-621, 2007.

²⁴⁹ Some tribes operate more than one WIC program, such as the Colville Confederate Tribe which has 5 WIC sites. Thus, there are 28 sites operated by 21 tribes or tribal organizations. See Table 6 in Appendix 1.

WIC funding and tribes do not have to match federal funds.²⁵⁰ Tribes that have the status of states follow the same rules and regulations as a large geographical state. They are able to apply for and receive additional funding that is reallocated with a region four times a year when states in that region do not use all of their funding.²⁵¹ Also, the tribes that have state status are able to receive funding for such things as building maintenance, cars for WIC workers who travel distances to deliver services, computer systems, and other infrastructure.²⁵² Some tribes that started WIC programs as contractors under state WIC programs have become Indian Tribal Organizations (ITOs) that report directly to the regional USDA offices.²⁵³

Issue 1. Shortage of Registered Dietitians (RDs)

Background

Washington State requires that Registered Dietitians (RDs) provide face-to-face consultation with high risk women, which includes most who qualify for WIC. There is a shortage of RDs nationally, particularly in rural areas where tribes are located.²⁵⁴ Often, WIC programs cannot compete with other employers that pay more for RDs.²⁵⁵ There are not enough clients in small tribes to support a full-time RD, and WIC does not pay a sufficient amount to hire RDs only for the WIC. While WIC does not require a full-time RD, the hourly cost for part-time RDs is greater than the hourly cost for a full-time employee, particularly when travel costs are considered.

RD certification is provided by the American Dietetic Association (ADA). It requires four years of education with a BS in nutrition, plus an ADA-approved internship and an RD exam. The internship requirements are 1,200 hours of work under the supervision of an RD in three different settings: 400 hours in a medical setting (usually a hospital), 400

²⁵⁰ Karen Griego-Kite, WIC Director for Five Sandoval (personal communications, August 18, 2010).

²⁵¹ Ruby Wolf, WIC Director for Zuni Pueblo (personal communications, August 16, 2010).

²⁵² Karen Griego-Kite, WIC Director for Five Sandoval (personal communications, August 18, 2010).

²⁵³ One example is Zuni Pueblo (personal communications, Ruby Wolf, Zuni WIC Program Director, August 16, 2010).

²⁵⁴ For example, the Navajo Nation was unable to fill an RD position for two years, according to their director, Adele King (personal communications, August 16, 2010).

²⁵⁵ According to Adele King, WIC Director at the Navajo Nation, the IHS pays more for RDs than the tribal WIC program (personal communications, August 16, 2010).

hours in food service (usually a school), and 400 hours in a community setting (which could include WIC). The internship is a bottleneck that restricts the number of RDs because there are limited internship opportunities, and there is a computer match for positions only once a year. Often preceptors for internship programs are not paid, so it is difficult to recruit internship sites.²⁵⁶ Another barrier to increasing the number of RDs is that universities and other organizations that sponsor internship programs charge fees (tuition) to interns that range as high as \$20,000 to \$39,000 out-of-state tuition for a 9-month internship program.²⁵⁷ The cost is even higher because nutritionists must quit their jobs and be an unpaid intern for 9 to 12 months and often assume the expense of required medical insurance. In Washington State, there are three ADA-approved internship programs with a total capacity of 30 internships statewide per year.²⁵⁸ These internships last 10-12 months and tuition cost ranges from \$5,000 to \$9,854 for state residents.²⁵⁹

WIC has tried several strategies nationally to reduce the need for RDs. USDA has established a category of paraprofessional nutrition counselors called Competent Professional Authorities (CPA); however they are expected to be supervised by an RD. The WIC program in Texas is piloting an interactive computer tutorial in a rural area to add a nutrition contact for WIC clients that meets the USDA requirements for a portion of the expected nutrition counseling.²⁶⁰ Telehealth has been used in Alaska for RD services through WIC; however, this approach has not been extended to other states.²⁶¹ New Mexico tribes are exploring using webcams for WIC certification in clinics where there is a medical assistant to obtain height and weight information, allowing the WIC employees to work from a different location.²⁶² One advantage of this approach is to reduce the risk of exposure during epidemics, such as the recent H1N1 epidemic.²⁶³

²⁵⁶ Karen Griego-Kite, WIC Director for Five Sandoval (personal communications, August 18, 2010).

²⁵⁷ Ibid

²⁵⁸ ADA website: <http://www.eatright.org/students/education/di.aspx>

²⁵⁹ The internships are available at Central Washington University in Ellensburg, Bastyr University in Kenmore, and Sea Mar Community Health Center in Seattle. Distance education programs are also available from other states.

²⁶⁰ Karen Griego-Kite, WIC Director for Five Sandoval (personal communications, August 18, 2010).

²⁶¹ Janet Jackson Charles, MSW, State WIC Nutrition Program Director, Office of Community Wellness and Prevention, Washington State Department of Health, personal communications, June 21, 2010.

²⁶² Karen Griego-Kite, WIC Director for Five Sandoval (personal communications, August 18, 2010).

²⁶³ Ibid

Evaluation of the effectiveness of alternative providers and systems of nutrition counseling is needed. If alternatives such as nutritionists and midlevel providers show comparable effectiveness, then there would be evidence to support more cost effective and manageable strategies for meeting tribal needs for nutrition counseling.

Recommendations:

WIC.1.1. Washington State should work with USDA and the AIHC to develop a telehealth demonstration project that allows RDs to provide distance counseling and monthly in-services in remote tribal areas via low cost computer technology with voice and camera capability.

WIC.1.2. Tribes and Washington State should work with USDA to explore options, such as Competent Professional Authority (CPA) or another type of midlevel practitioner, and compare the effectiveness and cost of culturally appropriate alternatives to provide nutrition counseling in tribal settings.

WIC.1.3. Washington State should provide funding for AIHC to investigate the potential for tribal colleges to provide training for tribal members to become nutritionists, RDs, Competent Professional Authorities, and/or other midlevel nutrition counselors.

WIC.1.4. The Northwest Portland Area Indian Health Board (NPAIHB) should coordinate an advocacy committee to work with the State Dietetic Association, WIC and universities utilizing various advocacy avenues to increase the number of Registered Dietitians in Washington State by increasing the number of internships, reducing the costs of internships, and adapting internships to meet the needs of tribes.

Issue 2. Indirect Cost Rates

Background

Tribes have federally-approved indirect cost rates that result from audits of tribal contracts. Typically, indirect cost rates include such things as buildings, maintenance, telephones, personnel departments, accounting, and other activities that support the WIC program. For federal grants and contracts, the indirect cost rate is applied to the direct costs and added to the contract. Even though WIC is a federally-funded program, the State of Washington fixes the cost of managing WIC programs at flat rate per client per year. Tribes may take indirect costs out of this amount, but Washington State does not add indirect costs to the program costs.

Recommendations:

WIC.2.1. Tribes should receive the federally-approved indirect costs in addition to the direct program costs for WIC.

WIC.2.2. Tribes should explore self-governance compacting with USDA as an alternative for funding WIC programs to include indirect cost rates.

Issue 3. Direct Cost Rates

Background

The \$160 per person per year that WIC pays to tribes is expected to cover the costs of outreach, enrollment, education, printing checks every three months for recipients, counseling by a Registered Dietitian twice a year, and program coordination.²⁶⁴

Washington State WIC acknowledges that 1,500 clients is the minimum number to break even with the current direct cost funding of \$160 per participant per year.

However, the largest tribal WIC program in Washington State has a caseload of only 800. Ten have caseloads of 200 or less, and they receive an additional \$2,000 per year in their contracts to help accommodate their diseconomies of scale. Five others have caseloads under 750, less than half needed to break even. This means that every tribe in Washington State with a WIC program is subsidizing the direct costs of operating their WIC program.

²⁶⁴ State WIC office provides all computer and printing equipment, check paper, outreach and nutrition education materials, and staff training.

The base rate per authorized participant for reimbursement to all local WIC agencies will increase from \$160 to \$185 beginning January 2011. The operational base grant for smaller agencies will increase from \$2,000 to \$10,000 per agency, which will apply to all tribes.

Recommendations:

WIC.3.1. Raise the amount that WIC pays tribes to operate the tribal and urban Indian programs, either by raising the amount paid per participant per year, or paying actual costs to staff a program according to WIC requirements.

WIC.3.2. Lower the cost of providing WIC programs in tribal areas by reducing the requirements (see recommendations for RD staffing, accounting, and training), or re-designing the program to be more appropriate for tribal settings.

Issue 4. Accounting

Background

WIC determines agency and tribal grants based on the number of WIC clients expected to be served multiplied by \$160²⁶⁵, but reimburses tribes based on actual costs not to exceed the amount of the grant. The accounting process is expensive for the state to monitor and for the tribes to comply. Sometimes tribes do not get paid for their expenditures to manage WIC programs because their accounting does not meet state standards. Years of experience have shown that the state pays less than it costs the tribes to run the program (see Issues 2 and 3). Enrollments can be tracked through the computerized enrollment system to provide accountability for the expenditure of state and federal funds. Indirect costs to tribes to manage WIC programs are higher than necessary due to accounting standards, billing requirements, and monitoring by the state.

Recommendations:

WIC.4.1. The accountability to WIC should relate to tribes meeting program requirements and there should not be the level of financial accounting requirements and oversight that currently exists.

²⁶⁵ The rate will be \$185 effective January 2011.

WIC.4.2. Tribes and urban Indian programs should be able to combine funding from Maternity Support Services (MSS), IHS Diabetes Grants, WIC and other sources to pay for recruitment, salary and benefits for RDs without requiring billing for specific services or accounting for specific services.

Issue 5. Training for WIC Program Coordinators and other Staff for Tribes

Background

The Survey of Indian Health Programs found that tribes would prefer that their employees receive training close to home, rather than travelling to the State WIC Offices in Olympia. The time and travel are paid by tribes out of the \$160 per person per year rate paid by WIC. There is relatively high turnover in these positions, so training is an on-going need. The state WIC office pays for travel costs and staff time at the training if, for example, a local WIC staff only works two days in the agency but needs to be in Olympia 5 days. However, some potential coordinators are unwilling or unable to leave their families for this period.

Three types of WIC training are offered for new staff²⁶⁶:

- Core WIC Training is offered to all new local WIC staff. The training is 4.5 days long and 5 trainers from the state WIC staff lead different portions of the training.
- Coordinator Training is offered to new WIC coordinators. The training is 3 days long and 4-6 state WIC staff plus some outside speakers lead the training.
- Nutritionist Training is offered to new WIC nutritionists. The training is 3 days long and 4-6 state WIC staff plus some outside speakers lead the training.

These trainings are not required but recommended, and are usually taken only once by new staff. Under the current arrangement, between 12 and 35 people attend the trainings and they benefit from the interaction among the participants from different programs. Providing training on site is difficult to “cost out” because training for local agency WIC staff is currently provided in Olympia to increase efficiency.

²⁶⁶ In addition, two trainings related to breastfeeding are usually offered every year: a 1-2 day breastfeeding training is provided regionally; and a 1-day Breastfeeding Promotion Coordinator Training usually in conjunction with the two-day state-wide training conference in Seattle.

Recommendations:

WIC.5.1. WIC should develop some training materials that are available on-line to reduce the costs of travel and make training available at any time for new employees.

WIC. 5.2. State WIC employees should travel to tribes to deliver training, thus reducing the cost of training to tribes and allowing state employees to better understand the circumstances in which tribes are operating WIC programs.

WIC.5.3. WIC should work with AIHC to develop mechanisms to involve tribes in training and mentoring other tribes.

Issue 6. Culturally Appropriate Outreach Materials for American Indians

Background

The WIC program has adapted the graphics in its materials to be culturally appropriate for various groups, but not for American Indians in Washington State.

Recommendations:

WIC.6.1. Washington State should provide funding for AIHC to hire a photographer and graphic artist to develop materials that are culturally appropriate for use by tribal and urban Indian WIC programs.

Issue 7. WIC Data

Background

Washington State generates data about WIC recipients by tribe, county and ethnic group. The data may be helpful for tribes and urban Indian health programs in planning and assessing programs.

Recommendations:

WIC.7.1. Washington State should fund AIHC to convene an ad hoc workgroup to review the WIC data and advise the state about a format for reporting data and mechanism for distributing those reports.

WIC.7.2. A WIC data specialist should participate in an interagency tribal health data team.

Issue 8. USDA Tribal Consultation on WIC Programs

Background

Some of the recommendations regarding the WIC program in Washington State may require changes in policy on a national level for implementation. Every department of federal government is expected to have a Tribal Consultation policy.

Recommendations:

WIC.8.1. Washington State should fund AIHC to provide tribal participation in tribal consultation with USDA on a national level.

WIC.8.2. If the recommendations in this plan regarding WIC meet resistance from USDA, then Washington State should provide funding through AIHC for the chair of AIHC and a technical support person representing tribes to accompany a state official responsible for WIC programs to Washington, DC, to meet with USDA officials to discuss a process for resolving problems.

WIC.8.3. AIHC should meet with tribal leaders to explore the need for a Tribal Technical Advisory Committee for the WIC program at USDA and seek partners at the regional and national levels for this effort, such as the Northwest Portland Area Indian Health Board (NPAIHB), the National Indian Health Board (NIHB), National Congress of American Indians (NCAI), and the National Indian Women's Health Resource Center (NIWHRC).

Issue 9. Implementation of WIC Recommendations

Background

The 19 recommendations for WIC issues 1-8, as well as the breastfeeding support recommendations contained in another section, will take a coordinated effort to involve tribes and the state to create long term change.

Recommendation:

WIC.9.1. The State of Washington should provide funding to the AIHC to hire a project coordinator and for travel and support for two years to coordinate with tribes and urban Indian health programs, as well as regional and national tribal

organizations, to implement the 19 recommendations for WIC in this strategic plan and participate in the tribal breastfeeding coalitions.

First Steps Maternity Support Services Program (FS)

Introduction

The Maternity Care Access Act of 1989 attempted to address the high rates of infant illness and death in Washington State and improve healthy birth outcomes for low income families. Among the principles used to design a maternity care access system were the following:

Unnecessary barriers to maternity care for eligible persons should be removed.

The system should be sensitive to cultural differences among eligible persons.

To the extent possible, decisions about the scope, content, and delivery of services should be made at the local level involving a broad representation of community interests.

The maternity care access system should be evaluated at appropriate intervals to determine effectiveness and need for modification.

Maternity care services should be delivered in a cost-effective manner.

(RCW 74.09.770)

Key elements of the system are the use of Medicaid to pay for medical providers and the MSS program to provide wrap around services.

While these principles and services seem to be ideally suited to reducing the health disparities for AI pregnant women and improve birth outcomes for AI babies, the program is not working in tribal areas. MSS services are best delivered by tribal health departments because they are considered to be more geographically accessible and more culturally appropriate. However, in 2009, only the Seattle Indian Health Board and one of the 29 tribes in Washington State were consistently providing MSS/ICM services. Two other tribes participated, but had billing problems. Seven tribes and the South Puget Intertribal Planning Agency (SPIPA), which serves six tribes, had been MSS/ICM providers at one time, but discontinued doing so. More than half (14 tribes and 1 urban Indian program) have never contracted as First Steps providers. While all pregnant

American Indian women are considered to have high risk pregnancies, a third of AI women who are on Medicaid do not participate in the Maternity Support Services.²⁶⁷

Issue 1. MSS payment for services to tribes and the IHS is too low and billing procedures are not consistent with other Medicaid services.

Background

Tribes expect to bill Medicaid at the federally-approved encounter rate of \$268 per visit and for the State to receive 100 percent Federal Medical Assistance Percentage (FMAP). Tribes are not set up to track and bill in 15 minute increments for the types of services covered by MSS/ICM. They use a different approach for documentation and are worried about audits. This is not a problem for the Seattle Indian Health Board because they are able to bill using a Federally Qualified Health Center (FQHC) rate.

Another reason that tribes are not participating in MSS is that the reimbursement rates are too low. One example cited by tribes is that reimbursement rate of \$60 for a series of 8 childbirth classes by a certified childbirth educator is too low to cover the costs of hiring the person, scheduling the classes and billing for the services.

Among AI enrolled in MSS, fewer than 20 percent receive services through a managed care plan and the other 80 percent have their services paid on a fee for service (FSS) basis.²⁶⁸ With 1,268 AI women enrolled in the program in 2008, the State of Washington spent approximately \$257,516 for MSS for AI.²⁶⁹

Table 7 in Appendix 1 considers several scenarios for funding MSS Services for AI. Scenario 1 presents the current situation in which 62 percent of pregnant women on Medicaid are enrolled in MSS at an average cost per client of \$548 for a total cost of \$1.4 million per year. Because the FMAP is 62.94 percent, the State of Washington pays \$536,492.

Scenario 2 considers the best case scenario for improving pregnancy outcomes by having all of the eligible AI women enrolled in MSS and receiving the maximum 40 units of service. The cost to the state would have been approximately \$859,319 in 2008

²⁶⁷ Laurie Cawthon, MD, MPH, Risk Factors for Low Birth Weight Among Washington Medicaid Women with Births in 2007, DSHS Research and Data Analysis, October 21, 2009.

²⁶⁸ Laurie Cawthon, MD, MPH, personal communication, April 13, 2010.

²⁶⁹ The Federal Medical Assistance Percentage (FMAP) for Washington State is 62.94 percent, which means that the State pays 37.06 percent of Medicaid costs for services delivered outside IHS and tribal facilities.

using the current fee structure. However, the current fee structure does not result in sufficient access for AI because tribes are unwilling to offer the program at such low pay. If the reimbursement rates are raised and more tribes offer the services, the costs to the state would actually be lower, because the federal government would pay 100 percent FMAP for services provided through IHS and tribal facilities.

Scenario 3 assumes that half the AI pregnant women on Medicaid would receive MSS through tribal or IHS programs, and that they would have 10 visits at the encounter rate, for an average cost per person of \$2,680. Because of the 100 percent FMAP, the cost to the state would be zero for this half of the AI population. For the other half that receives their services at the current FSS rate, even if they were increased to the maximum 40 units of service, the cost to the state would be an estimated \$268,246, which is less than the \$536,492 that the State is currently paying to deliver half the units of service and only serve about 63 percent of the eligible population.

Not only would the state benefit by using the encounter rate for MSS delivered by tribes and IHS, but the tribal programs would also benefit. On average, each of the 29 tribes would receive about \$95,000 per year for support services for pregnant women and infants. This amount would allow tribes to design and deliver culturally appropriate programs and staff them to carry out the goals and objectives of this MIH Strategic Plan.

The reason cited by Washington State for paying tribes at a FFS rate is the wording used in writing the Medicaid State Plan. The State Plan was written at a time when the Centers for Medicare and Medicaid Services (CMS) was under different leadership and may have discouraged use of the IHS encounter rate for MSS. The outcome measures for infant mortality and risk factors for poor pregnancy outcomes, as well rates of participation in MSS by AI, would justify any requests for changes in the Medicaid State Plan.

Recommendation:

FS.1.1. The State of Washington DSHS should work with tribes and CMS to consider what steps could be taken to change the reimbursement rate for MSS for tribes and the IHS from FFS to the federally-approved encounter rate in the context of federal health care reform.

Issue 2. Program requirements for MSS are too complicated and not culturally appropriate.

Background

In the past, the MSS program has had requirements that created barriers for tribal participation as providers and for AI enrollment. For example, intake documentation

took approximately 1 hour and was not considered by either provider or enrollee to be relevant or useful. Some tribes discontinued offering MSS, while others never became MSS providers.

The few tribes that have been First Steps providers have not provided the full range of services. For example, child care services are not being offered to clients because tribal staff cannot figure out how to fulfill the program requirements. Even when DOH is willing to make policy exceptions to accommodate tribes, tribes are afraid that it will take too much time and administrative effort to apply for the exceptions.

About 30 percent of pregnant women do not want the services offered. The acceptance rate increases if incentives and group activities are part of the program. Some effective approaches that are currently not reimbursable are lunches for women, craft activities (such as cradle boards), car seats, diaper bags and other equipment. To develop, advertise and sustain these types of programs, tribes need funding on an annual (or longer) basis.

Recommendations:

FS.2.1. DSHS should initiate a new effort to recruit tribes as MSS providers and provide outreach to tribes about how the enrollment process has been changed and simplified.

FS.2.2. Tribes and tribal organizations should invite DSHS representatives to their facilities to present the MSS program and provide training about how to bill for services provided.

FS.2.3. The State of Washington should create a small grant program through AIHC that can be used to fund incentives for women to participate in First Steps, including such things as culturally-relevant craft projects, equipment for babies, food for meetings, and contracts with people to provide special programs.

Issue 3. Staffing to meet MSS program requirements can be a problem for tribes.

Background

It is difficult to recruit and retain health professionals in rural areas. For example, childbirth educators may not have the credentials required by DOH. The Indian health system has relied on paraprofessionals to meet many needs, as well as expanding the functions within positions.

Staffing requirements should be flexible. People who provide services should be trained and supervised so that the services they provide meet standards of care. But the individuals should not be required to have specific credentials to provide specific types of services. For example, nutrition education could be provided by a nurse or a diabetes educator who 1) has completed additional training in prenatal nutrition, 2) uses standards approved by the appropriate authority, and 3) has access to a Registered Dietitian as a consultant.

The ways in which staff provides services should be flexible. For example, there should not be a requirement that clients have one-on-one counseling. The tribe should be able to decide whether to provide services on an individual basis, in groups, via telehealth, home visits, community activities, or other approaches.

Recommendations:

FS.3.1. The State of Washington should work with the tribes, the Indian Health Service, Bates Technical College in Tacoma, and tribal community colleges to develop mechanisms to recruit and train tribal members to become Childbirth Educators (CBE). MSS should pay for services provided by people with this certification.

FS.3.2. Staffing requirements for the MSS program should be reviewed and revised by DSHS in consultation with tribes to create greater flexibility for staffing programs and payment for services.

FS.3.3. The potential role and benefits of telehealth in the delivery of MSS services should be explored by DSHS through tribal demonstration projects.



ACCESS TO HIGH QUALITY OBSTETRICAL CARE AND HEALTHY LIFESTYLES



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printing purposes

Resources for Tribes to Expand and Improve MIH Services

Issue 1. Resources to Implement the MIH Strategic Plan

Background

This MIH Strategic Plan identifies goals and objectives, strategies to achieve those goals and objectives, and programs to implement those strategies. The implementation of relevant programs requires sources of funding. This could occur by reallocating existing funding through the Title V MCH Block Grant, acquiring new funding through a Healthy Start grant, utilizing new funding from the Patient Protection and Affordable Care Act of 2010, and/or seeking grant funding from philanthropic foundations.

Objective 2.3: Identify options and opportunities for tribes/urban Indian health programs to ensure access for all AI/AN women to high quality obstetrical care and develop methods to successfully engage them in healthy lifestyles

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Recommendations:

R.1.1. Planning and community organizing grants should be provided to tribes that would allow them to review this MIH Strategic Plan and use community organizing processes (coordinating committees, community meetings, focus groups, tribal resolutions, etc.) to select 2 objectives and/or 2-3 strategies that meet at least one objective to include in a proposal for an implementation grant. Technical support should be available to tribes during this process.

R.1.2. Implementation grants should be available for tribes that have completed the planning and community organization phase of the project and identified programs to carry out the strategies that they have selected as their focus for MIH improvements.

R.1.3. The AIHC should create a forum for tribes to share their experiences in developing and implementing programs to carry out the objectives and strategies in this MIH Strategic Plan.

Issue 2. Responding to New Initiatives in the Patient Protection and Affordable Care Act of 2010

Background

Health reform legislation, known as the Patient Protection and Affordable Care Act of 2010, includes many new programs and funding opportunities for states. Examples of new sources of funding at the federal level that could be accessed to implement this MIH Strategic Plan include \$114 million for a federal Teen Pregnancy Prevention Initiative (TPPI), up to \$400 million in 2014 for a Home Visitation Grant Program with a 3 percent set aside (\$12 million) for tribes and urban Indian programs, and new Indian Health Service grant programs for behavioral health services. The federal Department of Health and Human Services (DHHS) is issuing new program announcements with very short deadlines for submission of proposals that do not provide adequate time for significant tribal consultation.

In many states there is a history of bad feelings as a result of state government using health disparity data regarding AI/AN to apply for federal funding, receiving funding, and then not sharing the funding with tribes and urban Indian programs to address the disparities identified in the proposal. To avoid this situation, the State of Washington needs to work cooperatively with tribal organizations, such as the AIHC, to develop some principles that can be used in the development of proposals. For example, it should not be assumed that funding to counties will lead to increased services to tribes located within or adjacent to those counties. One way for the State of Washington to be responsive to tribal and urban Indian health needs is to incorporate the recommendations in this MIH Strategic Plan into proposals written to respond to federal initiatives. If there is insufficient time to consult in the development of a proposal, then the proposal should build in a step for tribal consultation in the implementation of a grant.

With the addition of policy analyst positions, the AIHC can assist the state the development of proposals and coordinating with tribes in the implementation of programs.

Recommendation:

R.2.1. Washington State should fund AIHC to assist State agencies responding to health care reform initiatives that involve new funding or new programs to

include tribes and urban Indian health programs in planning and implementing the state response to the initiatives, particularly if the funding is intended to reduce health disparities and data about AI/AN are used to justify funding requests.

Access to Care and Coordination of Services

Issue 1. Medical Homes and Access to Obstetrical Care

Background

If the tribal, IHS, or urban Indian clinic were the medical home for family and obstetrical services, there could be improvements in initiating prenatal care, continuity of care, case management and wraparound services. As the trend for hospitals to have hospitalists has begun to include “laborists”²⁷⁰, this creates the opportunity for Indian health clinic staff to provide prenatal care without being on-call for deliveries. Prenatal clinics could be held in Indian health centers by their own staff or by contracting with obstetricians and/or certified nurse midwives. Linkages could be created for tribal programs for nutrition, WIC, case management, community health nursing, patient education, childbirth education, mental health, substance abuse treatment, dental care, and other services.

To make the tribal medical home model work, there needs to be better coordination of electronic health records. Providers at Indian health clinics, medical specialists in private practice, and hospitals need to be able to access a patient’s medical record. Because pregnancies often present complicated medical problems, when a woman is in labor and delivery the doctor needs to know her medical condition.

If the medical home is the tribal, IHS, or urban Indian clinic, then most obstetrical services should be delivered there, not just wrap around services. This could be done by contracting with obstetricians to hold prenatal clinics at the Indian health facilities; however, with the shortage of providers in Washington State, this could be expensive or impossible. In some Indian health facilities in other states, arrangements are made for the Indian health providers to offer prenatal care until the third trimester, when the pregnant woman is referred to a private provider for the final weeks of prenatal care and delivery. Utilizing midwives might provide some options for delivering prenatal care with the Indian health clinic as the medical home.

²⁷⁰ A laborist is a physician or certified nurse midwife who attends to women during labor and delivery at a hospital, usually for a shift of 12 or 24 hours.

If there are economic and manpower limitations that prevent the development of tribal clinics as the medical home for pregnant tribal members, then other types of linkages should be explored to better coordinate referrals and information. For example, pregnant women from the same tribe could be scheduled for the same morning each week or month for prenatal care in a private physician's office. The office could hire a nurse from the tribal clinic to work in the office at those times, so that she would be familiar with the medical issues and follow up by serving as a case manager at the tribe and making referrals to appropriate services offered at the tribe. The nurse could also participate in case conferences after the prenatal clinics, and serve as a resource on cultural, family and community issues. The nurse could also visit patients in the hospital during and after deliveries, and do home visiting. These elements can help to bridge the tribal health care and private health care, and better serve pregnant women.

Recommendation:

AC.1.1 The State of Washington should work with tribes and Medicaid providers to develop 1-3 demonstration projects for tribal clinics to serve as medical homes while assuring that pregnant women receive high quality obstetrical care.

Issue 2. Services in Rural Areas

Background

Medicaid provides access to private sector medical care not available in reservation areas, such as obstetricians, pediatricians, and hospitals. However, access to obstetrical care is a problem that confronts the State of Washington due to a shortage of providers.²⁷¹ Despite their effectiveness in many other settings, Certified Nurse Midwives (CNMs) are not being utilized in Indian health programs, according to the survey of tribes and urban Indian programs (see Appendix 2, Table 5). The State recognizes that "Recruiting, training, and retaining additional obstetric providers, especially family physicians and CNMs, are essential to improve prenatal care access and to ensure healthy birth outcomes in Washington State."²⁷²

²⁷¹ Laurie Cawthon, MD, MPH and Peter Woodcox, County Profiles: Birth Statistics and Maternity Care Access 2000 to 2008, WA State Department of Social and Health Services, April 2010.

²⁷² Ibid, p. 3

Recommendations:

AC.2.1. The Seattle Indian Health Board model to train residents should be expanded to include rural tribal areas and to include other disciplines related to MIH.

AC.2.2. To increase the number of obstetricians available to serve tribal members, tribes should work with the State of Washington to leverage the Federal Tort Claims Act to provide malpractice coverage for obstetricians.

Smoking Prevention and Cessation

Background

Smoking prevention and cessation is a key strategy for reducing infant mortality overall, reducing SIDS deaths, and reducing low birth weight.

The AIHC survey of health directors indicates that most tribes currently have smoking prevention and cessation programs. However, after 8 years of funding tobacco prevention and control programs for tribes, the Washington State Department of Health will be ending this funding in June 2011.

The strategy currently used by Washington State is to provide training to health care providers to encourage pregnant women to quit smoking (ask, advise, assess, assist, arrange).²⁷³ The MSS program reimburses for counseling related to smoking cessation. A state quit line (1-800-QUIT-NOW) provides pregnant women with tobacco cessation materials, free intensive telephone counseling services (up to 10 calls), nicotine patches or gum, and prescription medications.

The opportunity to advise women about the harmful effects of smoking during pregnancy is reduced if women do not obtain early prenatal care. This problem can be mitigated through television advertising, which is a key ingredient in recruitment of quit line callers in California. Experience in California also shows that AI utilization of a quit line increases when a tribal organization provides cultural competency training for quit line counselors and prepares culturally appropriate materials, and when there is tracking of the number of AI callers.

Tribes that are running their own tobacco cessation programs and want to utilize state funding for prescription aids have found the process to be cumbersome. The process requires women to call the Washington State Quitline for a telephone counseling

²⁷³ Diane Bailley, P. Taylor, J. Thompson, G. Schauer (eds), *Smoking Cessation During Pregnancy: Guidelines for Intervention*, Washington State Department of Health, Revised Edition, 2009.

session. The telephone counselor fills out the paperwork requesting smoking aids that is sent to a doctor for a prescription and then to a pharmacy. The delay in process is regarded by some as a deterrent. Another perceived barrier is that women have only one opportunity to obtain this support for smoking cessation through Medicaid.

Recommendations:

SM.1.1. The State of Washington should review its policies to assure that the Washington Tobacco Quit Line offers culturally competent counselors, culturally appropriate materials to serve Native Americans, and consistent culturally appropriate messages across systems that refer and serve Native Americans.

SM.1.2. The State of Washington should review its policies regarding television advertising for the Washington Tobacco Quit Line to assure that it reaches markets where tribes are located.

SM.1.3. The State of Washington should monitor data regarding Native American utilization of the Tobacco Quit Line and smoking data from WIC, particularly for pregnant AI women, and set specific goals and strategies for improvement.

SM.1.4. The AIHC Smoking Prevention and Cessation Workgroup will make additional recommendations that should be adopted.

SM.1.5. Tribes and urban Indian clinics should prioritize pregnant women for smoking cessation activities as a way to reduce LBW, SIDS and overall infant mortality.

SIDS Risk Reduction

Background

In addition to smoking prevention and cessation and abstinence from alcohol and other drugs during pregnancy, the necessary components to reducing SIDS deaths are parent education and safe sleep environments. Two local programs are currently available and have acceptance in Indian communities, Bedtime Basics for Babies and the Cradleboard Project.

Recommendations:

SIDS.1.1. Tribes and urban Indian clinics should be encouraged to enroll pregnant women in the Bedtime Basics for Babies Program.

SIDS.1.2. Washington State should provide grant funding to Native American Women's Dialogue on Infant Mortality (NAWDIM) to enable them to expand the Cradleboard Project to tribes statewide and for evaluation of the program to learn if it is an effective educational tool for SIDS risk reduction.

SIDS.1.3. The proposed American Indian Maternal and Infant Health Data Coordinating Council for Washington State should take action to improve SIDS data collection regarding American Indians.

Injury Prevention

Background

Injuries are the third leading cause of infant mortality among AI in Washington State, and this is 5 times higher than the population as a whole. Until babies become toddlers, their risks of injuries are primarily due to child abuse, unsafe sleep environments and automobile crashes. SIDS education addresses safe sleep environments. In addition reducing driving under the influence of alcohol and other drugs, car seats and seat belts are the best strategy for reducing injuries from vehicle crashes.

Recommendations:

IP.1.1. Programs should be established to assure that every infant leaves the hospital in a car seat and that parents know the proper way to secure the car seat and the infant in it.

IP.1.2. Tribal fire departments or other employees should be trained in car seat installation and parents should be told that they can check to see that their car seats are properly installed.

IP.1.3. Tribes should pass and enforce tribal codes to require seatbelt use on tribal lands.

Preconception and Prenatal Counseling for Healthy Lifestyles

Background

The Institute of Medicine recommends preconception counseling to assist women in achieving health weight prior to conception. This service is not currently available through WIC, as women who are not pregnant are not eligible for WIC services. Also, women who are not on Medicaid may not have access to nutrition counseling.

A high percentage of American Indian women have gestational diabetes when they are pregnant, followed by Type 2 diabetes after their pregnancy. If diabetes is not controlled before and during pregnancy, it can lead to multiple complications for both fetus and mother.²⁷⁴

Recommendations:

PPC.1.1. Health care providers should include preconception counseling in annual exams for young women, to include information about stopping smoking, achieving a healthy weight, and taking folic acid prior to becoming pregnant.

PCC.1.2. Washington State Department of Health should develop provider guidelines for preconception counseling similar to the resources for providers that they have developed for domestic violence, smoking, and substance abuse during pregnancy.

PPC.1.3. All pregnant American Indian women should be screened for gestational diabetes; and if they have diabetes, they should be counseled by a culturally competent Certified Diabetes Educator with pregnancy training during and after their pregnancy.

Support for Breastfeeding

Issue 1. Building Coalitions to Support Breastfeeding in Tribal Communities

Background

The tribes recognized by WIC as having the highest rates of breastfeeding in 2009 were all located in New Mexico and Arizona. Consultants from the CDC and IHS who worked with the Navajo Nation attribute their success to building coalitions at the community and regional level. The New Mexico Breastfeeding Task Force was formed in 1988 to reach to Healthy People 2000 breastfeeding goals. The New Mexico Pediatric Society joined this effort in 1990. In 1992 the Taskforce reached out to communities to form local chapters. Native American WIC Programs helped to organize chapters among tribes.

²⁷⁴ Indian Health Service, Division of Diabetes Treatment and Prevention, "Indian Health Diabetes Best Practice: Diabetes and Pregnancy." Revised December 2009.

Washington State has a similar history of forming the Breastfeeding Coalition of Washington (BCW) with 23 local coalitions. However, it appears that tribes in Washington State have not been part of this effort. Washington State WIC Program has provided funding for a part-time coordinator and coalition activities since 1995 when the group was called Healthy Mothers Healthy Babies.

Recommendations:

BF.1.1. Washington State should provide funding to the AIHC for a position to help initiate and coordinate breastfeeding coalitions within tribes in association with other statewide programs, such as the Breastfeeding Coalition of Washington (a program of WithinReach).

BF.1.2. Community education messages and programs to encourage breastfeeding should include fathers and other family members.

Issue 2. Parent Education for Breastfeeding

Background

Parent education for breastfeeding should include both mothers and other family members. Social marketing has been shown to help women make the decision to breastfeed and to have the support of their families in this decision. A special outreach effort is needed for teenage mothers who often do not get information about the benefits of breastfeeding.

Recommendations:

BF.2.1. Childbirth education programs offered through tribes and urban Indian clinics should include information about the benefits of breastfeeding and practical information about how to breastfeed.

BF.2.2. Tribes and urban Indian clinics should be encouraged to adopt policies that eliminate all logos and advertising for infant formula from the clinics, including posters, educational materials, prescription pads, and promotional materials.

BF.2.3. Physicians providing obstetric care and other providers during prenatal care should include discussions of breastfeeding, including teen mothers.

Issue 3. Hospital Practices to Encourage Breastfeeding

Background

Hospital practices affect initiation and duration of breastfeeding.

Recommendations:

BF.3.1. Washington State should reward hospitals for Baby Friendly Hospital Initiative accreditation.

BF.3.2. Washington State Medicaid programs should require hospitals to implement the “Can Do 5” measures for encouraging breastfeeding.

BF.3.3. Washington State should encourage hospitals to coordinate with tribes to provide cultural competency training for labor and delivery staff, tell AI mothers about tribal resources to assist with breastfeeding after discharge, and develop innovative programs for tribal and IHS community health nurses, childbirth educators, and breastfeeding peer support counselors to visit new mothers in the hospital to develop relationships and provide support that is extended into the home after mothers are discharged from the hospital.

Issue 4. Peer Counseling and Community Support for Breastfeeding

Background

While “peer counseling” may sound like a volunteer program, the successful models involve paid staffs who are trained to provide lactation support. The word “peer” generally indicates that the individual hired is the same age and ethnic group as the mothers to whom they are providing services. Peer counselors require training and supervision from people with the expertise to help solve difficult breastfeeding problems. The highest level of training is International Board Certified Lactation Consultant (IBCLC). The Centers for Disease Control and Prevention (CDC) has recommended that an IBCLC be available in each community.

The first three recommendations for building community support for breastfeeding come from interviews conducted in the process of developing this MIH Strategic Plan. CDC

has recommended a number of action steps that can be taken to strengthen lactation support in communities, and these are the last 5 recommendations listed below.²⁷⁵

Recommendations:

BF.4.1. Training should be provided for at least 3 employees of each tribal health department to become peer breastfeeding counselors, utilizing resources provided by the WIC Loving Support Program and other funds.

BF.4.2. The WIC program should offer a variety of breast pumps so that the needs of American Indian and Alaska Native women can be matched to the pump that will likely result in breastfeeding for a longer period of time.

BF.4.3. Small grants should be available to tribes to sponsor craft programs and other incentives for new mothers for programs that provide support for breastfeeding.

BF.4.4. AIHC and the State WIC Program should collaborate with state Medicaid and insurance commissioners to ensure lactation support is included in standard, reimbursable perinatal care services for tribes and urban Indian programs.

BF.4.5. Fund the establishment of sustainable, financially supported, walk-in breastfeeding clinics available to all new mothers in tribal communities staffed by IBCLCs who are reimbursed for all services provided.

BF.4.6. Fund a program in which IBCLCs provide breastfeeding support to pregnant American Indian and Alaska Native adolescents as part of their parenting education at local schools.

BF.4.7. AIHC should develop and disseminate a tribal resource directory of culturally appropriate lactation support services locally available to new mothers, in coordination with WithinReach.

BF.4.8. WIC Loving Support Breastfeeding funding should be used to integrate lactation support services with home visitation programs at tribes to ensure that

²⁷⁵ Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM. The CDC Guide to Breastfeeding Interventions. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005, page 27. Available on-line at <http://www.cdc.gov/breastfeeding>.

lactation problems are identified early and that mothers are referred for appropriate help and services.

Issue 5. Work Place Breastfeeding Support

Background

Women often discontinue breastfeeding when they return to work, unless the workplace provides support for breastfeeding mothers, such as a room to pump milk and flexibility in break times. Tribes are the largest employer in most tribal areas, so most AI in tribal areas are affected by tribal workplace policies. State laws about workplace health and safety do not apply on reservation lands.

Recommendation:

BF.5.1. Tribal breastfeeding coalitions should work with Tribal Councils to pass tribal codes that require tribes to create supportive environments for breastfeeding employees.

Involving Youth

Because many of the risk factors for poor pregnancy outcomes begin with children at 13 years old or younger, it is important that strategies be developed for preconception health. Youth leadership is needed to help develop strategies and messages, and to provide mechanisms for youth to take ownership of MIH issues. Youth involvement should not only produce viable strategies for risk reduction, but it should also serve as a method to inform youth, motivate youth, empower youth, create social support for youth, and change the perceptions of normative behavior for youth.

Youth involvement should be designed in a way to involve the broadest possible number of AI youth in both urban and tribal areas. There should be a program to involve those in grades 5 through 8, as well as another program for those in grades 9 through 12.

Issue 1. Elevate the Focus on American Indian Youth in Addressing MIH issues.

Background

Youth must be involved in developing strategies for risk reduction. An advisory panel at the Secretary's level would show the youth that a great deal of importance is attached to their opinions and advice. The AI Youth Advisory Panel should include representation from tribes and urban areas, both male and female, from children in the 5th through 8th

grade, as well as the 9th through 12 grade. The AI Youth Advisory Panel should meet about 2-3 times per year. Selection of members to the AI Youth Advisory Panel should be by youth through a process that could include the activities described in other recommendations.

Recommendation:

Y.1.1. The State of Washington should establish an American Indian Youth Advisory Panel with youth representation from tribes and urban areas, and participation by high level administrators in state government agencies that provide health and education services.

Issue 2. Involve AI Youth Statewide in Designing Interventions to Reduce Risk Factors that Lead to Poor Maternal and Infant Health.

Background

There needs to be a process to organize AI youth in taking responsibility for healthy lifestyles that is broad based and involves youth who are at risk, as well as youth leaders. One approach would be a statewide AI Youth Advisory process where youth select representatives to meet to develop strategies to improve maternal and infant health and then bring those strategies back to their communities for discussion among their peers. The process could look something like this:

- Each tribe and urban Indian clinic develops a process that involves as many youth as possible to select a representative to a statewide meeting of AI youth. The process could involve an essay contest, an election in the schools, or a random drawing to select youth to serve.
- The representatives go to a statewide meeting where they learn about infant mortality rates, risk factors, the underlying issues of equity and social justice, and leadership skills. At the meeting they are divided into smaller groups to brainstorm and discuss strategies to reduce rates of risk related behaviors.
- After the meeting, the representatives go back to their communities to meet with youth to share the ideas developed at the meeting, to get feedback on the feasibility of those ideas, and to get more ideas from their peers.
- A second statewide meeting is held with the representatives, where they share the results of their community meetings and refine their recommendations.

- At the second statewide meeting, the group may be divided into geographic areas of the state and select representatives to the Secretary's AI Youth Advisory Panel (see recommendation for Issue 1).

Recommendation:

Y.2.1. Washington State should provide funding to the AIHC to hire a Youth Services Coordinator to work with DOH, tribes, and urban Indian programs to develop and implement a program to involve youth in considering strategies for improving maternal and infant health within their tribes and urban Indian communities.

Issue 3. Work with schools and educators to incorporate MIH risk reduction as part of curriculum and other student activities.

Background

Raising awareness of factors related to maternal and infant health can occur as part of existing school programs. For example:

- Work with teachers to formulate age appropriate lesson plans that involve MIH in subjects such as social studies, mathematics (calculating percentages and rates and comparing them), biology, health and sex education.
- Work with organizations that develop topics for high school debate teams and speech contests to include MIH topics.
- Work with high school journalism teachers and students to provide information and strategies to include MIH topics in school newspapers.

Essay contests, poster contests, and video contests are ways to involve youth, particularly if prizes are offered as incentives for their participation. The Young Native Writers Essay Contest sponsored by the Holland & Knight Charitable Foundation in conjunction with the National Museum of the American Indian provides an excellent model for this type of program.²⁷⁶

Recommendations:

²⁷⁶ For more information, go to the website: <http://nativewriters.hklaw.com/>

Y.3.1. A cooperative effort between the AIHC, the Washington Office of Superintendent of Public Instruction and Department of Health should be established to work with teachers in tribal areas to integrate MIH information into educational curriculum and school activities.

Y.3.2. Sponsors should be recruited to create annual essay contests, poster contests and/or video contests with prizes for children at different ages around subjects related to MIH.

Issue 4. Enlist Youth to Speak to their Peers and Younger Children about MIH Risk Reduction Issues.

Background

Young people may be more willing to listen to other youth about lifestyle issues, especially when older teenagers talk to younger teenagers or “tweens”. A speakers bureau can help train youth as speakers and give them accurate information to convey. Consider pairing the teenage speakers with a public health nurse or another health professional for speaking engagements at middle schools. Publicizing a youth speakers bureau is needed both to recruit youth as speakers and to solicit venues for conveying the information.

Recommendations:

Y.4.1. The State of Washington should provide grant funding to an established organization that is in many tribal and urban communities to develop a youth speakers bureau and train youth speakers to talk about subjects related to MIH in an informative and non-judgmental way.

Issue 5. Use Internet and Social Networking Technology to Reach Youth

Background

Youth seek and receive information through the internet and social networking technology. In focus groups conducted for this MIH Strategic Plan, teenage girls said that they do not have access to sex education classes, would not seek information about birth control from health care providers, and would be more likely to use over-the-counter products for protection from pregnancy. They are concerned about protecting their privacy. Internet sources and social networking are private ways to receive

information. Many sites and programs are already available; however, further work is needed to assess the unmet needs and to create linkages that would provide teens with information about how behaviors can affect the health of their future children.

Recommendation:

Y.5.1. Assess the opportunity and needs for providing information to American Indian teenagers in Washington State about maternal and infant health via the internet and social networking technology.

Access to Behavioral Health Services

Background

There are opportunities in the future to improve the availability of behavioral health services for American Indians in Washington State. Patient Protection and Affordable Care Act (H.R. 3590) signed into law March 23, 2010, included the Indian Health Care Improvement Reauthorization and Extension Act (IHCA). Title VII of the IHCA expands the authorization of behavioral health prevention and treatment services and requires the IHS to work with the Secretary of the Interior to develop a comprehensive strategy for addressing Indian alcohol and substance abuse and mental health issues (Section 703).²⁷⁷ Title 1, Subtitle B, Section 127, directs IHS to develop a plan to increase behavioral health staffing by 500 positions within five years with at least 200 of those positions devoted to children, adolescents and families; however, resources have not yet been made available by Congress.²⁷⁸

The new legislation authorizes the IHS to provide competitive grants to establish innovative community-based behavioral health services, as well as grants to Indian health programs to develop and implement comprehensive behavioral health programs that specifically address the cultural, historical, and social and child care needs of Indian women.²⁷⁹ It also expands the authority for urban Indian organizations to establish behavioral health programs. The IHCA authorizes a mental health technician program within IHS and allows urban Indian organizations to utilize Community Health

²⁷⁷ Memo from Yvette Roubideaux, Director of the Indian Health Service, March 24, 2010, re: IHCA Summary,

²⁷⁸ Dear Tribal Leader letter from Yvette Roubideaux, MD, MPH, Director, IHS, July 22, 2010.

²⁷⁹ Ibid

Representatives (CHRs).²⁸⁰ It also provides new authorizations for programs to prevent and treat fetal alcohol spectrum disorders, child sexual abuse, and domestic and sexual violence.²⁸¹

While the IHClA expands the authority of the IHS to offer behavioral health services, it is likely that the actual services that are authorized may not be available immediately. The federal government is expected to consult with tribes and write regulations first. Then, there is the issue of funding for programs. If history is a guide, Congress may not appropriate sufficient direct funding to the IHS, and Medicaid will continue to be a major source of third party revenues.

Tribes and urban Indian organizations will need to work closely with the State of Washington and the Indian Health Service to assure that American Indians can benefit from the exciting new opportunities in the IHClA to improve behavioral health services. Washington State has provided \$68,000 to the Northwest Portland Area Indian Health Board to provide technical assistance in the development of a Tribal-Centric Mental Health System.²⁸² Nancy Weller is serving as a consultant to provide an assessment of current services and funding, identify gaps, describe the types of services that tribes need, and incorporate these concepts into an 1115 waiver.

Recommendations:

BH.1.1. The State of Washington should provide planning grants to tribes to prepare proposals for Indian Health Service behavioral health grant funding for innovative community-based behavioral health services, as well as grants to Indian health programs to develop and implement comprehensive behavioral health programs that specifically address the cultural, historical, and social and child care needs of Indian women.

BH.1.2. The State of Washington should provide technical assistance to tribes, including epidemiological data, to assist in the preparation of grant applications for behavioral health services.

BH.1.3. AIHC and the State of Washington should co-sponsor a forum for tribes to learn more about behavioral health planning and funding opportunities under the Reauthorization of the Indian Health Care Improvement Act.

²⁸⁰ Ibid

²⁸¹ Ibid

²⁸² Report from Jim Roberts, Northwest Portland Area Indian Health Board, to the American Indian Health Commission on June 11, 2010.

BH.1.4. Tribes and urban Indian clinics should develop protocols for screening and treatment of prenatal and postpartum depression.

Research and Data Analysis

While this MIH Strategic Plan is about taking actions to improve maternal and infant health, there is need for additional information to help guide future recommendations to further reduce infant mortality and improve the health of AI infants.

Issue 1. Infant Death Reviews

Background

On average, about 17 AI infants die each year in Washington State. Some of these deaths are unavoidable, but about 35 percent are considered preventable using the benchmark of the infant mortality rate for the total population in Washington State. A review of individual cases of infant deaths – including the medical, social, environmental, and systems of care potential contributions to the cause of death– could lead to a greater understanding of opportunities for intervention to prevent future deaths from similar causes.

In Washington State 20 years ago, there was a Fetal/Infant Mortality Review (FIMR) in some jurisdictions, but it was replaced by passive surveillance through a voluntary Birth Defects Registry. Today, 19 local health jurisdictions in 22 of the 39 counties in Washington State conduct Child Death Reviews (CDR). They can use MCH Block Grant funding to support these efforts to review preventable causes of mortality in children from birth to age 17. Washington State DOH provides some training to CDR teams and technical assistance through two employees who each devote about a quarter of their time to this activity. The survey of health directors found that about a third of tribal and urban Indian clinics have had staff participating in county infant death reviews.

More than 1,800 reviews have been completed by local teams and included in a statewide data base. The results have produced many innovations at the county level, including training day care providers on safe sleep practices and dangers of aspirating small objects, improving crime scene investigations, a child bicycle helmet ordinance, firearm safety education and a gun lock distribution program, life vest loaner stations and low cost personal floatation devices.

Dr. Peter Talbot, Pediatrician and Medical Director at the Seattle Indian Health Board, has been participating in the Seattle-King County CDR for many years. It meets monthly at the Medical Examiner's Office and 6-12 deaths are reviewed at each meeting. Paid staff at the coroner's office identifies the causes of death, puts the cases into categories and organizes the meetings. Police reports may be part of the records that are reviewed.

Dr. Talbot says that the causes of death have changed over time as a result of interventions. For example vaccinations have reduced deaths from meningitis and pneumonia. Children are considered to have higher risks when they become mobile because they can be harmed by choking, electrical shocks, poisoning, and drowning. Dr. Talbot's participation in the CDR has changed the way he practices pediatrics, by providing anticipatory guidance to parents as new risks emerge. For example, a change from galvanized metal buckets to plastic buckets led to more child drowning. Because of what he learned through CDR, he incorporated parent education on water heaters and fireproof pajamas before there were national campaigns addressing these risks.

While the CDR process provides an excellent opportunity for interdisciplinary and interagency teams to raise community awareness about injury prevention in about 25 percent of the counties in Washington State, it has limited benefit for reducing infant mortality within tribes for a number of reasons. First, tribal participation in the CDRs is very limited, and tribes may be reluctant to have their own cases reviewed by an entity that does not understand them, particularly one with ties to a county or local health jurisdiction that does not respect tribal sovereignty. Second, the Indian health system is unique and the issues are different than the rest of the population may encounter. Third, the CDR process eliminates consideration of LBW babies and that may be too restrictive. Fourth, there are so few AI infant deaths in each county that it is not possible to detect patterns within the AI population when review is done at the county level.

The rate of infant deaths from ill-defined or unknown causes among AI is 4.5 times greater than that for the total population in Washington State. While this disparity is statistically significant, it means that about 1 death per year is not understood. In addition, the coding of death certificates for AI babies is often confusing and unclear. Even when the cause of death is listed on a death certificate, there are many questions about the events that lead to a death that may have been preventable.

For example, there are 7 times more deaths due to influenza and pneumonia among AI infants as compared to the total infant deaths due to influenza and pneumonia in Washington State. Among the 6 deaths over an 8 year period, 2 occurred at home and

3 in an emergency room.²⁸³ These 5 deaths could be responsible for the excess mortality and there should be an investigation to learn if anything could have been done to prevent those deaths. These are some of the questions an Infant Death Review could answer:

Did the parents know the signs of a sick child in need of medical care? Did they have a thermometer in the home to take the baby's temperature? Did the child get sick on the weekend or in the evening when the local clinic was closed? How far did the family have to go to a hospital? Did they have a problem arranging transportation to take the baby to the hospital? Did they call an ambulance? Were the EMTs properly prepared to treat an infant? Were the parents afraid that they would have to pay for an emergency room visit and not have the money to do so? Did they have a telephone number to call in an emergency? Did they have a telephone? Was the baby subjected to secondhand smoke? Was the baby neglected and nobody noticed the illness? Was there drinking in the home and no responsible adult to care for the infant? Did the child have all of his/her immunizations, including influenza and pneumonia? Was the mother breastfeeding the baby? Was the baby already seen by a doctor and put on antibiotics? Was everyone in the family sick and there was nobody to call for help? Was the mother suffering from postpartum depression and unable to respond to the needs of her child? Did they wait a long time after they got to the emergency room before the baby was evaluated? Did the family get grief counseling and support after the death of this baby? What is the baby's story and what can be learned from this situation to prevent another infant death?

Trust is needed for people to share information to answer these types of questions. Data gathering has to involve local community health nurses, as well as clinic and hospital records, and possibly emergency responder records. To piece together the story requires information from both on-reservation and off-reservation providers, particularly since infants are likely to be on Medicaid.

Current law only authorizes infant death review at the county level, so a change in the law would be required to have a Statewide AI/AN Infant Death Review. The structure for this activity that could be put into place would include representation from tribes in each region (medical, community health nursing, behavioral health, and health directors to participate), the Seattle Indian Health Board, and DOH staff to review AI infant deaths statewide on an annual or semi-annual basis. Participants should be required to maintain confidentiality of information about specific families and tribes. The outcome of

²⁸³ Laurie Cawthon, MD, MPH, personal communications March 17, 2010.

these activities should be recommendations that could reduce the prevalence and incidence of infant mortality among AI populations in both tribal and urban areas.

Recommendations:

RDA.1.1. The AIHC and the State of Washington Department of Health should work together to develop legislation to create the necessary legal authority and protections for a statewide AI/AN Infant Death Review process.

RDA.1.2. The AI Infant Death Review process should also consider reviewing maternal deaths and near miss maternal mortality.

Issue 2. Research on Disparities in Birth Defects in Eastern Washington

Background

On average, 3 AI infants die each year from birth defects (congenital malformations) in Washington State. While this is the second leading cause of infant mortality, the rates are not significantly different between the AI population statewide and the total population in Washington State. However, there are some regional disparities within the AI population. The rate of infant mortality from birth defects is higher among AI living in the interior regions of the state, as compared to people living in the coastal areas. Nearly 60 percent of the infant mortality from birth defects occurs in the eastern part of Washington State, while only 36 percent of the births and infant deaths are from that area.²⁸⁴

In Region 1, which includes the Confederated Tribes of the Colville Reservation, Kalispel Tribe, and Spokane Tribe, the rate of infant mortality from birth defects is 2.46 per 1,000 births.²⁸⁵ In Region 2, which includes the Yakama Nation, the rate of infant mortality from birth defects is 2.98 per 1,000. For the other four regions combined, the rate of infant mortality from birth defects is 1.1 per 1,000. Within Region 1, the AI infant mortality from birth defects is 46 percent greater than the total Medicaid population for that region. Within Region 2, the AI rate is twice as high as the rate for the total Medicaid population in that Region.

²⁸⁴ All the data in this section is from Laurie Cawthon, MD, MPH, Infant Mortality by Race/Ethnicity by Region, 2000-2007, March 15, 2010.

While cleft lip and cleft palate are usually treatable and do not result in infant mortality, there is a disparity in this condition among births in the eastern part of Washington State. Researchers have observed high rates of cleft lip and cleft palate among people in Japan, and the indigenous people of British Columbia and Montana²⁸⁶, who could be related genetically to the plateau tribes of Washington State. More research is needed on the possible contributions of genetics, environment and behavior to the incidence of birth defects, particularly cleft lip and cleft palate, among tribes in Eastern Washington.

Recommendation:

RDA.2.1. State of Washington should fund a research team that includes genetics, anthropology, medical and dental researchers working with an advisory group representing tribes in Eastern Washington to review existing data and research, and learn more about the disparity in birth defects and to suggest strategies to reduce those birth defects and improve infant mortality rates, including access to genetic testing for families with a history of cleft lip and cleft palate.

Issue 3. Data Coordination, Analysis, and Use for Monitoring Progress Toward Goals

Background

One way to know if the interventions recommended in this MIH Strategic Plan are making a difference is to measure outcomes in a consistent way over time. Decisions must be made about data analysis, including how to define American Indian, the most appropriate group for comparison and benchmarking data, the definition of urban and rural, and how to aggregate data by risk factor and cause of death, geographically, and over time to both protect confidentiality and have meaningful and useful results. There are also choices about how to present data and distribute it to those who will use it.

Within State government, there are a variety of agencies that are collecting data on aspects of maternal and infant health, and some very knowledgeable individuals. Some of these people are already collaborating with the Seattle Indian Health Board and the Urban Indian Health Institute on data monitoring, interpretation and research projects.

The State of Washington DSHS proposed to the Indian Policy Advisory Committee (IPAC) in January 2010 to work with tribes to develop meaningful data:

²⁸⁶ Jerry D. Niswander and Morton S. Adams, Oral Clefts in the American Indian, Public Health Reports, Vol 82, No. 9, September 1967.

We would like to work with a committee of IPAC members, to develop a list of indicators we could provide which would likely be useful to Tribal Governments and Indian Health Clinics. We can provide those indicators by region and race-ethnicity, as we have here. And – for those Tribal Governments who want data specific to their members, we are willing to match our client data to their enrollment lists, and provide the same indicators for their members. We will do the same for American Indian health organizations.²⁸⁷

The data manager for the Women, Infant and Children Nutrition Program (WIC) also has offered the present data in a way that is meaningful and useful to tribes.

Some types of reporting are not readily available, such as AI infant immunization data for influenza and pneumonia, and this reporting should be institutionalized.

Recommendations:

RDA.3.1. The State of Washington should establish an American Indian Maternal and Infant Health Data Coordinating Council that includes epidemiologists and others maintaining and analyzing MIH databases in various agencies of state government, as well as representation selected by the American Indian Health Commission of Washington State from tribes, the Seattle Indian Health Board and Urban Indian Health Institute, and the Northwest Portland Area Indian Health Board.

RDA.3.2. The State of Washington should institutionalize reporting of AI immunization data, including pneumococcal and influenza vaccines for infants.

Issue 4. National Children's Study

Background

The Children's Health Act of 2000 authorized the National Children's Study to better understand the relationship between health and environmental factors. The National Children's Study²⁸⁸ will follow 100,000 children across the United States from birth until

²⁸⁷ Laurie Cawthon, E. Kohlenberg, D. Mancuso, B. Felver, H. Axelsson, Employment and Health among DSHS Clients, by Race and Ethnicity and Region. Presented to the Indian Policy Advisory Committee, January 14, 2010.

²⁸⁸ For more information, see <http://www.nationalchildrensstudy.gov/Pages/default.aspx>

they turn 21 years old. This investment in research is funded by federal government²⁸⁹ which has already spent over \$53 million developing the study methods and partnerships; and the annual budget for implementation has grown each year with the federal government expected to spend \$193 million in 2010. There are 40 study centers that will carry out the research at 105 different locations. The Pacific Northwest Center for the National Children's Study at the University of Washington in Seattle is one of the study centers, and they will be recruiting participants in three counties: Grant, King and Thurston. The results are expected to influence government policy about child health. To be able to make conclusions, comparisons and recommendations about American Indian populations, there must be sufficient enrollment of American Indian infants in the study.

Recommendation:

RDA.4.1. The Pacific Northwest Center for the National Children's Study at the University of Washington should consult with tribes in Washington State about the study and enlist their support in recruiting participants.

²⁸⁹ Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the National Institute of Environmental Health Sciences, the National Institute of Child Health and Human Development, and the U.S Department of Environmental Protection.



SUMMARY AND IMPLEMENTATION



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printing purposes

Plan Summary and Implementation

MIH Strategic Plan Summary

The goal of this strategic plan is to eliminate the disparities in maternal and infant health for American Indians in Washington State. Specific measurable objectives were developed after identifying disparities in causes of infant mortality and risk factors for poor pregnancy outcomes, as well as a survey of tribes and urban Indian clinics. These objectives are:

- Reduce overall AI infant mortality by 38 percent.
 - Reduce AI SIDS deaths by 54 percent.
 - Reduce AI infant deaths due to injuries by 69 percent.
 - Reduce AI infant deaths due to infectious disease by 68 percent.
 - Reduce AI infant deaths from unknown causes by 74 percent.
- Reduce low birth weight births for AI by 22 percent.
 - Reduce the number of AI pregnant women with an untreated mental health diagnosis by 63 percent.²⁹⁰
 - Reduce the number of AI pregnant women who are consuming alcohol and other nonprescription drugs by 70 percent.
 - Reduce smoking among AI pregnant women by 40 percent.
 - Reduce the number of AI women who threaten pre-term labor by 50 percent.
 - Reduce the incidence of low birth weight, preterm labor and fetal death in first pregnancies of AI women by 35 percent.
- Reduce number of AI pregnant women with BMI >30 who gain weight outside IOM guidelines by 25 percent.

²⁹⁰ Mental health diagnosis is a risk factor that is too complicated to address in this MIH Strategic Plan, so the statement of goal has been altered to reduce untreated mental health diagnoses.

- Reduce the number of births to AI women between 15 and 19 years old by 43 percent.
- Increase breastfeeding among AI mothers and infants
 - Increase the initiation of breast feeding by AI women by 7 percent.
 - Increase the percentage of AI women breastfeeding at 6 months by 34 percent.
- Increase AI enrollment in First Steps/Maternity Support Services by 17 percent
- Increase chemical dependency treatment for AI pregnant women with substance abuse problems by 50 percent.

Using the best available research, strategies were identified to achieve each of the objectives. Some strategies can be employed to achieve more than one objective. Some objectives can be achieved using more than one strategy. A summary of strategies is provided in Figure 1 on page 45.

More than 39 programs have been identified to implement the strategies. These include 4 established programs, 15 model programs that have been evaluated and demonstrated their effectiveness, 10 promising programs that have not been evaluated, and 10 best practices that could be used in the design of new programs and/or the improvement of existing programs. Figure 2 on page 97 links the strategies to the programs described in this MIH Strategic Plan. In most cases, there are proven programs to carry out the strategies; however, two strategies may have an uncharted course. Involving youth in addressing MIH issues appears to be a new idea, although there are many organizations throughout the state and the country devoted to empowering and engaging youth. Assuring that infants are receiving immunizations for pneumonia and influenza appears to be a new focus, although there are many programs that are intended to assure that infants have other recommended immunizations.

Recommendations have been offered to increase American Indian enrollment in the WIC and First Steps programs and make it more likely that tribes will become providers of services through those programs. Recommendations have also been offered to ensure access for all AI/AN women to high quality obstetrical care and develop methods to successfully engage them in healthy lifestyles. Recommendations have been reviewed by the MIH Workgroup and by focus groups held in both urban and tribal areas in Washington State. A list of all 81 recommendations is provided in Appendix 3.

With resources and focus, the goal of this MIH Strategic Plan is completely achievable. To implement the MIH Strategic Plan, there are roles for the American Indian Health Commission (AIHC), the State of Washington, and tribes. These are summarized below along with estimated costs for implementation. A spreadsheet showing the estimated costs of implementing specific recommendations is provided in Appendix 3.

A. AIHC Role in Program Coordination and Advocacy

Because the American Indian Health Commission for Washington State (AIHC) represents all 29 tribes and 2 urban Indian programs, and has engaged with the State of Washington in this MIH planning effort, it seems to be ideally positioned to help coordinate the implementation of many of the recommendations. This could be done by funding and staffing 5 initiatives: 1) MIH improvement grants to tribes, 2) health care reform implementation, 3) involving youth, 4) promoting breastfeeding programs and policy development within tribes; and 5) WIC program and policy development. To carry out these activities, the AIHC would need funding from the State of Washington and/or philanthropic foundations.

1. MIH Improvement Grants to Tribes and Urban Indian Clinics

To implement programs that would carry out the strategies to achieve the objectives in this MIH Strategic Plan requires funding for tribes. Two types of grants are needed, one for community organizing and planning, and another for implementation. Ideally, AIHC would provide technical assistance and coordinate the grants program for tribes and urban Indian clinics. A full-time MIH Small Grants Program Coordinator should be hired by AIHC to work with tribes to understand this MIH Strategic Plan, to assist them in developing tribal-specific implementation plans, and provide technical assistance as they are carrying out their plans to improve maternal and infant health. In Year 1, planning grants would be available to approximately 8 tribes or urban Indian clinics (\$30,000 each) to raise awareness, engage a broad segment of the tribal communities, and to select 2-3 objectives that they want to address in the following year. In Year 2, planning grants would be available to an additional 8 tribes, and implementation grants would be available to the first group of 8 tribes that completed the planning process to help them carry out their plans (\$50,000 each). In this stepwise fashion, it will take 4 years to get all tribes and urban Indian programs engaged in planning and implementing their plans to improve MIH. The AIHC coordinator would organize a forum for grant recipients to share their experiences in implementing their MIH improvements.

Estimated cost:

		Planning Grants	Implementation Grants
Year 1	\$390,000	8	0
Year 2	\$795,000	8	8
Year 3	\$1,195,000	8	16
Year 4	\$1,535,000	7	24
On-going	\$1,705,000	0	31

Implementation of Recommendations: R.1.1, R.1.2, R.1.3

2. Health Care Reform Implementation

New resources are becoming available through the federal Patient Protection and Affordable Care Act of 2010 (PPACA), which includes the Reauthorization of the Indian Health Care Improvement Act. Notification is sent to the State of Washington about new funding sources with very fast turnaround times. AIHC estimates that it would require \$365,000 to hire policy analysts and provide the support they need to be engaged in implementation of the PPACA on behalf of tribes in Washington State. About 40 percent of their effort would address issues related to maternal and infant health, including such items as new grants for home visiting and changes to Medicaid policy.

Estimated cost: \$146,000 annually

Implementation of Recommendation: R.2.1

3. Youth Involvement in Improving MIH

AIHC should hire a Youth Services Coordinator to develop and implement strategies to involve tribal and urban Indian youth in reducing risk factors and improving outcomes for maternal and infant health. The AIHC Youth Services Coordinator would begin by listening to people at the tribal level, including teenagers, people who work in youth organizations, health care providers, educators and others to gain a better understanding of the resources, needs and opportunities to engage youth in MIH issues. This information would be used to develop a plan and a process for raising awareness of issues that require interventions at a young age, engaging youth in providing ideas for pre-conception risk reduction and implementing those ideas at a

tribal level. Another role for the AIHC Youth Services Coordinator is to assist the State of Washington in recruiting and identifying young people to serve on an AI Youth Advisory Committee. The AIHC Youth Services Coordinator could work with the Office of the Superintendent for Public Instruction to identify strategies to integrate MIH information into the school curriculum for various subjects. The AIHC Youth Services Coordinator could also be responsible for recruiting sponsors for contests, such as essay, poster and/or video contests. Another task for the AIHC Youth Services Coordinator is to assess the opportunities and needs to use the internet and social networking to inform youth about risk factors related to maternal and infant health.

Estimated costs: \$144,000 annually

Implementation of Recommendations: Y.2.1, Y.3.1, Y.3.2, Y5.1.

4. Breastfeeding Promotion and Policy Development within Tribes

The AIHC can serve a key role to promote breastfeeding programs and policy development within tribes. An AIHC Breastfeeding Coordinator (.5 FTE) can be a resource person, work with tribes to initiate tribal breastfeeding coalitions, and coordinate with hospitals where tribal members deliver babies to provide training, referrals and peer support. AIHC Breastfeeding Coordinator can develop and disseminate a tribal resource directory for lactation support services, and work with the State of Washington to produce culturally-appropriate community education messages that include fathers and others. A small grant program for tribes to provide incentives to participate in breastfeeding support programs (\$3,500 per tribe or urban Indian clinic) could be managed by the AIHC Breastfeeding Coordinator. The AIHC Breastfeeding Coordinator could serve as a liaison between tribes and the State of Washington in the implementation of recommendations related to breastfeeding that would be carried out by state agencies. Another role for this position is to facilitate training for tribal employees to become lactation specialists and peer counselors.

Estimated costs:

Year 1	\$206,500
Year 2	\$186,500
On-going	\$176,500

Implementation of Recommendations: BF.1.1, BF.3.3, BF.4.7, BF.4.3, BF.1.2

5. Tribal Liaison for WIC Program and Policy Development

Some of the WIC recommendations in this MIH Strategic Plan can be carried out at the state level, while others may require policy changes at the federal level. At the AIHC there needs to be a Tribal WIC Liaison (.5 FTE) who can represent tribes in discussions with the WIC State Agency and the U.S. Department of Agriculture (USDA). The Tribal WIC Liaison could assist the state WIC agency in developing culturally-appropriate materials for American Indians, and convening a workgroup to improve the usefulness of WIC data for tribes. Another role for the Tribal WIC Liaison is to work with Tribal Colleges and other institutions to increase the number of American Indians who are trained as Registered Dietitians and midlevel nutritionists.

Estimated costs:

Year 1	\$118,000
Year 2	\$ 78,000
On-going	\$ 68,000

Implementation of Recommendations: WIC.1.1, WIC.1.2, WIC.1.3, WIC.2.1, WIC.2.2, WIC.3.1, WIC.3.2, WIC.4.1, WIC.6.1, WIC.7.1, WIC.8.1, WIC.8.2, WIC.8.3, WIC.9.1

B. Washington State Implementation of Policy and Program Recommendations

The previous section outlines ways that the American Indian Health Commission (AIHC) can assist with implementation of recommendations in this MIH Strategic Plan. The State of Washington is asked to fund the 5 positions²⁹¹ and programs that would become activities of the AIHC for an estimated cost of \$916,500 in Year 1, \$1,261,500 in Year 2, and \$1,326,500 ongoing. Funding for the positions can and should be implemented quickly so that AIHC has the capacity to work with the State of Washington to carry out the goals, objectives and recommendations in this MIH Strategic Plan.

²⁹¹ Two half-time positions could be combined to hire a single person full-time to implement both WIC and breastfeeding recommendations, thereby creating 4 full-time positions at AIHC, rather than 3 full-time and 2 half-time positions.

In addition, there are 8 areas of recommendations that require action on the part of the state Department of Social and Health Services and/or the Department of Health. To implement these recommendations, the State needs to assign responsibility to a leader of the effort and provide adequate resources. The 8 areas are: 1) new resources to improve health services; 2) low cost programs that can be implemented quickly; 2) implementing WIC recommendations at state level; 3) change State policies and programs to encourage breastfeeding; 4) increase tribal participation as First Steps Providers; 5) research and data analysis; 7) review policies and practices for the WA State Tobacco Quit Line; and 8) long range system changes to increase the number of rural providers and increase access maternal and infant health services.

1. New Resources to Improve Health Services

New funding is becoming available through the Patient Protection and Care Act of 2010 (health care reform) including the Reauthorization of the Indian Health Care Improvement Act. Several recommendations in the MIH Strategic Plan suggest ways that the state and tribes can work together to acquire more resources for tribes in Washington State to improve maternal and infant health. These recommendations need to be implemented immediately in order to leverage federal funding.

Estimated costs: \$320,000 in Year 1, and \$10,000 annually after first year.

Implementation of Recommendations: R.2.1, BH.1.1, BH.1.2, BH.1.3

2. Low Cost Programs that can be Implemented Quickly

Four other low cost programs have been identified that could be implemented quickly: 1) funding for NAWDIM for the Cradleboard Project to be extended to tribes statewide; 2) develop and distribute provider guidelines for preconception counseling; 3) initiate an American Indian Youth Advisory Panel for the DOH, DSHS, and the Office of Superintendent of Public Education; and 4) fund a youth speaker's bureau on MIH issues through an existing youth organization.

Estimated Costs: \$333,615 in Year 1, and \$198,800 annually after first year.

Implementation of Recommendations: SIDS.1.2, PPC.1.2, Y.1.1, Y.4.1

3. Implementing WIC Recommendations at State Level

In addition to the recommendations that involve WIC listed in the AIHC Role in Program Development and Advocacy, there are recommendations in this MIH Strategic Plan regarding training of WIC employees and WIC support for breastfeeding in tribal communities. Implementation of some of the recommendations is already planned and included in the WIC budget, including raising payments to tribes from \$160 to \$185 per person beginning January 2011.

Estimated costs: \$771,000 in Year 1, and \$627,000 annually after first year

Implementation of Recommendations: WIC.5.2, WIC.5.3, BF.4.1, BF.4.2, BF.4.8, WIC.5.1, WIC.2.1, WIC.3.1, WIC.1.1

4. Change State Policies and Programs to Encourage Breastfeeding

Three recommendations have been made to change state policies and programs to encourage breastfeeding, including: 1) Reward hospitals for BFHI accreditation; 2) Require hospitals to implement “Can Do 5” measures; and 3) ensure lactation support is reimbursable by insurance and Medicaid.

Estimated costs: \$110,000 annually

Implementation of Recommendations: BF.3.1, BF.3.2, BF.4.4

5. Increase Tribal Participation as First Steps Providers

Six recommendations have been made to increase tribal participation as First Steps Providers. Some of these can be done rather quickly and inexpensively, such as outreach to tribes to let them know about changes to simplify the program and provide training on billing. Others may save the State of Washington money, but require some planning and possibly policy changes, such as using telehealth for counseling and more flexibility in MSS staffing requirements. Overall, greater tribal participation is expected to lower costs to the State by an estimated \$590,000 per year because of the 100 percent FMAP for services delivered through tribal facilities (see Table 7 in Appendix 1). The recommendation to consider using the encounter rate rather than FFS for tribal First Steps providers is expected to create the greatest incentive for tribal participation; however, this recommendation is in Long Range Planning section of the state implementation.

Estimated costs: It is estimated that the State would save money.

Implementation of Recommendations: FS.2.1, FS.2.2, FS. 2.3, FS.3.1,
FS.3.2, FS.3.3

6. Research and Data Analysis

There are three main recommendations for research and data analysis. The first is the creation of an AI/AN MIH Data Coordinating Council that would include analysts from a variety of agencies within DOH and DSHS that could serve to standardize data and definitions used in the collection of data, make periodic reports of data on maternal and infant health, and monitor the implementation of this plan and its outcomes. The second new activity is statewide AI infant death review that would involve a planning process to includes tribes, the IHS and state government and require enabling legislation. The third major initiative is to report AI immunization rates for pneumococcal and influenza vaccines in the first year of life. Other recommendations involve research on disparities in birth defects among tribes in Eastern Washington, and improvement of WIC and SIDS data.

Estimated costs: \$58,700 in Year 1, and \$50,000 in Year 2.

Implementation of Recommendations: RDA .1.1, RDA.1.2, RDA.2.1, RDA.3.1,
WIC.7.2, RDA.3.2, SIDS.1.3

7. Review Policies and Practices for the WA State Tobacco Quit Line

Smoking cessation is a strategy that can impact 6 of the 15 objectives identified in this MIH Strategic Plan to bring American Indians to parity with the rest of the population of Washington State. The WA State Tobacco Quit Line is already in place, but the policies and practices should be reviewed to assure that the services are culturally appropriate and to maximize the utilization of those services by American Indian women and their families. A major problem with estimating costs is that the Tobacco Quit Line and other tobacco prevention and cessation programs are threatened with elimination through budget cuts.²⁹² AIHC has a workgroup that is considering these issues and these recommendations will be referred to them for implementation.

Estimated costs: unknown

Implementation of Recommendations: SM.1.1, SM.1.2, SM.1.3, SM.1.4

²⁹² David Harrelson, Department of Health, Washington State, personal communications August 31, 2010.

8. Long Range System Changes to Increase Number of Rural Providers and Improve Access to MIH Services

Access to care issues are complex and may take more time to resolve than some of the other issues identified in this MIH Strategic Plan. Four recommendations have been offered to provide long range system changes: 1) demonstration projects for tribes to serve as medical homes for obstetric care; 2) expand the Seattle Indian Health Board residency training model to rural tribal areas and MIH disciplines; 3) leverage the Federal Tort Claims Act (which reduces or eliminates malpractice insurance costs for tribes and the IHS) to increase the number of obstetric providers in rural areas; and 4) consider changing MSS reimbursement from fee for service to the federally approved encounter rate. To further research and develop these ideas, a workgroup is recommended that will meet monthly for the first year and quarterly after that. The workgroup would include participation from multiple programs in DOH, DSHS, tribes, urban Indian clinics and the University of Washington. A consultant would be hired to coordinate the workgroup activities.

Estimated costs: \$25,680 in Year 1, and \$8,065 in Year 2.

Implementation of Recommendations: AC.1.1, AC2.1, AC.2.2, WIC.1.4, FS.1.1

C. Actions Tribes Can Take to Improve Maternal and Infant Health

While many of the recommendations in this plan require funding and policy changes, as well as tribal participation, some things have been identified that tribes can do immediately to improve the health of pregnant women and infants who are tribal members. There are five categories for tribal action: 1) support breastfeeding; 2) focus existing tribal services to improve maternal and infant health; 3) advocate for a USDA tribal consultation policy that includes a Tribal Technical Advisory Group (TTAG) for the WIC program at the national level; and 4) engage with universities to increase training for health professions and research to improve MIH in Native American communities.

1. Support Breastfeeding

There are many steps that tribes can take as employers, educators, and health service providers to encourage breastfeeding by tribal members. Tribal governments can adopt codes to promote breastfeeding in the workplace, and tribal offices and businesses can review their policies to assure that women who return to work after giving birth can continue to breastfeed their babies. Tribal clinics can eliminate advertising for infant

formula and train some providers to become lactation specialists and peer counselors to provide support to breastfeeding women. Childbirth education programs offered by tribes can include information about breastfeeding. Tribally operated high schools and youth programs that provide life skills education can include breastfeeding and other topics related to maternal and infant health.

Estimated costs: no additional costs, if other recommendations for tribal support are funded

Implementation of Recommendations: BF.5.1, BF.2.1, BF.2.2, BF.2.3, BF.4.5, BF.4.6

2. Focus Existing Tribal Services to Improve Maternal and Infant Health

Tribes can modify their existing services to create greater focus on improving maternal and infant health. For example, preconception counseling can become a regular part of annual exams for young women. Tribes can develop systems to screen women who are pregnant or postpartum for depression, and refer them for treatment. All pregnant women should be screened for gestational diabetes and receive nutrition counseling during and after their pregnancy. Tribal smoking cessation programs should prioritize pregnant women. To participate in Bedtime Basics for Babies, a free program that provides portable cribs and SIDS risk reduction information, tribes need to make sure their protocols facilitate the research component, and pass tribal resolutions. Tribes should designate an office, such as CHS, to enroll pregnant women in Bedtime Basics for Babies. To reduce childhood injuries and deaths, tribes that have the resources could provide car seats and teach parents how to use them. If a tribe has a fire department, it could serve as a place where parents can drop by to make sure their car seats are installed properly. Tribes can pass and enforce codes requiring the use of seatbelts.

Estimated costs: No additional costs, except for car seats, if other recommendations to support tribes are funded.

Implementation of Recommendations: PPC.1.1, BH.1.4, SM.1.5, SIDS1.1, IP.1.1, IP.1.2, IP.1.3

3. Advocate for Tribal Technical Advisory Group (TTAG) for WIC Nationally

Many of the WIC recommendations in this MIH Strategic Plan may require policy changes at the national level and possibly changes in federal regulations. To make this happen requires involvement of tribal leaders with the U.S. Department of Agriculture, a federal agency that has not historically developed close working relationships with tribes. Tribal leaders individually and through the Northwest Portland Area Indian Health Board and national tribal organizations can advocate for the USDA to have a tribal consultation policy that includes a Tribal Technical Advisory Group (TTAG) for the WIC program at the national level. One model that tribes can use as a reference is the TTAG for the Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services. Through the TTAG and through other tribal consultation processes, tribal leaders can use the issues in this MIH Strategic Plan as agenda items and the basis for testimony and resolutions.

Estimated costs: The costs to tribes can range from zero for writing letters, to several thousand dollars for travel to meetings and engaging in advocacy.

Implementation of Recommendations: WIC.1.1, WIC.1.2, WIC.2.1, WIC.2.2, WIC.3.1, WIC.3.2, WIC.4.1, WIC.4.2, WIC.5.1, WIC.8.3

4. Engage with Universities to Promote Training and Research to Improve MIH

If tribes in Washington State are going to benefit from the federal investment in the National Children's Study, there must be sufficient enrollment of American Indian infants. The University of Washington should be asked to consult with tribes about the study and to address any concerns that tribes may have. In addition, tribes can support the Northwest Portland Indian Health Board to coordinate an effort to make internships more accessible to increase the number of Registered Dietitians available to work with tribes and urban Indian clinics in WIC programs and other programs that will improve maternal and infant health.

Estimated Costs: minimal

Implementation of Recommendation: RDA.4.1, WIC1.4

Costs and Savings

Altogether it is estimated that implementation of the 81 recommendations in the MIH Strategic Plan would cost about \$2 million in the first year, if all recommendations were implemented simultaneously. However, the first year for one set of recommendations may be in a different calendar year or fiscal year than the first year for another set of recommendations. Some programs that have been described have implementation staggered over several years to spread out the costs. For some recommendations, it is impossible to figure the costs at this time.

A direct investment of \$2-3 million dollars per year by the State of Washington to improve maternal and infant health among Native Americans is expected to increase funding from federal sources and save state Medicaid expenses in both the short term and the long term.

In Washington State, an average hospital cost for a preterm birth is over \$50,000, while it costs approximately \$1,500 for a low-risk normal weight birth.²⁹³ If just 41 of the 2031 American Indian pregnant women reduced their risk factors and delivered normal weight babies, it would pay for a \$2 million investment in maternal and child health. If just 62 women reduced their risk factors and delivered normal weight babies, it would pay for a \$3 million investment. Behavioral changes in just 2 to 3 percent of the population of current and future pregnant American Indian women would pay for all the recommendations in this report. Changes in more than 4 percent of the AI pregnancies from high risk to normal would achieve cost savings for Medicaid.

Oversight of MIH Strategic Plan Implementation

The AIHC MIH Workgroup should be continued to provide oversight for the implementation of the MIH Strategic Plan. The spreadsheet that provides budget information has been adapted to provide a template for quarterly reporting of implementation status for each of the recommendations. This on-going evaluation of the implementation process will provide accountability and assure that changes are made to create the intended outcomes. The goals and objectives of this plan to eliminate disparities in maternal and infant health for American Indians in Washington State can be achieved if there is the commitment, the resources, the management, and the leadership to implement the recommendations in this plan.

²⁹³ Amira Y. el-Bastawissi, R. Peters, K. Sasseen, T. Bell, R. Manolopoulos, Effect of the Washington Special Supplemental Nutrition Program for Women, Infants and Children (WIC) on Pregnancy Outcomes. *Journal of Maternal and Child Health* 11:611-621, 2007. After the research reported in this publication, the State of Washington changed their payment rates for deliveries, which may change the difference in costs between preterm births and low-risk normal births.

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Healthy Start Native Peoples Council

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Additional Resources

Information about a Variety of Programs Available On-Line

The Maternal and Child Health Library at Georgetown University
http://www.mchlibrary.info/knowledgepaths/kp_infmort.html

Promising Practices Network on Children, Families and Communities
<http://www.promisingpractices.net/program.asp?programid=14>

Resource Center for Adolescent Pregnancy Prevention at ETR
<http://www.etr.org/recapp/index.cfm?fuseaction=pages.home>

Websites for Evidence-based Programs used by Tribes in Minnesota

Positive Parenting
<<http://www.positiveparenting.com/>>

Partners for a Healthy Baby (Florida State U)
<<http://www.cpeip.fsu.edu/books.cfm?assetID=74>>

NCAST (U of Washington - Seattle)
<http://www.ncast.org/index.html>

Steps Toward Effective Enjoyable Parenting (STEEP) (U of Minnesota)
<http://www.cehd.umn.edu/ceed/publications/manuals/STEEPSIB.htm>

Seeing is Believing (accompanies STEEP but also may be used independently)
(U of Minnesota)
<http://www.cehd.umn.edu/ceed/profdev/inpersontrainings/steepsib.htm>

Bright Futures (Georgetown College)
<http://www.brightfutures.org/>

American Indian Life Skills (many components including suicide prevention) U of Wisconsin
<http://uwpress.wisc.edu/books/0129.htm>

Nurse Family Partnership
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American Indian Lifeskills, evidence based, Teresa LaFromboise, Ph.D.

Live It! Teen Pregnancy Prevention, promising practice, Noya Woodrich, Ph.D candidate

Native American Parenting Traditions Revisited, promising practice, Rosemary White Shield, Ph.D

Native H.(helping) O.(our) P.(people) E.(endure), Clayton Small Ph.D.

Leading Next Generation to Healthy Relationships, promising practice, Theda New Breast (trainer), MPH

Wellbriety, Don Coyhis

Nurse Family Partnership, currently being adapted for three MN tribal communities, David Olds, Ph.D

Gathering of Native Americans (GONA)

American Indian Strengthening Families Program, Ceceilia Tso

Family-Based Approach to Promoting Health in American Indian Communities, Yvonne Davis-Thompson and Francene Larzelere-Hinton

Eye Movement Desensitization and Reprocessing (EMDR), Indian Health Service

Language of Life – Bringing Traditional Parenting Skills Back to Our Parents, Marla Bosch

Native STAND, Indian Health Service, Coalition of STD Directors and Native American advisory committee

²⁹⁴ List compiled by Eileen J. Grundstrom, Training Coordinator for Minnesota Tribes, Community & Family Health Division, Minnesota Department of Health, eileen.grundstrom@state.mn.us

Native Path to Resiliency: Beyond Historical Trauma

Historical Trauma and Unresolved Grief Intervention (HTUG), Takini Network including Maria Yellow Horse Brave Heart Ph.D

Motivational Interviewing, Rollnick and Miller, Native American trainer

Institutional Racism, The People's Institute for Racism and Beyond (People's Institute North), John Morrin & Edye Howes

Traditional Parenting Practices, Skip and Babette Sandman, MN American Indian elders

The Native Path to Resiliency, Pam and Gordon James

The SPIRIT Incredible Years (culturally tailored for American Indians) Renda Dionne, Ph.D, Cahulla Band of Indians

NCAST (promoting maternal mental health during pregnancy – adapted to MN tribes), Barb Richards (NCAST trainer)

Positive Indian Parenting

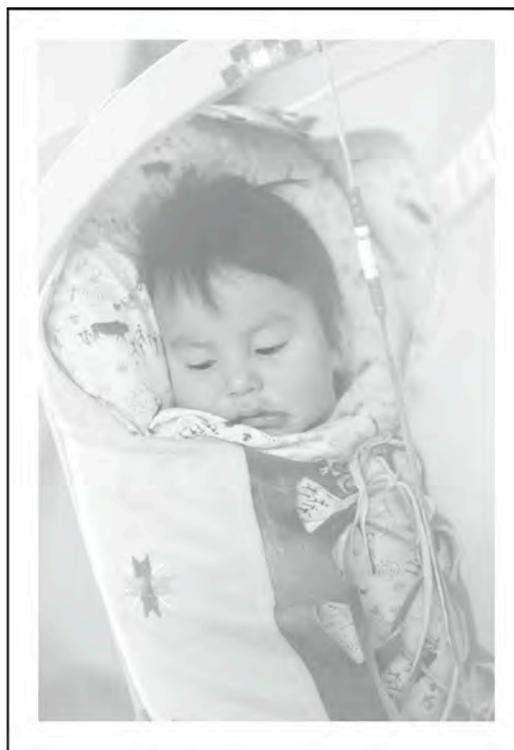
Building Brighter Futures in Indian Country, Department of Justice with tribal youth focus groups

In the Body: The Biology of Trauma, Oppression, and Healing; Somatic Experiencing, Tommy Woon and Thea Lee



APPENDIX 1

MAPS & TABLES



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printing purposes

DSHS Regions: ESA



Table 1. Causes and Rates of Infant Deaths

Cause of Infant Death	Number of AI Deaths		Rates per 100,000 Births		
	2000-2007	Annual Average	AI	Total Pop.	Disparity
1 <u>SIDS</u>	26	3	209	68	<u>3.1</u>
2 Birth Defects	20	3	161	128	1.3
3 <u>Injuries and Accidents</u>					
Hanging, Strangulation, Suffocation	6		48	13	3.7
Homicide	6		48	7	7.3
Poisoning	1		8	1	7.3
Transportation Accidents	3		24	4	6.5
Other accidental injury	3		24	6	4.0
Subtotal	19	2	153	31	<u>5.0</u>
4 Complications of Pregnancy & Delivery					
Maternal Complications	9		72	58	1.3
Intrauterine hypoxia, birth asphyxia	3		24	14	1.8
Respiratory distress of the newborn	3		24	10	2.4
Subtotal	15	2	121	81	1.5
5 Prematurity and Low Birth Weight	12	2	96	61	1.6
6 <u>Infectious Disease</u>					
Influenza and Pneumonia	6		48	7	7.2
Perinatal Infection	6		48	17	2.9
Infectious diseases, incl. septicemia	1		8	8	1.0
Subtotal	13	2	105	32	<u>3.3</u>
7 Digestive System Problems					
Digestive system disorders (perinatal)	6		48	10	4.6
Diseases of the digestive system	2		16	10	1.6
Subtotal	8	1	64	21	3.1
8 <u>Ill-defined and unknown causes</u>	7	1	56	13	<u>4.5</u>
9 Other Causes	18	2	145	89	1.6
<u>Total Infant Deaths from All Causes</u>	138	17	1109	522	<u>2.1</u>
Rate per 1000			11	5.2	

Notes Disparities **bold underlined** are statistically significant, confidence levels provided by DSHS. AI means American Indian is only race/ethnicity listed on birth certificate. Death certificates were individually matched to birth certificates. Total population includes AI. Causes of death from death certificates using ICD-10, some were combined into groups.

Table 2. Risk Factors for Poor Pregnancy Outcomes, 2008

	All Medicaid Pg Women		AI PG Women			AI Risk Factor Ranking by			
	Number	Percent	Number	Percent	Disparity	Disparity	Prevalence	Severity	Average
Total # on Medicaid	42,629		2,031						
Singleton low birth weight rate	2,302	5.4%	140	6.9%	1.3				
Risk Factors									
Alcohol/SA during pg or 1 yr pp	2302	5.4%	366	18.0%	3.3	1	5	1	2.3
Developmental Disability	353	0.8%	55	2.7%	3.3	2	16	1	6.3
Mental health diagnosis	5620	13.2%	720	35.5%	2.7	3	1	1	1.7
Threaten pre-term labor	3248	7.6%	309	15.2%	2.0	4	8	1	4.3
Smoked within 3 months of pg	1096	2.6%	89	4.4%	1.7	5	13	3	7.0
16 yrs old at conception	970	2.3%	78	3.8%	1.7	6	14	3	7.7
Up through age 15 at conception	741	1.7%	59	2.9%	1.7	7	15	2	8.0
Smoked during this pg	7065	16.6%	561	27.6%	1.7	8	2	2	4.0
Prior LWB/Preterm/fetal death	4500	10.6%	329	16%	1.5	9	7	1	5.7
Current hypertension	3712	8.7%	248	12.2%	1.4	10	10	1	7.0
Interpregnancy interval < 9 mos	5186	12.2%	331	16.3%	1.3	11	6	3	6.7
BMI>30 and wt gain outside	7707	18.1%	492	24%	1.3	12	4	2	6.0
BMI>30 and wt gain in guidelines	2516	5.9%	148	7%	1.2	13	12	3	9.3
PNC began after 6 mos (no PNC)	5205	12.2%	301	15%	1.2	14	9	2	8.3
Diabetes current pregnancy	4116	9.7%	218	10.7%	1.1	15	11	1	9.0
BMI 25 to 29.9	10256	24.1%	468	23%	1.0	16	3	3	7.3

Severity of Risk Ranking : Severity of risk factors is based on the MSS Prenatal Eligibility Tool used by Washington State (DSHS form number 13_874) and coded as follows:

Category A rank = 3

Category B rank = 2

Category C rank = 1

Notes:

Being a Native American is considered a Category C risk factor.

Other risk factors were selected if 1) there was a prevalence of 100 pregnant AI women in 2008 with risk factor, or 2) there was a disparity in incidence between AI and the total population of Medicaid pregnant women.

Table 3. Percent American Indian Breastfeeding in WIC, May 2010

	AI Women Enrolled in WIC			Total	Percent Breastfeeding
	# sites	Post Partum	Breastfeeding		
Tribal Programs					
Auburn Public Health-Muckleshoot	1	19	9	28	32%
Colville	5	31	32	63	51%
Yakama	2	29	43	74	58%
SPIPA (6 tribes)	6	21	12	33	36%
Other Tribes (11)	13	109	87	196	44%
Puyallup Tribal HA	1	31	38	69	55%
Seattle Ind H Bd	1	12	18	30	60%
<i>Subtotal</i>	29	252	239	493	48%
All Other Local WIC Agencies' Sites	187	361	407	768	53%
Total Statewide	216	613	646	1,261	51%

Note: Postpartum means up to 1 year after giving birth and not breastfeeding.

Table 4. Percent Reduction or Increase Needed for Parity

	Total Population	AI Goal Number w/Parity	2008 Actual/Est. AI Number	Percent Reduction Needed for Parity
Number Births with Medicaid in 2008	42,629	2,031	2,031	
Infant Mortality ¹				
SIDS	0.07%	1.4	3	54%
Injuries	0.03%	0.6	2	69%
Infectious Disease	0.03%	0.6	2	68%
Unknown causes	0%	0.3	1	74%
Total	0.52%	10.6	17	38%
LBW Risk Factors				
Mental Health Diagnosis	13.2%	268	720	63%
Alcohol, Substance Abuse	5.4%	110	366	70%
Smoking during Pregnancy	16.6%	337	561	40%
Threaten pre-term labor	7.6%	154	309	50%
Prior LBW/preterm/fetal death	10.6%	215	329	35%
Total LBW rate	5.4%	110	140	22%
HBW Risk Factor				
BMI>30 + wt gain outside guidelines	18.1%	368	492	25%
Teen Birth Rate (15-19 years old) ²	3%	136	239	43%
				Percent Increase Needed for Parity
Support Services				
Participation in First Steps/MSS	73.1%	1485	1268	17%
Breastfeeding ³				
Initiate breastfeeding	92%	1869	1747	7%
Breastfeeding at 6 mos.	67%	1361	1016	34%

Notes: 1. Average 2000-2007 (Cawthon, 3/16/10)
2. Teen birth rates are calculated as the number of births per 1,000 in the population of women 15-19 years old (2008), when the female teen population in WA for AI was 4,280 and the total was 229,650.
3. Breastfeeding rates are from PRAMS data, 2004-2007. Data for 2-6 months is considered 6 months

Table 5. WIC Participation by American Indians, May 2010

	# sites	American Indian/Alaska Native Enrolled					Total	All Races Total	Percent AI
		Pregnant	PostPartum	Breastfeeding	Infant	Child			
Tribal Programs									
Auburn Public Health-Muckleshoot	1	49	19	9	72	73	222	307	72%
Colville	5	162	31	32	230	379	834	1,120	74%
Yakama	2	177	29	43	305	498	1,052	1,292	81%
SPIPA	6	51	21	12	97	177	358	503	71%
Port Gamble S'Klallam	1	24	3	5	42	58	132	243	54%
Puyallup Tribal HA	1	168	31	38	225	287	749	980	76%
Other Tribes (10)	12	387	106	82	620	801	1,996	2,794	71%
Seattle Ind H Bd	1	105	12	18	92	134	361	882	41%
<i>Subtotal</i>	29	1,123	252	239	1,683	2,407	5,704	8,121	70%
All Others	187	1,592	361	407	2,410	3,721	8,491	348,835	2%
Total Statewide	216	2,715	613	646	4,093	6,128	14,195	356,956	4%

Table 6. Dollar Value of Food Provided to American Indians through WIC, May 2010

Agency	Site	Pregnant	Breastfeeding	Postpartum	Infant	Child	Total
Tribal WIC Agencies							
Colville Confederated Tribes	Grand Coulee	\$542	\$58	\$264	\$4,885	\$4,088	\$9,838
Colville Confederated Tribes	Inchelium	\$8,506	\$1,452	\$441	\$21,862	\$22,761	\$55,022
Colville Confederated Tribes	Keller	\$1,381	\$0	\$305	\$10,655	\$3,283	\$15,624
Colville Confederated Tribes	Nespelem	\$15,101	\$2,258	\$665	\$49,516	\$26,904	\$94,444
Colville Confederated Tribes	Omak	\$10,983	\$2,077	\$616	\$36,446	\$24,738	\$74,860
	<i>Subtotal</i>	\$36,514	\$5,845	\$2,291	\$123,363	\$81,774	\$249,787
Quileute Tribe	Hoh Tribe- Hoh	\$253	\$198	\$0	\$4,091	\$2,204	\$6,745
Quileute Tribe	Quileute Tribe-La Push	\$2,794	\$788	\$159	\$13,002	\$8,797	\$25,541
	<i>Subtotal</i>	\$3,047	\$986	\$159	\$17,093	\$11,001	\$32,286
Quinalt Indian Nation	Queets	\$2,487	\$0	\$514	\$12,474	\$6,450	\$21,925
Quinalt Indian Nation	Taholah	\$11,757	\$2,463	\$1,569	\$43,058	\$26,014	\$84,860
	<i>Subtotal</i>	\$14,244	\$2,463	\$2,083	\$55,532	\$32,464	\$106,785
SPIPA	Jamestown	\$495	\$458	\$0	\$3,455	\$4,281	\$8,689
SPIPA	Chehalis	\$1,926	\$486	\$934	\$29,014	\$13,236	\$45,595
SPIPA	Nisqually	\$1,852	\$388	\$531	\$11,218	\$7,624	\$21,614
SPIPA	Shoalwater Bay	\$701	\$0	\$0	\$0	\$2,916	\$3,617
SPIPA	Skokomish	\$1,129	\$358	\$266	\$3,090	\$8,304	\$13,145
SPIPA	Squaxin Island	\$4,033	\$252	\$339	\$11,256	\$6,514	\$22,395
	<i>Subtotal</i>	\$10,136	\$1,942	\$2,071	\$58,033	\$42,875	\$115,056
Yakama Nation	Toppenish	\$41,826	\$7,197	\$2,744	\$198,568	\$142,579	\$392,915
Yakama Nation	White Swan	\$2,692	\$645	\$244	\$22,996	\$17,759	\$44,336
	<i>Subtotal</i>	\$44,518	\$7,842	\$2,988	\$221,564	\$160,339	\$437,251
Auburn Public Health Center	Muckleshoot	\$10,063	\$940	\$2,492	\$46,076	\$18,064	\$77,636
Spokane Tribe of Indians	Spokane Tribe	\$16,242	\$910	\$1,786	\$63,562	\$34,651	\$117,152
Suquamish Tribe	Suquamish Tribe	\$3,906	\$989	\$818	\$18,610	\$13,278	\$37,602
Swinomish Indian Tribal Community	Swinomish Indian Tribal Community	\$7,360	\$1,229	\$419	\$11,791	\$10,365	\$31,164
Tulalip Tribes	Tulalip Health Clinic	\$15,324	\$1,552	\$3,717	\$79,303	\$24,287	\$124,183
Lower Elwha Tribe	Lower Elwha Tr-Port Angeles	\$4,467	\$1,536	\$204	\$14,409	\$14,258	\$34,875
Lummi Nation	Lummi Indian Health Ctr - Bellingham	\$24,410	\$2,189	\$3,012	\$87,023	\$52,159	\$168,793
Makah Tribe	Makah Tribe-Neah Bay	\$8,080	\$1,705	\$203	\$16,178	\$17,620	\$43,786
Nooksack Indian Tribe	Nooksack Indian Tribal Clinic	\$4,432	\$1,608	\$846	\$22,511	\$14,012	\$43,409
Port Gamble S'Klallam Tribe	Port Gamble S'Klallam - Kingston	\$8,152	\$1,000	\$147	\$26,778	\$19,533	\$55,612
Puyallup Tribal Health Authority	Puyallup Tribal HA - Tacoma	\$41,914	\$7,830	\$3,024	\$128,703	\$70,609	\$252,080
	<i>Subtotal</i>	\$144,352	\$21,488	\$16,669	\$514,944	\$288,838	\$986,291
Seattle Indian Health Board	Seattle-King County	\$26,086	\$5,076	\$1,508	\$47,040	\$33,808	\$113,519
Total Tribal WIC Programs		\$278,897	\$45,641	\$27,770	\$1,037,569	\$651,099	\$2,040,976
Total AI Statewide		\$662,293	\$133,465	\$67,847	\$2,279,655	\$1,593,402	\$4,736,633
Tribal WIC Programs as % of Statewide AI		42%	34%	41%	46%	41%	43%

Table 7. Estimated Costs for Various Scenarios for MSS

Scenario 1: Current Situation

Current MSS enrolled	1,268
MSS cost per client (AI)	\$ 548.00
Cost of MSS now for AI	\$ 1,447,633.33
State cost @ 62.94% FMAP	\$ 536,492.91

Scenario 2: Cover all AI Pregnant Women at Current FFS Cost for 40 Units

# AI women eligible	2031
Average cost per unit	\$ 28.54
Cost for 40 units	\$ 1,141.67
Cost to cover all	\$ 2,318,725.00
State cost @ 62.94% FMAP	\$ 859,319.49

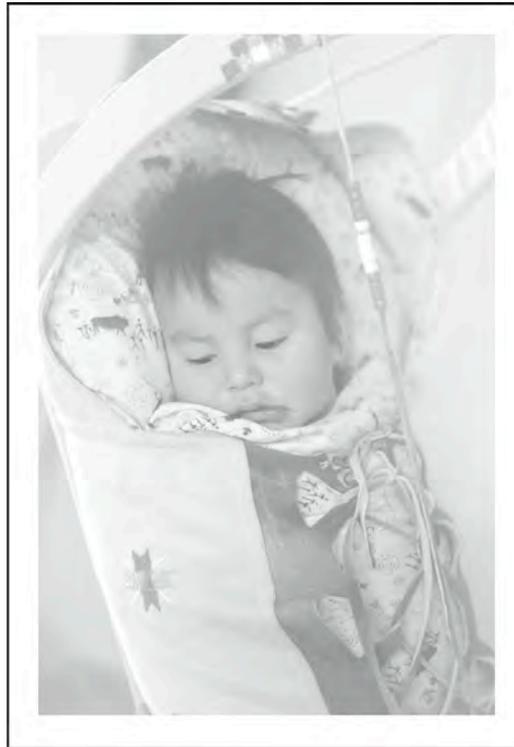
Scenario 3: Cover All AI Pregnant Women, with Half at IHS Encounter Rate (Assume 10 Visits per Person)

IHS Outpatient Encounter Rate	\$ 268.00
Cost per person, assume 10 visits per person	\$ 2,680.00
Assume half AI covered	\$1,015.50
Cost for services by tribe, IHS	\$ 2,721,540.00
Cost to state at 100 % FMAP	0
Assume costs divided equally by 29 tribes	\$ 93,846.21
Cost to state for half at current FFS	\$ 268,246.46



APPENDIX 2

SURVEY OF TRIBES AND URBAN INDIAN PROGRAMS IN WASHINGTON STATE - APRIL 2010



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Survey of Tribes and Urban Indian Programs in Washington State
Regarding Maternal and Infant Health

April 2010

Methods

During April 2010, the American Indian Health Commission for Washington State (AIHC) sent e-mails to health directors of all 29 tribes and 2 urban Indian programs in Washington State with a link to an on-line survey using the Survey Monkey program. The survey sample includes 16 responses from 13 tribes and one urban Indian program.

Sample of Tribes

In addition to the Seattle Indian Health Board (SIHB), 45 percent of the tribes in Washington State responded to the survey.

The tribes in the sample are fairly representative of the tribes in the State of Washington with regard to size and location. The tribes responding to the survey included 6 with less than 700 tribal members, 5 with between 700 and 1,500 tribal members, and 2 with more than 1,500 members. The AI/AN user population for health care facilities for tribes that responded ranged from 190 to 8,288.²⁹⁵ The following table compares the sample of tribes in the survey with all tribes in the state on the basis of AI user populations for IHS-funded health services. Tribes with the largest user populations are slightly underrepresented in the sample.

*Table 1. User Population of Tribes in Survey Sample Compared to All Tribes in State*²⁹⁶

User Population	All tribes in Washington State		Tribes in Survey Sample	
	Number	Percentage	Number	Percentage
Less than 500	10	34%	5	38%
500 – 1,000	5	17%	3	23%
Over 1,000	14	48%	5	38%

²⁹⁵ Source: 2009 Indian Health Care Improvement Fund (IHCIF) formula, available on-line at <http://www.ihs.gov/NonMedicalPrograms/Inf/2008/IHCIFAllAreaAllSites5-8-08.pdf>

²⁹⁶ Ibid

State government services are organized into 6 DSHS Regions. The following table shows the number of tribes in each DSHS Region and the number and percentage responding to the survey.

Table 2. Geographic Distribution of Tribes Responding to Survey by DSHS Region

DSHS Region	Number of Tribes in Region	Number of Tribes Responding to Survey	Percentage of Tribes Responding to Survey
1	3	1	30%
2	1	0	0
3	8	4	50%
4	1	1	100%
5	2	0	0
6	14	7	50%
Total	29	13	45%

Respondents

Some health directors responded to the survey, but most health directors asked others on their staff to respond. In some tribes, one person started to respond and quit after filling out identifying information, and then another person attempted to respond. In one tribe, four different people started to respond to the survey and two finished taking the survey. In another tribe, one person started and stopped, but two others completed the survey. Altogether 15 tribes and one urban Indian program attempted to respond to the survey.

The actual sample includes 16 responses from 13 tribes and one urban Indian program. Two tribes had two respondents. One of the tribes with two respondents is a large tribe and each respondent represents different clinics operated by the tribe in different regions with different levels of service. The other tribe with two respondents is a small tribe with some direct programs and most medical services contracted. Including both responses

from the smaller tribe may affect the results by 6 percent. In other words, if both agreed on the answer to a question, then the weighting for the tribe may be 6 percent greater than if only one respondent was included. If they disagree, their responses may have cancelled each other out. Because of this, survey findings reported as percentages should be considered as + or – 6 percent.

Respondents included administrators, medical directors, public health nurses, Dietitians, mental health therapists and others. It is possible that the training and type of work that the respondent does affects their perspectives of MIH issues and what they consider to be important. For example, in the same tribe one respondent ranked teen pregnancy as the most important issue listed, while the other respondent ranked teen pregnancy as the least important issue listed. Rather than looking for consensus about issues, the survey is most useful in identifying a range of issues that those who provide services to American Indian women and infants consider important.

While the survey responses reflect 16 respondents from 13 tribes and 1 urban Indian clinic in Washington State, this is simplified in this report by using the term, “AI health programs.”

Number of Pregnant Women and Infants Served by AI Health Programs

To estimate the number of pregnant women and infants served by AI Health Programs, the survey asked for the number of children registered in the clinic that were born in the years 2007, 2008, and 2009. The numbers ranged from 3 to 169 births per program per year, with the Seattle Urban Indian Clinic at the high end of the scale. The programs were divided into groups and an annual average number of programs in each group was calculated along with percentages, as shown in the following table.

Table 3. Number of Pregnant Women Served by AI Health Programs (n=12)

Number of Pregnant Women Annually	Percentage of AI Health Programs
10 or fewer	25%
11 to 25	33%
26 to 50	17%
Over 50	25%

Half the tribes have between 11 and 50 births per year, while a fourth have fewer and a fourth have more. Considering that women are pregnant for 9 months, on average a third of the tribes have between 8 and 38 women pregnant each month.

Medicaid Enrollment

The survey asked about the level of Medicaid enrollment among pregnant women served by the AI health programs. Among the 13 responses, 9 were educated guesses and 5 were actual calculations. In nearly two-thirds the programs, 90 percent or more of the pregnant women were receiving Medicaid. Only one program had fewer than 10 percent enrolled in Medicaid. The following table shows the distribution of AI health programs by percentage of pregnant women enrolled in Medicaid.

Table 4. Percentage of Pregnant Women Enrolled in Medicaid by AI Program (n=13)

Percentage of Pregnant Women Enrolled in Medicaid	Percentage of AI Health Programs with this Medicaid Participation
100 % enrolled	31%
90-99% enrolled	31%
50-90% enrolled	15%
10-49% enrolled	15%
Under 10% enrolled	8%

Infant Mortality

Asked to recall or research the number of infant deaths in the past three years, most respondents did not report any infant deaths in the tribes they serve. Among respondents, 77 percent said there were no infant deaths in 2007, 69 percent said there were no infant deaths in 2008, and 61 percent said there were no infant deaths in 2009. On average, only 3 (23 percent) of the 13 people who responded to this question could recall one infant death in a year.

The low rate of experience with infant mortality may have influenced the response to another question asking people to rank seven MIH problems. Infant mortality was ranked highest by only 3 people. One of the largest AI health programs had the highest number of infant deaths (3 in 2007, 0 in 2008, 3 in 2009), and the survey respondent from that program considered infant mortality to be the most important problem.

Services Provided by AI Health Programs

A list of services related to MIH was presented and survey respondents were asked to indicate whether those services were available to tribal members through their clinic or through a tribal health program (not through CHS referral). The table on the following page shows the percentage of Indian health programs offering the services.

In addition to the programs listed in the question, three respondents said they were providing other programs, including "Reach Out and Read," medical social worker, and referral and linkage to OB-GYN and other specialty providers, as well as diagnosis, treatment and education for sexually transmitted diseases.

Among the 7 who responded that they provide case management for high risk pregnant women, 5 said this is through the Washington State Maternity Support Services (MSS) program, while one said it was not through MSS and one didn't know.

Table 5. Services Currently Provided by Indian Health Programs (n= 16)

Service or Program	Percentage of Indian Health Programs Providing the Service
Lactation consultation	56%
Women's health care (annual exams)	69%
Women's health care nurse practitioner	50%
Public Health Nurse /Community Health Nurse	56%
Pregnancy testing	69%
WIC program	88%
Prenatal care: 1 st and 2 nd trimester	25%
Prenatal care: 3 rd trimester	19%
Family practice MD delivers babies	6%
Midwife delivers babies	0%
OB-BYN delivers babies	13%
Case management for high risk pregnant women	44%
Infant case management	38%
Pediatrician	25%
Pediatric nurse practitioner	0%
Well child clinics and vaccines	63%
Infant car seats for clients	57%
Cribs for clients	19%
Breastfeeding program	50%
Home visits to new parents	50%
Parenting education classes/counseling	31%
New parent support groups	19%
Smoking cessation programs	88%

Access to Care Outside the AI Health Programs

Overall, survey respondents seemed to think that their clients had access to specialty medical care. Among respondents, 93 percent felt women are generally successful getting into OBGYN services, 100 percent said women were delivering their babies in hospitals, 100 percent felt that neonatal and pediatric ICU services were available to their clients, and 81 percent said that their clients could generally get into pediatrician services. Only 71 percent of respondents said that women are generally successful getting into inpatient drug or alcohol treatment services.

Transportation to Services

The survey asked respondents to check statements that describe how their clinic or Tribal health program assists pregnant women and new mothers with transportation to medical services. From the survey, it appears that most women do not get transportation assistance, as shown in the following table.

Table 6. Transportation Assistance from AI Health Programs (n = 16)

Transportation Arrangement	Percent of Programs
CHR or outreach worker provides transportation to appointments with private sector OBGYN.	56%
Medicaid pays for most transportation for pregnant women and infants	31%
Tribe has a contract with transportation broker to provide Medicaid transportation.	13%
CHS or another tribal program provides financial assistance for transportation.	25%
Women in labor are usually transported to hospital for delivery by tribal ambulance.	13%
Women in labor are usually transported to hospital by private vehicle.	69%
Women in labor are usually transported to hospital for delivery by non-tribal ambulance.	0%

One respondent provided this comment: “CHR provided transportation is limited and used as a last resort. Families usually provide transport.” Another respondent commented, “Inadequate CHS funds to provide transportation assistance. CHR only provides transportation in the most acute situations.”

Domestic Violence Policies and Programs

Respondents were asked to check statements that describe how their tribe or clinic handles domestic violence. About a third of the tribes seem to have not addressed this issue, as indicated in the following table which summarizes responses to this question.

Table 7. Domestic Violence Policies and Programs (n=16)

Statement	Percentage Agreeing
We have protocols in our health clinic to ask patients about domestic violence.	63%
Tribal codes are enforced by Tribal Courts.	63%
We treat domestic violence and child abuse in our mental health programs.	63%
There are foster homes with tribal foster parents in our area.	63%
We have tribal codes prohibiting domestic violence.	56%
This is primarily a matter handled by tribal police.	50%
We have violence prevention programs in the schools and/or the community.	38%
This is primarily a matter handled by non-tribal police departments.	25%
We have a shelter for women and children who are victims of domestic violence.	13%
Other	13%

Among those who checked other, one person explained that depending on where the domestic violence occurs determines whether the tribe or the county responds to it. Another respondent said that their tribe has a Domestic Violence Task Force comprised of Tribal Police, Courts, DV Advocates, Clinic staff and others. A third person replied, “We have domestic violence advocates on staff. Advocates help clients develop safety plans, help with court proceedings and protection orders. They do education and outreach.”

Workplace Breastfeeding Policies

Only 10 of the respondents answered questions about workplace breastfeeding policies implemented by their tribe for tribal employees. Some said that the tribe did not have specific policies, but new mothers can bring their infants to work, or go home to breastfeed if they live nearby.

Table 8. Tribal Policies to Encourage Workplace Breastfeeding (n=10)

Workplace Policy at Tribe	Percentage of Tribes
Special room for employees for breastfeeding and/or breast pumping	40%
Breastfeeding employees are given longer break times.	30%
Childcare center for infants on premises where employees work	10%
Employees may bring breastfeeding infants to work with them.	70%

One respondent said that the tribe has an Early Childhood Daycare and Head Start Program that takes infants, presumably providing childcare in the workplace so that mothers can breast feed during their breaks; however, there is a waiting list so not all employees can access this service. Another respondent said that managers are supportive of employees who breastfeed, and there is a Breastfeeding Peer Educator, but there are no policies in place about breastfeeding.

Ranking MIH Issues

When asked to rank 7 issues from most important to least important there was virtually no consensus among the 16 respondents. In the table below, the responses are combined to create two categories: important (=1, 2, 3 ranks) and not so important (= 5, 6, 7 ranks). The only issue that more than half the respondents ranked as important was teen pregnancy.

Table 9. Ranking of Seven MIH Issues by Survey Respondents (n=16)

Issue	Important		Not So Important	
	Number	Percent	Number	Percent
Lack of or very late prenatal care	8	50%	4	25%
Poor nutrition	6	38%	8	50%
Low breastfeeding initiation/duration	8	50%	7	44%
Babies born with disabilities	5	31%	10	63%
Infant mortality	5	31%	7	44%
Infants removed from their home	4	25%	8	50%
Teen pregnancy	12	75%	4	25%

An open ended question asked respondents if there were other MIH issues important to their tribes and 8 respondents (50 percent) cited alcohol and substance abuse. The responses to the open-ended question are significant because they identify a range of issues that are important to tribes. These are listed in the following table.

Table 10. MIH Issues Identified by Survey Respondents (n=16)

Issues Identified by Survey Respondents	Number Responses	
	Subtotal	Total
Substance Abuse		8
Quality of care issues		3
Culturally sensitive staff	1	
High quality prenatal care	1	
Support for mothers during labor (need doulas)	1	
Transportation, transportation funding in rural areas		2
Access to care issues		2
Lack of MDs willing to take DSHS referrals	1	
OB providers not willing to see pts until they have signed up with DSHS - delay in care	1	
Contraception		2
Pregnancy prevention in patients who don't want to be pregnant	1	
Post-pregnancy contraception	1	
Patient education		2
Lack of access or utilization of parenting classes	1	
Provide prenatal education through primary care provider	1	
More breast pumps needed		1
Smoking		1
Mental Health services		1
Sexual abuse		1
Oral health		1

In another question, respondents were given a list of risk factors for maternal and infant health with the instructions, “Given the limitation on resources, please indicate the three risk factors that you think could be changed to make the biggest difference in maternal and infant health outcomes in your Tribe/clients.” This time alcohol and substance abuse ranked the highest with 94 percent of respondents selecting it among the top three choices. Smoking and teen pregnancy tied for second place with 50 percent of respondents selecting those risk factors. And mental health issues were third with 44 percent selecting it. While breastfeeding was considered important by 50 percent of respondents in an earlier question, it was not selected as one of the top three risk factors by any of the respondents in this question. The results of this question are summarized in the following table.

Table 11. *Risk Factors that Could Be Changed*

(to make the biggest different in maternal and infant health outcomes for your tribe/clients – respondents could select only three from list provided)(n=16)

Risk Factor Listed	Percentage of Respondents Selecting as One of Top Three
Alcohol and substance abuse	94%
Smoking	50%
Teen pregnancy	50%
Mental health issues	44%
Baby sleeping arrangements	19%
Lack of child development information and parenting skills	19%
Domestic violence	13%
Poor nutrition	6%
Lack of support/knowledge of breastfeeding	0%
Lack of access to health care	0%

Special Supplemental Program for Women, Infants and Children (WIC)

The survey asked respondents to check any barriers or problems that affect the participation of Indian health clients in WIC. The barrier most frequently noted was lack of transportation. The results for the question are given in the following table.

Table 12. Problems that Affect AI Participation in WIC (n=12)

Barriers/Problems Listed	Percent
Lack of transportation	58%
Personal/family issues with mental health, substance abuse and/or domestic violence	58%
Lack of Information about WIC services	25%
Lack of culturally appropriate providers	8%
Lack of culturally appropriate services	8%
Distrust of local/state government services	8%
Lack of trust with the WIC Program	8%
Lack of access to a grocery store/market that accepts WIC checks or vouchers	0%
Other	42%

Among those who checked “other,” one respondent said she was unaware of any barriers to participation in WIC, noting “our WIC staff person sees clients constantly.” Another person replied that tribal members live in 5 counties, do not get their prenatal services at the tribe, and the tribal offices are not conveniently located to offer that service. An additional barrier listed by one respondent was patients not having telephone service. A fourth comment stated, “Young parents that are not active in getting WIC because they are not caring for their own children.”

In addition to asking about barriers/problems for Native American clients, the survey also asked about barriers/problems with tribal participation as a provider delivering WIC

Services. Several tribes responded that WIC is provided in their facility through an agreement with the South Puget Intertribal Planning Agency (SPIPA). The barrier most often cited by respondents was burdensome billing and reporting requirements. The following table summarizes the response to the question.

Table 13. Problems that Affect the Participation of Tribal Health Programs in Delivering Services (n=6)

Barrier/Problem Listed	Percentage
Burdensome billing and reporting requirements	50%
Eligibility requirements to be a WIC provider	33%
Complex contracting process for amount of funds received	33%
Insufficient funds to meet the needs of clients	33%
Did not know about the program	17%
Other	50%

One respondent said that they had a WIC program, but they were encountering all the problems listed in the question. Another respondent reported that they refer out all WIC-eligible clients. Only one respondent said that they had no problems delivering WIC program to clients, and that was one of programs with a large user population.

Respondents that are managing WIC programs were asked to indicate where they prefer to have their staff receive training. Three options were provided and respondents were asked to rank them. The first choice for 73 percent of respondents was at their clinic or offices. The second choice for 70 percent of respondents was at the office of another WIC provider that is close to the Indian health provider. The least preferred choice for 64 percent of respondents was at Washington State offices in Olympia.

First Steps Program

The survey asked about barriers and problems “your” clients to participate in the First Steps Program. Only 10 people answered the question. Some replied that they didn’t have a First Steps program at their tribe or didn’t know if First Steps was provided at

their clinic. One person stated, “Demographics preclude a successful program.” For those who did answer the question, the most frequent barrier cited was personal and family issues with mental health, substance abuse, and/or domestic violence. The following table provides a summary of responses to the question.

Table 14. Problems that Affect the Participation of Native Americans in the First Steps Program (n=10)

Barriers/ Problems Listed	Percentage
Personal/family issues with mental health, substance abuse, and/or domestic violence	50%
Lack of transportation	30%
Distrust of local/state government services	20%
Lack of easy access to a First Steps retailer	20%
Lack of culturally appropriate providers	10%
Lack of trust in First Steps Program	10%
Lack of information about First Steps services	10%
Lack of culturally appropriate services	0%
Other	30%

One respondent commented that “Infant/Child needs are best met close to where patients live.”

A separate question asked about barriers and problems for tribal health programs to deliver services under the state-funded First Steps program. There was a mistake in the question in which one of the barriers/problems listed was “Eligibility requirements to be a WIC provider” rather than “eligibility requirements to be a First Steps Provider.” While one person checked that problem, it has been deleted from the analysis of responses to the question. The barrier most frequently cited was burdensome billing and reporting requirements. Responses are provided in the following table.

Table 15. Problems that Affect the Participation of Tribal Health Programs in Delivering Services under First Steps Program (n=11)

Barriers/Problems Listed	Percentage
Burdensome billing and reporting requirements	55%
Insufficient funds to meet the needs of clients	36%
Complex contracting process for amount of funds received	27%
Did not know about the program	18%
Other	27%

The people who checked “other” offered the following additional problems:

- Small caseload size.
- Tribal members are scattered over a wide geographic area.
- Complex documentation requirements.
- Services provided do not extend long enough – should be up to the first 3 to 5 years of a child’s life.
- The amount of provider reimbursement keeps going down.
- Clients get contacted by the county First Steps programs and cannot use both.
“They have way more staff to outreach, and we only have one person at our clinic working with clients in First Steps.”

Relationships with County Health Departments and Public Health Jurisdictions

The survey asked respondents to list the names of counties or public health jurisdictions that are adjacent to the tribe or urban area, and then give each a grade for how well they work with the Indian health clinic. A similar question was asked about relationships with counties that are part of the tribe’s Contract Health Service Delivery Area (CHSDA), but not adjacent to the reservation. Most counties were ranked as B, which is defined as acceptable communication and cooperation.

Table 16. Evaluation of Relationships with Adjacent Counties or Public Health Jurisdictions

Grade	Definition	Percentage of Respondents Giving Grade to:	
		1 st County Listed (n=15)	2 nd County Listed (n=10)
A	Ideal working relationship	27%	10%
B	Acceptable communication and cooperation	53%	70%
C	No hostility, but no advantages of relationship	7%	20%
D	Problems with communication and cooperation	13%	0%
F	Hostility, lack of cooperation, lack of understanding of AI issues and culture	0%	0%

Table 17. Evaluation of Relationships with Counties or Public Health Jurisdictions that are Part of Contract Health Service Delivery Area (CHSDA), but Not Adjacent to Tribe

Grade	Definition	Percentage of Respondents Giving Grade to:	
		1 st County Listed (n=6)	2 nd County Listed (n=3)
A	Ideal working relationship	17%	0%
B	Acceptable communication and cooperation	50%	67%
C	No hostility, but no advantages of relationship	17%	33%
D	Problems with communication and cooperation	17%	0%
F	Hostility, lack of cooperation, lack of understanding of AI issues and culture	0%	0%

About a third of AI health programs have had clinic staff participate in county or local health jurisdiction infant or child death review boards. Most respondents said that their clinic staff either had not participated (44 percent) or they didn't know (25 percent).

Other Comments

At the end of the survey, respondents we asked to add their comments regarding anything that they would like the AIHC for Washington State to consider in the development of recommendations on maternal and infant health. One person listed Medicaid spend down on another question. Among the final comments were these:

- “National guidance in detail for children and parents.”
- “Please do not cut funds any further. It is difficult to meet the clients’ needs.”
- “More funding to provide more services to our clients, prenatal classes, parenting classes, education for young teenagers, etc.”

Conclusions from the Survey

- About one-fourth of AI health programs have fewer than 10 pregnant women each year, which makes it difficult to provide staffing for a full-range of services. The design of prenatal services for the 25 percent of tribal programs that are very small must be different from the 25 percent that serve more than 50 pregnant women and infants each year.
- For individual tribes, infant mortality is a rare occurrence. Based on this first-hand experience alone, reducing infant mortality may not seem like a priority for health care. Sharing statistical data showing the disparities in infant mortality may raise awareness that this is a largely preventable problem that requires the attention of tribal leadership.
- The most important issues related to maternal and infant health perceived by survey respondents are alcohol and substance abuse, smoking, teen pregnancy, and mental health.
- Access to care for pregnant women and infants is not perceived as a significant problem, except for alcohol and substance abuse treatment for about a third of respondents.

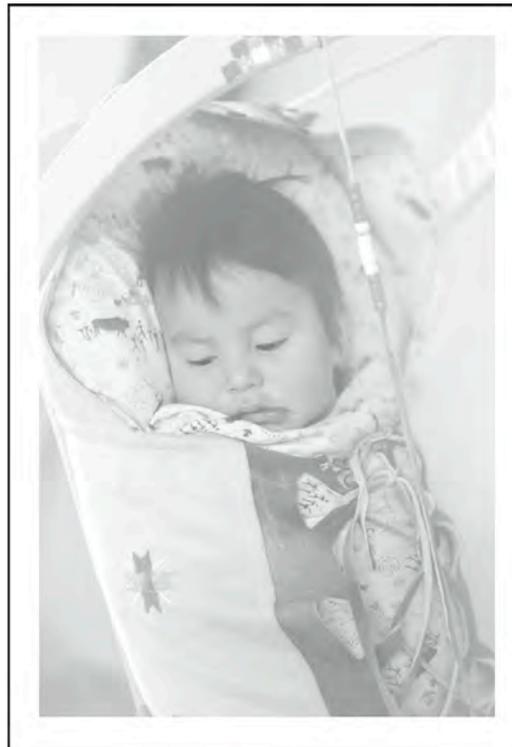
- Mental health, substance abuse, and domestic violence are not only risk factors, but they also keep women from seeking services that might help to address these risk factors, such as WIC making referrals and First Steps providing services.
- Most pregnant women and parents of infants do not obtain transportation assistance to access medical care.
- About a third of tribes seem have not addressed domestic violence.
- Half the AI health programs do not offer breastfeeding programs or home visiting programs. Fewer than 20 percent of the AI health programs are utilizing Bedtime Basics for Babies, a free SIDS risk reduction program.
- Significant problems contributing to low AI participation in WIC and First Steps include lack of transportation and personal/family issues with mental health, substance abuse and/or domestic violence.
- Half of the tribal health programs that do not deliver WIC or First Steps services cite burdensome billing and reporting requirements as a barrier to their participation.
- Most WIC programs would prefer to have the state provide training in their tribal offices.
- Most tribes grade their relationships with county health departments and public health jurisdictions as “B” (acceptable communication and cooperation).

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APPENDIX 3

SUMMARIES OF RECOMMENDATIONS



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MIH Strategic Plan Recommendations

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

Issue 1. Shortage of Registered Dietitians

WIC.1.1. Washington State should work with USDA and the AIHC to develop a telehealth demonstration project that allows RDs to provide distance counseling and monthly in-services in remote tribal areas via low cost computer technology with voice and camera capability.

WIC.1.2. Tribes and Washington State should work with USDA to explore options, such as Competent Professional Authority (CPA) or another type of midlevel practitioner, and compare the effectiveness and cost of culturally appropriate alternatives to provide nutrition counseling in tribal settings.

WIC.1.3. Washington State should provide funding for AIHC to investigate the potential for tribal colleges to provide training for tribal members to become nutritionists, RDs, Competent Professional Authorities, and/or other midlevel nutrition counselors.

WIC.1.4. The Northwest Portland Area Indian Health Board (NPAIHB) should coordinate an advocacy committee to work with the State Dietetic Association, WIC and universities utilizing various advocacy avenues to increase the number of Registered Dietitians in Washington State by increasing the number of internships, reducing the costs of internships, and adapting internships to meet the needs of tribes.

Issue 2. Indirect Cost Rates

WIC.2.1. Tribes should receive the federally-approved indirect costs in addition to the direct program costs for WIC.

WIC.2.2. Tribes should explore self-governance compacting with USDA as an alternative for funding WIC programs to include indirect cost rates.

Issue 3. Direct Cost Rates

WIC.3.1. Raise the amount that WIC pays tribes to operate the tribal and urban Indian programs, either by raising the amount paid per participant per year, or paying actual costs to staff a program according to WIC requirements.

WIC.3.2. Lower the cost of providing WIC programs in tribal areas by reducing the requirements (see recommendations for RD staffing, accounting, and training), or re-designing the program to be more appropriate for tribal settings.

Issue 4. Accounting

WIC.4.1. The accountability to WIC should relate to tribes meeting program requirements and there should not be the level of financial accounting requirements and oversight that currently exists.

WIC.4.2. Tribes and urban Indian programs should be able to combine funding from Maternity Support Services (MSS), IHS Diabetes Grants, WIC and other sources to pay for recruitment, salary and benefits for RDs without requiring billing for specific services or accounting for specific services.

Issue 5. Training for WIC Program Coordinators for Tribes

WIC.5.1. WIC should develop some training materials that are available on-line to reduce the costs of travel and make training available at any time for new employees.

WIC. 5.2. State WIC employees should travel to tribes to deliver training, thus reducing the cost of training to tribes and allowing state employees to better understand the circumstances in which tribes are operating WIC programs.

WIC.5.3. WIC should work with AIHC to develop mechanisms to involve tribes in training and mentoring other tribes.

Issue 6. Culturally Appropriate Outreach Materials for American Indians

WIC.6.1. Washington State should provide funding for AIHC to hire a photographer and graphic artist to develop materials that are culturally appropriate for use by tribal and urban Indian WIC programs.

Issue 7. WIC Data

WIC.7.1. Washington State should fund AIHC to convene an ad hoc workgroup to review the WIC data and advise the state about a format for reporting data and mechanism for distributing those reports.

WIC.7.2. A WIC data specialist should participate in an interagency tribal health data team.

Issue 8. USDA Tribal Consultation on WIC Programs

WIC.8.1. Washington State should fund AIHC to provide tribal participation in tribal consultation with USDA on a national level.

WIC.8.2. If the recommendations in this plan regarding WIC meet resistance from USDA, then Washington State should provide funding through AIHC for the chair

of AIHC and a technical support person representing tribes to accompany a state official responsible for WIC programs to Washington, DC, to meet with USDA officials to discuss a process for resolving problems.

WIC.8.3. AIHC should meet with tribal leaders to explore the need for a Tribal Technical Advisory Committee for the WIC program at USDA and seek partners at the regional and national levels for this effort, such as the Northwest Portland Area Indian Health Board (NAIHB), the National Indian Health Board (NIHB), National Congress of American Indians (NCAI), and the National Indian Women's Health Resource Center (NIWHRC).

Issue 9. Implementation of WIC Recommendations

WIC.9.1. The State of Washington should provide funding to the AIHC to hire a project coordinator and for travel and support for two years to coordinate with tribes and urban Indian health programs, as well as regional and national tribal organizations, to implement the 19 recommendations for WIC in this strategic plan and participate in the tribal breastfeeding coalitions.

First Steps Maternity Support Services Program (FS)

Issue 1. MSS payment for services to tribes and the IHS is too low and billing procedures are not consistent with other Medicaid services.

FS.1.1. The State of Washington DSHS should work with tribes and CMS to consider what steps could be taken to change the reimbursement rate for MSS for tribes and the IHS from FFS to the federally-approved encounter rate in the context of federal health care reform.

Issue 2. Program requirements for MSS are too complicated and not culturally appropriate.

FS.2.1. DSHS should initiate a new effort to recruit tribes as MSS providers and provide outreach to tribes about how the enrollment process has been changed and simplified.

FS.2.2. Tribes and tribal organizations should invite DSHS representatives to their facilities to present the MSS program and provide training about how to bill for services provided.

FS.2.3. The State of Washington should create a small grant program through AIHC that can be used to fund incentives for women to participate in First Steps, including such things as culturally-relevant craft projects, equipment for babies, food for meetings, and 231 contracts with people to provide special programs.

Issue 3. Staffing to meet MSS program requirements can be a problem for tribes.

FS.3.1. The State of Washington should work with the tribes, the Indian Health Service, Bates Technical College in Tacoma, and tribal community colleges to develop mechanisms to recruit and train tribal members to become Childbirth Educators (CBE). MSS should pay for services provided by people with this certification.

FS.3.2. Staffing requirements for the MSS program should be reviewed and revised by DSHS in consultation with tribes to create greater flexibility for staffing programs and payment for services

FS.3.3. The potential role and benefits of telehealth in the delivery of MSS services should be explored by DSHS through tribal demonstration projects.

Resources for Tribes to Expand and Improve MIH Services (R)

Issue 1. Resources to Implement the MIH Strategic Plan

R.1.1. The State of Washington should provide planning and community organizing grants for tribes that would allow them to review this MIH Strategic Plan and use community organization processes (coordinating committees, community meetings, focus groups, tribal resolutions, etc.) to select 2 objectives and/or 2-3 strategies that meet at least one objective to include in a proposal for an implementation grant. Technical support should be available to tribes during this process.

R.1.2. The State of Washington should provide implementation grants to tribes that have completed the planning and community organization phase of the project and identified programs to carry out the strategies that they have selected as their focus for MIH improvements.

R.1.3. With funding from the State of Washington, the AIHC should create a forum for tribes to share their experiences in developing and implementing programs to carry out the objectives and strategies in this MIH Strategic Plan.

Issue 2. Responding to New Initiatives in the Patient Protection and Affordable Care Act of 2010

R.2.1. Washington State should fund AIHC to assist State agencies responding to health care reform initiatives that involve new funding or new programs to include

tribes and urban Indian health programs in planning and implementing the state response to the initiatives, particularly if the funding is intended to reduce health disparities and data about AI/AN are used to justify funding requests.

Access to Care and Coordination of Services (AC)

Issue 1. Medical Home and Obstetrical Care

AC.1.1. The State of Washington should work with tribes and Medicaid providers to develop 1-3 demonstration projects for tribal clinics to serve as medical homes while assuring that pregnant women receive high quality obstetrical care.

Issue 2. Services in Rural Areas

AC.2.1. The Seattle Indian Health Board model to train residents should be expanded to include rural tribal areas and to include other disciplines related to MIH.

AC.2.2. To increase the number of obstetricians available to serve tribal members, tribes should work with the State of Washington to leverage the Federal Tort Claims Act to provide malpractice coverage for obstetricians.

Smoking Prevention and Cessation (SM)

SM.1.1. The State of Washington should review its policies to assure that the Washington Tobacco Quit Line offers culturally competent counselors, culturally appropriate materials to serve Native Americans, and consistent culturally appropriate messages across systems that refer and serve Native Americans.

SM.1.2. The State of Washington should review its policies regarding television advertising for the Washington Tobacco Quit Line to assure that it reaches markets where tribes are located.

SM.1.3. The State of Washington should monitor data regarding Native American utilization of the Tobacco Quit Line and smoking data from WIC, particularly for pregnant AI women, and set specific goals and strategies for improvement.

SM.1.4. The AIHC Smoking Prevention and Cessation Workgroup will make additional recommendations that should be adopted.

SM.1.5. Tribes and urban Indian clinics should prioritize pregnant women for smoking cessation activities as a way to reduce LBW, SIDS and overall infant mortality.

Sudden Infant Death Syndrome Risk Reduction (SIDS)

SIDS.1.1. Tribes and urban Indian clinics should be encouraged to enroll pregnant women in the Bedtime Basics for Babies Program.

SIDS.1.2. Washington State should provide grant funding to Native American Women's Dialogue on Infant Mortality (NAWDIM) to enable them to expand the Cradleboard Project to tribes statewide and for evaluation of the program to learn if it is an effective educational tool for SIDS risk reduction.

SIDS.1.3. The proposed American Indian Maternal and Infant Health Data Coordinating Council for Washington State should take action to improve SIDS data collection regarding American Indians.

Injury Prevention (IP)

IP.1.1. Programs should be established to assure that every infant leaves the hospital in a car seat and that parents know the proper way to secure the car seat and the infant in it.

IP1.2. Tribal fire departments or other employees should be trained in car seat installation and parents should be told that they can check to see that their car seats are properly installed.

IP.1.3. Tribes should pass and enforce tribal codes to require seatbelt use on tribal lands.

Preconception and Prenatal Counseling for Healthy Lifestyles (PPC)

PPC.1.1. Health care providers should include preconception counseling in annual exams for young women, to include information about stopping smoking, achieving a healthy weight, and taking folic acid prior to becoming pregnant.

PCC.1.2. Washington State Department of Health should develop provider guidelines for preconception counseling similar to the resources for providers that they have developed for domestic violence, smoking, and substance abuse during pregnancy.

PPC.1.3. All pregnant American Indian women should be screened for gestational diabetes; and if they have diabetes, they should be counseled by a culturally competent Certified Diabetes Educator with pregnancy training during and after their pregnancy.

Support for Breastfeeding (BF)

Issue 1. Building Coalitions to Support Breastfeeding in Tribal Communities

BF.1.1. Washington State should provide funding to the AIHC for a position to help initiate and coordinate breastfeeding coalitions within tribes in association with other statewide programs, such as the Breastfeeding Coalition of Washington (a program of WithinReach).

BF.1.2. Community education messages and programs to encourage breastfeeding should include fathers and other family members.

Issue 2. Parent Education for Breastfeeding

BF.2.1. Childbirth education programs offered through tribes and urban Indian clinics should include information about the benefits of breastfeeding and practical information about how to breastfeed.

BF.2.2. Tribes and urban Indian clinics should be encouraged to adopt policies that eliminate all logos and advertising for infant formula from the clinics, including posters, educational materials, prescription pads, and promotional materials.

BF.2.3. Physicians providing obstetric care and other providers during prenatal care should include discussions of breastfeeding, including teen mothers.

Issue 3. Hospital practices to encourage breastfeeding

BF.3.1. Washington State should reward hospitals for Baby Friendly Hospital Initiative accreditation.

BF.3.2. Washington State Medicaid programs should require hospitals to implement the “Can Do 5” measures for encouraging breastfeeding.

BF.3.3. Washington State should encourage hospitals to coordinate with tribes to provide cultural competency training for labor and delivery staff, tell AI mothers about tribal resources to assist with breastfeeding after discharge, and develop innovative programs for tribal and IHS community health nurses, childbirth educators, and breastfeeding peer support counselors to visit new mothers in the hospital to develop relationships and provide support that is extended into the home after mothers are discharged from the hospital.

Issue 4. Peer Counseling and Community Support for Breastfeeding

BF.4.1. Training should be provided for at least 3 employees of each tribal health department to become peer breastfeeding counselors, utilizing resources provide by the WIC Loving Support Program and other funds.

BF.4.2. The WIC program should offer a variety of breast pumps so that the needs of American Indian and Alaska Native women can be matched to the pump that will likely result in breastfeeding for a longer period of time.

BF.4.3. Small grants should be available to tribes to sponsor craft programs and other incentives for new mothers for programs that provide support for breastfeeding.

BF.4.4. AIHC and the State WIC Program should collaborate with state Medicaid and insurance commissioners to ensure lactation support is included in standard, reimbursable perinatal care services for tribes and urban Indian programs.

BF.4.5. Fund the establishment of sustainable, financially supported, walk-in breastfeeding clinics available to all new mothers in tribal communities staffed by IBCLCs who are reimbursed for all services provided.

BF.4.6. Fund a program in which IBCLCs provide breastfeeding support to pregnant American Indian and Alaska Native adolescents as part of their parenting education at local schools.

BF.4.7. AIHC should develop and disseminate a tribal resource directory of culturally appropriate lactation support services locally available to new mothers, in coordination with WithinReach.

BF.4.8. WIC Loving Support Breastfeeding funding should be used to integrate lactation support services with home visitation programs at tribes to ensure that lactation problems are identified early and that mothers are referred for appropriate help and services.

Issue 5. Work Place Breastfeeding Support

BF.5.1. Tribal breastfeeding coalitions should work with Tribal Councils to pass tribal codes that require tribes to create supportive environments for breastfeeding employees.

Involving Youth (Y)

Issue 1. Elevate the focus on American Indian youth in addressing MIH issues.

Y.1.1. The State of Washington should establish an American Indian Youth Advisory Panel with youth representation from tribes and urban areas, and participation by high level administrators in state government agencies that provide health and education services.

Issue 2. Involve AI youth statewide in designing interventions to reduce risk factors that lead to poor maternal and infant health.

Y.2.1. Washington State should provide funding to the AIHC to hire a Youth Services Coordinator to work with DOH, tribes, and urban Indian programs to develop and implement a program to involve youth in considering strategies for improving maternal and infant health within their tribes and urban Indian communities.

Issue 3. Work with schools and educators to incorporate MIH risk reduction as part of curriculum and other student activities.

Y.3.1. A cooperative effort between the AIHC, the Washington Office of Superintendent of Public Instruction and Department of Health should be established to work with teachers in tribal areas to integrate MIH information into educational curriculum and school activities.

Y.3.2. Sponsors should be recruited to create annual essay contests, poster contests and/or video contests with prizes for children at different ages around subjects related to MIH.

Issue 4. Enlist youth to speak to their peers and younger children about MIH risk reduction issues.

Y.4.1. The State of Washington should provide grant funding to an established organization that is in many tribal and urban communities to develop a youth speakers bureau and train youth speakers to talk about subjects related to MIH in an informative and non-judgmental way.

Issue 5. Use Internet and Social Networking Technology to Reach Youth

Y.5.1. Assess the opportunity and needs for providing information to American Indian teenagers in Washington State about maternal and infant health via the internet and social networking technology.

Access to Behavioral Health Services (BH)

BH.1.1. The State of Washington should provide planning grants to tribes to prepare proposals for Indian Health Service behavioral health grant funding for innovative community-based behavioral health services, as well as grants to Indian health programs to develop and implement comprehensive behavioral health programs that specifically address the cultural, historical, and social and child care needs of Indian women.

BH.1.2. The State of Washington should provide technical assistance to tribes, including epidemiological data, to assist in the preparation of grant applications for behavioral health services.

BH.1.3. AIHC and the State of Washington should co-sponsor a forum for tribes to learn more about behavioral health planning and funding opportunities under the Reauthorization of the Indian Health Care Improvement Act.

BH.1.4. Tribes and urban Indian clinics should develop protocols for screening and treatment of prenatal and postpartum depression.

Research and Data Analysis (RDA)

Issue 1. Infant Death Reviews

RDA.1.1. The AIHC and the State of Washington Department of Health should work together to develop legislation to create the necessary legal authority and protections for a statewide AI/AN Infant Death Review process.

RDA.1.2. The AI Infant Death Review process should also consider reviewing maternal deaths and near miss maternal mortality.

Issue 2. Research on Disparities in Birth Defects in Eastern Washington

RDA.2.1. State of Washington should fund a research team that includes genetics, anthropology, medical and dental researchers working with an advisory group representing tribes in Eastern Washington to review existing data and research, and learn more about the disparity in birth defects and to suggest strategies to reduce those birth defects and improve infant mortality rates, including access to genetic testing for families with a history of cleft lip and cleft palate.

Issue 3. Data Coordination, Analysis, and Use for Monitoring Progress Toward Goals

RDA.3.1. The State of Washington should establish an American Indian Maternal and Infant Health Data Coordinating Council that includes epidemiologists and

others maintaining and analyzing MIH databases in various agencies of state government, as well as representation selected by the American Indian Health Commission of Washington State from tribes, the Seattle Indian Health Board and Urban Indian Health Institute, and the Northwest Portland Area Indian Health Board.

RDA.3.2. The State of Washington should institutionalize reporting of AI/AN immunization data, including pneumococcal and influenza vaccines for infants.

Issue 4. National Children's Study

RDA.4.1. The Pacific Northwest Center for the National Children's Study at the University of Washington should consult with tribes in Washington State about the study and enlist their support in recruiting participants.

Estimated Cost for Implementing Recommendations

Costs in the following spreadsheet are estimates based on assumptions and incomplete information. Changes to the assumptions used in estimating costs, as well as unknowns, could significantly change these estimates.

The following guidelines were used in preparing the cost estimates:

- **Dollar amounts** in the budget spreadsheet are funds that would have to be provided or reallocated in order to implement the recommendation. In many cases, funds are already available for a staff position that could be assigned to carry out tasks needed to implement a recommendation, so those costs would not be included in the spreadsheet numbers. In other words, this is not the total cost to the state, but rather the additional funding needed.
- A **one (1)** in the budget means that the costs of implementing the recommendation are already included in another line in the spreadsheet. In other words, this recommendation could not be implemented without the funding that has been identified in a separate line.
- A **zero (0)** in the spreadsheet means that there are no additional costs for the recommendation and/or that existing staffing and programming can provide the support needed to carry out the recommendation.
- A **blank** in the spreadsheet means that it is not possible to provide a cost estimate at the present time. In some cases, a planning phase is needed before estimates can be prepared for implementation.
- The **last column** in the spreadsheet provides page numbers in the MIH Strategic Plan where the issues and recommendations are summarized. Additional information about the issues may be found in the section of the MIH Strategic Plan called, "Research Findings on Outcomes and Risk Factors," pages 15 through 41.

Figure 3. Estimated Costs to Implement Recommendations in MIH Strategic Plan

Topic	Issue	Rec#	Recommendation	Funding from State of WA			
				YR 1	YR 2	On-Going	Pg. #
A. AIHC PROGRAM COORDINATION AND ADVOCACY							
<i>1. MIH Improvement Grants to Tribes (1FTE plus program costs)</i>				\$150,000	\$150,000	\$150,000	142
R	1	1	Planning and community organizing grants to select objectives/strategies (8/yr@ \$30,000)	240,000	240,000	0	115
R	1	2	Implementation grants to carry out strategies for MIH improvements (8/yr @ \$50,000)	0	400,000	1,550,000	115
R	1	3	State funding to AIHC for forum for tribes to share experiences implementing.	0	5,000	\$5,000	115
Subtotal				\$390,000	\$795,000	\$1,705,000	
<i>2. Health Care Reform Implementation- Advising and Coordinating Tribal Input (40% of HCR costs)</i>				\$146,000	\$146,000	\$146,000	143
R	2	1	State response to health care reform initiatives should include tribes, urban AI clinics.	1	1	1	116
Subtotal				\$146,001	\$146,001	\$146,001	
<i>3. Youth Involvement in Improving MIH (1 FTE plus program costs)</i>							143
Y	2	1	State funding to AIHC to hire Youth Service Coordinator to develop, implement.	\$144,000	\$144,000	\$144,000	127
Y	3	1	Integrate MIH information into educational curriculum and school activities.	1	1	1	128
Y	3	2	Recruit sponsors for activities that engage youth in sharing MIH information.	1	1	1	128
Y	5	1	Assess opportunity/needs for MIH information on internet and social networking.	1	1	1	129
Subtotal				\$144,003	\$144,003	\$144,003	
<i>4. Breastfeeding Promotion and Policy Development within Tribes (.5 FTE plus program costs)</i>				\$58,000	\$58,000	\$58,000	144
BF	1	1	State to fund AIHC to initiate, coordinate tribal breastfeeding coalitions.	1	1	1	122
BF	3	3	Hospitals should coordinate with tribes for training, referrals, peer support.	1	1	1	124
BF	4	7	AIHC develop, disseminate tribal resource directory for lactation support services.	1	1	1	124
BF	4	3	Small grants to tribes/urban clinics for incentives for BF support programs (31 @ \$3,500)	\$108,500	\$108,500	\$108,500	124
BF	1	2	Community education messages and programs to include fathers and others.	\$40,000	\$20,000	\$10,000	122
Subtotal				\$206,503	\$186,503	\$176,503	

AC=Access to Care, BH=Behavioral Health, BF=Breastfeeding, FS=First Steps, IP=Injury Prevention, PCC=Pre-Conception Counseling, R=Resources, RDA=Research & Data Analysis, SM=Smoking, Y=Youth

Figure 3. Estimated Costs to Implement Recommendations in MIH Strategic Plan

Topic	Issue	Rec#	Recommendation	Funding from State of WA			
				YR 1	YR 2	On-Going	Pg. #
A. AIHC PROGRAM COORDINATION AND ADVOCACY -continued							
<i>5. Tribal Liaison for WIC Program and Policy Development (.5 FTE plus program costs)</i>							145
WIC	9	1	State funding for project coordinator for AIHC to implement WIC recommendations.	\$58,000	\$58,000	\$58,000	108
WIC	8	1	State should fund AIHC for tribal consultation with USDA	\$10,000	\$10,000	\$10,000	108
WIC	8	2	State, AIHC chair travel to Washington, DC, & meet with USDA to resolve problems.	\$10,000	\$10,000		108
WIC	1	3	Investigate potential tribal college training for RDs and/or midlevel nutritionists	1	1	1	101
WIC	6	1	State should fund AIHC to develop culturally appropriate WIC materials.	\$40,000			107
WIC	7	1	State should fund AIHC to convene workgroup on WIC data	1	1	1	107
			Subtotal	\$118,002	\$78,002	\$68,002	
B. STATE OF WASHINGTON POLICY AND PROGRAM RECOMMENDATIONS							
<i>1. New Resources to Improve Health Services</i>							146
R	2	1	State response to fed health care reform initiatives to include tribes, urban clinics.	1	1	1	116
BH	1	1	State planning grants to tribes for proposals to IHS (\$10,000x31)	\$310,000			130
BH	1	2	State technical assistance to tribes for grant applications for behavioral health.	0	0	0	130
BH	1	3	State and AIHC sponsor forum for tribes on behavioral health planning, funding.	\$10,000	\$10,000	\$10,000	130
			Subtotal	\$320,000	\$10,000	\$10,000	
<i>2. Low Cost Programs that Can Be Implemented Quickly</i>							146
SIDS	1	2	State should fund NAWDIM for Cradleboard Project for tribes, and evaluation	\$120,000	120,000	120,000	120
PPC	1	2	State to develop provider guidelines for preconception counseling	\$11,215	1,400	1,400	121
Y	1	1	American Indian Youth Advisory Panel on MIH	52,400	52,400	52,400	126
Y	4	1	State grant funding for youth speaker's bureau	150,000	25,000	25,000	129
			Subtotal	\$333,615	\$198,800	\$198,800	

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Figure 3. Estimated Costs to Implement Recommendations in MIH Strategic Plan

Topic	Issue	Rec#	Recommendation	Funding from State of WA			Pg. #
				YR 1	YR 2	On-Going	
B. STATE OF WASHINGTON POLICY AND PROGRAM RECOMMENDATIONS - continued							
<i>3. Implementing WIC Recommendations at State Level</i>							147
WIC	5	2	State employees travel to tribes to deliver WIC training	\$114,000	\$114,000	\$114,000	106
WIC	5	3	Involve tribes in training and mentoring other tribes.	\$77,000	\$13,000	\$13,000	106
BF	4	1	WIC funds to train at least 3 tribal employees as peer bf counselors at each tribe.	0	0	0	124
BF	4	2	WIC should provide a variety of breast pumps.	0	0	0	124
BF	4	8	Integrate WIC funding with home visitation programs for lactation support services.	0	0	0	124
WIC	5	1	WIC training on-line	0	0	0	106
WIC	2	1	Federally-approved indirect costs for tribal WIC programs	500,000	500,000	500,000	104
WIC	3	1	Increase WIC payments to tribes for direct costs				104
WIC	1	1	Telehealth demonstration for RD counseling and monthly in-service	80,000			101
			Subtotal	\$771,000	\$627,000	\$627,000	
<i>4. Change State Policies and Programs to Encourage Breastfeeding</i>							147
BF	3	1	State should reward hospitals for BFHI accreditation.	\$100,000	\$100,000	\$100,000	124
BF	3	2	State should require hospitals to implement "Can Do 5" measures.	\$10,000	\$10,000	\$10,000	124
BF	4	4	State should ensure lactation support is reimbursable by insurance, Medicaid.	0	0	0	124
			Subtotal	\$110,000	\$110,000	\$110,000	
<i>5. Increase Tribal Participation as First Steps Providers (reduce state funding for MSS)</i>							147
FS	2	1	DSHS should recruit tribes as MSS Providers.	116,000	116,000	116,000	111
FS	2	2	Tribes should invite DSHS to their facilities to provide training on billing for MSS.	100,000	94,000	94,000	111
FS	2	3	State should create small grant program through AIHC for incentives for First Steps.	50,000	50,000	50,000	111
FS	3	2	MSS staffing requirement should be reviewed to be more flexible.	1	1	1	112
FS	3	3	Demonstration project to explore telehealth in delivery of MSS services.				112
FS	3	1	Increase AI with CBE training and pay for their services through MSS.				112
			Subtotal	\$(325,072)	\$(331,072)	\$(331,072)	

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Figure 3. Estimated Costs to Implement Recommendations in MIH Strategic Plan

Topic	Issue	Rec#	Recommendation	Funding from State of WA			
				YR 1	YR 2	On-Going	Pg. #
B. STATE OF WASHINGTON POLICY AND PROGRAM RECOMMENDATIONS - continued							
<i>6. Research and Data Analysis</i>							148
RDA	1	1	Statewide AI Infant Death Review process.	8700			132
RDA	1	2	Consider reviewing maternal deaths and near miss maternal mortality.	0	0	0	132
RDA	2	1	State funding for birth defects disparity research among Eastern WA tribes.	\$50,000	\$50,000	0	135
RDA	3	1	State should establish AI/AN MIH Data Coordinating Council	0	0	0	136
WIC	7	2	State WIC data specialist should participate in interagency tribal health data team.	0	0	0	107
RDA	3	2	State should report AI infant immunization, including pneumococcal and influenza.	0	0	0	136
SIDS	1	3	Improve SIDS data collection	1	1	1	120
			Subtotal	\$58,701	\$50,001		
<i>7. Review Policies and Practices for WA State Tobacco Quit Line.</i>							148
SM	1	1	Culturally competent counselors, materials, messages for Tobacco Quit Line.				119
SM	1	2	TV advertising for Tobacco Quit Line in tribal areas.				119
SM	1	3	Monitor data for AI/AN use of Tobacco Quit Line, set goals and strategies.				119
SM	1	4	Implement additional recommendations from AIHC Workinggroup re smoking				119
			Subtotal				
<i>8. Long Range, System Changes to Improve MIH - Planning Process</i>				\$25,680	\$8,060		149
A	1	1	Demonstration projects for tribes to serve as medical homes for OB care.	1	1		117
A	2	1	Expand SIHB residency training model to rural tribal areas and MIH disciplines	1	1		118
A	2	2	Leverage FTCA to increase number of OB practitioners in rural tribal areas	1	1		118
FS	1	1	Consider changing MSS reimbursement from FFS to encounter rate for tribes.	1	1		110
			Subtotal	\$25,684	\$8,064		

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Figure 3. Estimated Costs to Implement Recommendations in MIH Strategic Plan

Topic	Issue	Rec#	Recommendation	Funding from State of WA			Pg. #
				YR 1	YR 2	On-Going	
C. ACTIONS TRIBES CAN TAKE TO IMPROVE MATERNAL AND INFANT HEALTH							
<i>1. Support Breastfeeding</i>							
BF	5	1	Tribal codes to create workplace support for breastfeeding.	1	1	1	126
BF	2	1	Childbirth education programs to include breastfeeding	0	0	0	123
BF	2	2	Clinic policies to eliminate logos and advertising for infant formula	0	0	0	123
BF	2	3	Prenatal care providers should discuss breastfeeding, including teen mothers.	0	0	0	123
BF	4	5	Walk-in breastfeeding clinics in tribal communities.	1	1	1	124
BF	4	6	IBCLC breastfeeding support to pregnant AI/AN teens with parenting ed in schools	1	1	1	124
<i>2. Focus Existing Tribal Services to Improve MIH</i>							
PPC	1	1	Annual exams for young women to include preconception counseling.	1	1	1	121
BH	1	4	Tribal protocols for screening and treatment of prenatal & postpartum depression.	1	1	1	130
PPC	1	3	Screen all pregnant women for gestational diabetes and provide counseling.				121
SM	1	5	Tribes should prioritize pregnant women for smoking cessation activities.	0	0	0	119
SIDS	1	1	Tribes, urban Indian clinics should enroll women in Bedtime Basics for Babies	1	1	1	120
IP	1	1	Car seats for all infants leaving hospital and parent training to use them.				121
IP	1	2	Tribal fire departments or others trained for car seat installation.				121
IP	1	3	Pass and enforce tribal codes to require seatbelt use on tribal lands.	0	0	0	121

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Figure 3. Estimated Costs to Implement Recommendations in MIH Strategic Plan

Topic	Issue	Rec#	Recommendation	Funding from State of WA			
				YR 1	YR 2	On-Going	Pg #
C. ACTIONS TRIBES CAN TAKE TO IMPROVE MATERNAL AND INFANT HEALTH-continued							
<i>3. Advocate for a Tribal Technical Advisory Group (TTAG) for WIC Nationally</i>							151
WIC	8	3	Explore Tribal Technical Advisory Committee for WIC at USDA nationally.				108
WIC	1	2	Explore midlevels for nutrition counseling				101
WIC	2	1	Federally-approved indirect costs for tribal WIC programs				104
WIC	2	2	Explore self-governance compacting with USDA for WIC programs				104
WIC	3	2	Reduce requirements for WIC and/or re-design for tribal settings				104
WIC	4	1	Change financial accounting and reporting for tribes operating WIC programs				105
WIC	4	2	Combine funding sources to hire RDs and simplify payment processes.				105
WIC	5	1	WIC training on-line				106
WIC	3	1	Increase WIC payments to tribes for direct costs				104
WIC	1	1	Telehealth demonstration for RD counseling and monthly in-service				101
<i>4. Engage with Universities to Increase Training and Research to Improve MIH</i>							151
RDA	4	1	Tribal participation in National Children's Study				137
WIC	1	4	NPAIHB coordinate effort to make RD internships more responsive to tribal needs				101
TOTAL ESTIMATED COST TO IMPLEMENT ALL RECOMMENDATIONS				\$2,298,437	\$2,022,302	\$2,854,238	

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APPENDIX 4

CONTRIBUTORS TO THE PLAN



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printing purposes

Acknowledgements

The American Indian Health Commission for Washington State would like to thank the Maternal and Infant Health Workgroup which provided guidance and oversight for this MIH Strategic Plan, reviewing countless drafts and participating in frequent teleconferences and meetings. Funding and other support from the Washington State Department of Health was essential for the development of this MIH Strategic Plan.

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The MIH Workgroup provided oversight for this project, reviewed draft reports, and provided helpful information. They include:

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Project Team

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Sheryl Lowe (Jamestown S'Klallam) is the Executive Director of the American Indian Health Commission for Washington State. She worked for her own Tribe for 15 years in the areas of self-governance, administration, planning and special projects before transitioning into the aging and long-term care field, where she served as a Planning Director and Tribal Liaison in developing a comprehensive, long-term care service delivery system for older adults and adults with disabilities in a 4-county region. Sheryl also served as the Executive Director of the Community Partnerships for Rural Elders organization, charged with fundamentally changing aging and long-term care service systems across health and human service care. One of 15 individuals in the nation selected, Ms. Lowe completed a National Rural Health fellowship in 2007, where personal leadership, health policy and advocacy, and non-profit organizational development training was provided. Her higher education is in Business/Public Administration, with a focus both in her undergraduate and graduate programs on Indian Policy, Governance, and American Indian Studies.

Mim Dixon

Mim Dixon has worked with tribes as a policy analyst, researcher, facilitator, planner and health care administrator. She lived in Alaska for more than 20 years where she administered a tribally-operated health clinic that served Fairbanks and 42 villages in Interior Alaska. After moving to Colorado in 1993, she worked for the National Indian Health Board as a policy analyst and researcher, travelling throughout the United States listening to issues important to tribes. She also served as health director for the Cherokee Nation in Oklahoma. She is the author and/or editor of four books and numerous articles, studies and reports. She earned her BA in economics from Washington University (St. Louis, MO) and her MA and Ph.D. in anthropology from Northwestern University (Evanston, IL). She currently lives in Albuquerque, NM.

Lorie Wayne Chesnut

Lorie Wayne Chesnut has worked in the field of maternal and child health (MCH) epidemiology for over 15 years, initially for the Kentucky March of Dimes Birth Defects Foundation and later for the Kentucky Department for Public Health. She has been working to improve federal and state systems of care for American Indian and Alaskan Native women, infants, and children through enhanced system integration and expanded resources for both tribal and state governments. Her research interests include the history of maternal and child health care for American Indians/Alaskan Natives and the First Nations of Canada. She has been evaluating CenteringPregnancy and the effectiveness of midwives. Ms. Chesnut received her MPH from the University of Kentucky and is currently completing her doctorate in public health at the University of Alabama at Birmingham.

Bridjette P. March

Bridjette March (Athabascan G'wichin) was born and raised in Anchorage, Alaska. She graduated from the University of Oregon with a BA in psychology, and enrolled in graduate studies in anthropology at the University of Alaska Fairbanks. In 2005, she earned a Master's of Criminal Justice from Boston University. She has worked with youth as a counselor with the State of Alaska Boarding Home Program, a volunteer with the Guardian Ad Litem Program in Washington State, a board member of the Alaska Children's Service, and a substitute teacher in elementary and junior high schools. Her research and consulting interests include domestic violence, parenting issues, sexual assault and dating violence. She currently lives in Mukilteo, Washington.

Roger Fernandes

Roger Fernandes (Lower Elwah S'Klallam Tribe) is a storyteller and artist, who created the cover artwork for the MIH Strategic Plan. His work focuses on the culture and arts of the Coast Salish tribes of western Washington. He studied art at the University of Washington and has a degree in Native American Studies from the Evergreen State College. He has produced a variety of Salish art including paintings, prints, and graphic designs used in posters, cards, and books. He has also designed and worked on petroglyphic art and cedar carving projects. In addition he has taught Coast Salish design courses through the Evergreen State College and Northwest Indian College.

Maisie MacKinnon

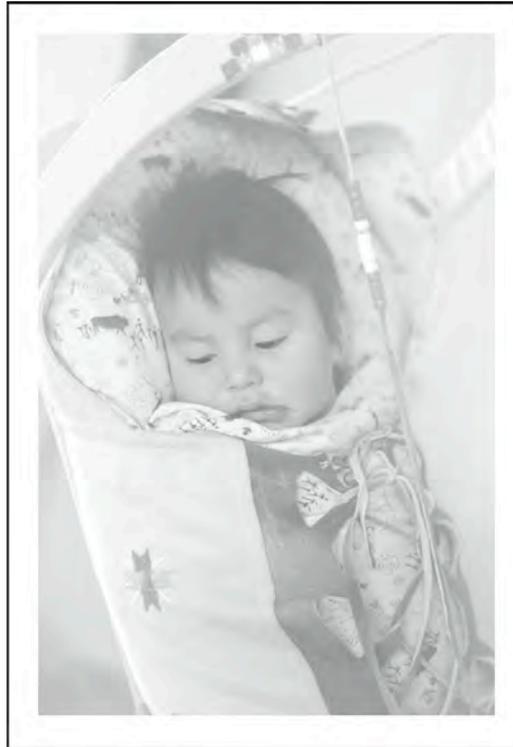
Maisie MacKinnon's 30 years as a journalist, photographer and graphic designer began with mainstream weekly and daily newspapers, and led to managing the Northwest Bureau of *Indian Country Today*. She also served as communications officer at South Puget Intertribal Planning Agency. Currently she works on social/health marketing efforts for numerous Native health programs including the National Indian Women's Health Resource Center, Northwest Portland Area Indian Health Board, the Association of American Indian Physicians, and others. Her award-recognized work includes writing and designing culturally relevant health brochures, booklets, posters, presentations, magazines and training manuals for print and the web. She owns her own business, Cultural Communications, in Oregon.

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APPENDIX 5

LIST OF ABBREVIATIONS



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Abbreviations

ACOG	American Congress of Obstetricians and Gynecologists
ADA	American Dietetic Association
AHRQ	Agency for Healthcare Quality and Research
AI	American Indian
AI/AN	American Indian and Alaska Native
AIHC	American Indian Health Commission for Washington State
ANA	Administration for Native Americans
AOD	Alcohol and other drugs
BFHI	Baby Friendly Hospital Initiative
BMI	Body mass index
CBE	Childbirth Educators
CD	Chemical dependency
CDC	Center for Disease Control and Prevention
CDR	Child Death Review
CHR	Community Health Representative
CHS	Contract Health Services
CHSDA	Contract Health Services Delivery Area
CMHC	Community and Migrant Health Centers
CMS	Center for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
CPEP	Comprehensive Program Evaluation Project
CPS	Child Protective Services
CRIOB	California Rural Indian Health Board
DOH	Department of Health, Washington State
DSHS	Department of Social and Health Services, Washington State
DV	Domestic violence
FASD	Fetal Alcohol Spectrum Disorders
FIMR	Fetal Infant Mortality Review
FMAP	Federal Medical Assistance Percentage for Medicaid
FQHC	Federally Qualified Health Center
FSS	Fee for service
FTCA	Federal Tort Claims Act
GLITC	Great Lakes Inter-Tribal Council
GPRA	Government Performance Results Act
HBW	High birth weight
HOC	Honoring Our Children (a program in Wisconsin)
HRSA	Health Resources and Services Administration
IBCLC	International Board Certified Lactation Consultant
ICM	Infant case management

IHCIA	Indian Health Care Improvement Reauthorization and Extension Act (part of PPACA)
IHS	Indian Health Service
IOM	Institute of Medicine
ITCA	Inter-tribal Council of Arizona
ITCM	Inter-Tribal Council of Michigan
ITO	Indian Tribal Organization
LBW	Low birth weight
MCH	Maternal and Child Health
MIH	Maternal and Infant Health
MSS	Maternity Support Services
NAWDIM	Native American Women's Dialogue on Infant Mortality
NCAI	National Congress of American Indians
NFP	Nurse Family Partnership
NIHB	National Indian Health Board
NIWHRC	National Indian Women's Health Resource Center
NN	Navajo Nation
NNED	Network to Eliminate Disparities in Behavioral Health
NPAlHB	Northwest Portland Area Indian Health Board
OMB	United States Office of Management and Budget
PPACA	Patient Protection and Affordable Care Act of 2010 (health reform)
PPOR	Perinatal Periods of Risk
PRAMS	Pregnancy Risk Assessment Monitoring System
PTD	Preterm Delivery
RD	Registered Dietitian
RTR	Reducing the Risk program
SBSM	Safe Babies, Safe Moms
SCHIP	State Child Health Insurance Program
SIDS	Sudden Infant Death Syndrome
SIHB	Seattle Indian Health Board
SPIPA	South Puget Intertribal Planning Agency
TICM	Targeted Intensive Case Management
TOP	Teen Outreach Program
TPPI	Teen Pregnancy Prevention Initiative (in PPACA)
TTAG	Tribal Technical Advisory Group
UNITY	United Indian Tribal Youth
USDA	United States Department of Agriculture
WIC	Special Supplemental Nutrition Program for Women, Infants and Children
YRBS	Youth Risk Behavior Survey



American Indian Health Commission for Washington State
“Improving Indian Health through Tribal-State Collaboration”

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Jamestown S’Klallam
Kalispel
Lower Elwha Klallam
Lummi
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Port Gamble S’Klallam
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Squaxin Island
Stillaguamish
Suquamish
Swinomish
Tulalip
Upper Skagit



To request a full report of the
Tribal Maternal and Infant Health
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Member Organizations:
Seattle Indian Health Board
NATIVE Project of Spokane

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