THE AMERICAN INDIAN HEALTH COMMISSION

PULLING TOGETHER FOR WELLNESS

AMERICAN INDIAN AND ALASKA NATIVE STATEWIDE MATERNAL CHILD HEALTH BLOCK GRANT

2025 AMERICAN INDIAN AND ALASKA NATIVE MATERNAL, INFANT, CHILD, ADOLESCENT HEALTH (MICAH) STATEWIDE ASSESSMENT

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AMERICAN INDIAN HEALTH COMMISSION

The American Indian Health Commission (AIHC) a Tribally driven non-profit that focuses on American Indian and Alaska Native (AI/AN) health in Washington state. Our membership includes 29 federally recognized Indian Tribes whose traditional lands and territories included parts of Washington, and two Urban Indian Health Organizations (UIHOs). Our goal is to bring wellness to our communities and honor the sovereignty of our ways. We work with Washington State government agencies to develop policies that reflect and support our resilience. Our ways are resilient.

Website: https://aihc-wa.com/

Facebook: https://www.facebook.com/AIHCWA/

Facebook: https://www.facebook.com/pullingtogetherforwellness/

ACKNOWLEDGEMENTS

AIHC is grateful to our delegates, Tribal and Urban Indian leaders, staff from Tribes and UIHOs, and other Tribal organizations for their guidance and support of this project.

We have deep gratitude to the Tribal elders, grandparents, parents, aunties and uncles, and community that helped to shape our plan for the implementation of the MICAH statewide assessment and to the focus group participants for trusting us with their stories, insights, and inspirations. We are committed to Tribal and Urban Indian communities' health and wellness and are inspired by the participants' courage, dedication, and love for their communities. We hold their hopes and dreams as the vision and direction for our work.

We also appreciate the Department of Health (DOH) staff for their dedication in public service and for their work to improve the health of populations in the state, including AI/AN people. We are grateful for the partnership with DOH in working to identify the needs of the AI/AN population for the Washington State's Title V Health Resources and Services Administration (HRSA) Maternal Child Health Block Grant assessment.

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AMERICAN INDIAN AND ALASKA NATIVE STATEWIDE MATERNAL CHILD HEALTH BLOCK GRANT ASSESSMENT

EXECUTIVE SUMMARY

This report is in response to Washington State's invitation to contribute to the Title V Health Resources and Services Administration (HRSA) Maternal Child Health Block Grant (MCHBG) assessment. It is the first time significant engagement to ensure participation of American Indian and Alaska Native (AI/AN) people has been included in the assessment for the state of Washington.

It is well documented by the Washington State Department of Health, and through both academic peer-reviewed research and findings from health professional research, that AI/AN people continually experience among the highest health disparities and poorest health outcomes compared to any other racial or ethnic group in Washington State and nationally. Yet, the current health status of AI/AN people conflicts with their histories, traditional practices, and knowledge of their health, strength, and longevity during traditional times.

The significance of understanding that the root causes for AI/AN health inequities are based in the historical advents of trauma and intergenerational transmission of trauma, forced assimilation, ongoing discrimination and racism, as well as inequitable access to resources, is essential to understanding the complexity of AI/AN health. These issues have a direct impact on longstanding chronic disease rates and the physical, social, and behavioral health disparities of AI/AN people. (Brave Heart, et al, 1998[i]), (Gone, et.al 2014[ii]), (Gone, et.al, 2019[iii]), (Walters, et.al, 2011[iv])

AIHC's Pulling Together for Wellness framework serves as a guide for strategies and processes for much of their work, including the MCHBG assessment project. Examples include:

- Aligning the focus group design with the principle of meeting AI/AN people where they are by having physical presence in community spaces and environments familiar to participants and an understanding and ability to relate to participants' life context.
- Applying culturally relevant trauma informed approaches by prioritizing trust and acknowledging the importance of relationships within the focus group implementation.
- Beginning each session with an engagement exercise to build interpersonal connections and building participants' openness to sharing and listening.
- Being emotionally present with open hearts to the challenges and concerns expressed by AI/AN community members.
- Engaging community and leadership of all ages, perspectives, and varying levels of involvement in Tribal and community driven initiatives.
- Strengthen initiative methods and findings by balancing the integration of "Native Ways of Knowing" and Western science practices in our process.

We conducted four regional gatherings with multiple Tribes and UIHO community members, 1 Tribal gathering with community members from a single Tribe, and 7 small group virtual gatherings. There were 110 total participants and over 1500 individual responses for the identified issues and recommendations. Participants created over 225 feathers sharing their hopes and dreams for themselves, their families, Tribes, and future generations.

We integrated concepts of "Native Ways of Knowing" with a public health approach to look strategically at the levels of healing needed and designed appropriate responses for what is trying to be accomplished. These levels are referred to as primary, secondary and tertiary prevention in Recommendation Tables 1 and 2.

The tables mentioned above reflect participants' responses to 12 questions regarding the health of moms, babies, children, adolescents, and children with special health care needs, plus an additional question regarding the impacts of the opioid/fentanyl epidemic on Tribal and urban Indian communities in our state.

Participant responses not only reflected what was happening in their communities, and their responses were remarkably similar across communities. These common themes are to be expected, as AI/AN people, their relatives, and ancestors, have survived common traumatic historical and current events. Common needs identified include:

- Indigenous Healers and Indigenous Systems of Care for all health care and social service domains across all ages: physical, emotional, behavioral, birthing, postpartum, parenting, etc.
- Services and resources in their home communities – they emphasized the critical importance of getting care when it is needed to address immediate and urgent health issues.
- Educational classes and gatherings covering a series of prevention and health information and education opportunities.
- Support groups for postpartum women, parents, families with children with special health care needs, and children and adolescents with appropriate age groups.
- Support for the impacts of substance misuse and generational trauma in the daily lives of children and adolescents.
- Understanding that cultural and traditional activities be supported as they are vital to healing and wellness.
- Education and support for bonding between infants and parents and the need for supportive and longer paid family and sick leave.

INTRODUCTION

OVERVIEW OF PROJECT INTENTION

AIHC was the successful applicant for the State of Washington Request for Qualifications and Quotations (RFQQ) to conduct a survey of AI/AN people in Washington State to inform the State's application of the HRSA Title V Maternal Child Health Block Grant (MCHBG).

The State of Washington is a long-time recipient of the federal MCHBG funds. It is a requirement to conduct a needs assessment regarding the MCHBG population domains every five (5) years for states to be eligible for continuation funding. The State of Washington has complied with the needs assessment requirements, however, there has been no notable engagement or participation of AI/AN people in those assessments. This is concerning as AI/AN people have persistently experienced dramatic disparities in overall health status, longevity and years of potential life lost, maternal morbidity and mortality, and infant mortality in Washington State and nationally.

This is the first time that Washington State has opened a request for proposal to conduct a MCHBG needs assessment of AI/AN people within our state. AIHC participation in the assessment phase of the work is critical to understand the true needs and current challenges of AI/AN people in Tribal and Urban Indian communities.

OVERVIEW OF STATE MATERNAL CHILD HEALTH BLOCK GRANT

The Maternal Child Health Block Grant (MCHGB), a department currently within the Health Resources and Services Administration (HRSA), is the oldest federal-state partnership, with roots in the Title V Social Security Act enacted by Congress in 1935 to provide services and funding to improve the health of mothers and children. In 1981, programs were modernized and consolidated into the renamed statute "Title V-the Maternal Child Health Services Block Grant" with the intention to empower states to use the funding to address the specific maternal child health needs in their state. In 1989, again, there were significant changes for the MCHBG, including increased funding levels and increased accountability in the application, implementation, and reporting requirements. These changes also included a mandate for a statewide needs assessment to be conducted every 5 years to qualify as a recipient of Title V MCHBG funds.

The Washington State MCHBG 2023 Report and 2025 Application states:

"Our Title V work focuses on issues of justice, addressing the needs of underserved populations, and where there is demonstrated need. This has led us to focus our work on increasing health equity by supporting community-driven solutions and tailoring system improvements tied to disparities. This includes working to deepen our partnerships with the 29 federally recognized Tribes and other Tribal serving organizations across the state. We are also identifying gaps where the demand for services is more than the supply…"

The Washington State DOH stated its goal to ensure representation of AI/AN people in this mandatory maternal and child health needs assessment and to gain understanding of the specific health needs and gaps among AI/AN people. Therefore, AIIHC had the unique opportunity to conduct a needs assessment

with the Tribes and Urban Indian communities in Washington State for the Title V MCHBG for the first time.

The HRSA requires that MCHBG state action plans cover 5 population domains:

1. Women/Maternal Health
2. Perinatal/Infant Health
3. Child Health
4. Adolescent Health
5. Children and Youth with Special Health Care Needs

Additionally, states can select priorities from a menu of national performance measures. The selected national performance priority measures aligned with Population Domains for Washington State are:

Population Domain	National Performance Measures
Women's/Maternal Health	Well Women Visits
Infant/Perinatal Health	Breastfeeding
Child Health	Developmental Screening
Adolescent Health	Adolescent Well Visit
Children with Special Health Care Needs	Medical Home and Adequate Insurance

The priority activities that were identified in the last Washington State MCHBG needs assessment in 2020 and a focus of the current work include:

- Increase capacity of the local public health workforce to strategically identify, plan for, and address the needs of women and children throughout the state.
- Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve people's health across the life course.
- Identify and reduce barriers to quality health care.
- Improve the safety, health, and supportiveness of communities.
- Promote mental wellness and resilience through increased access to behavioral health and other support services.
- Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.
- Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.
- Optimize the health and well-being of children and youth, using holistic approaches.

- Identify and reduce barriers to needed services and support for children and youth with special health care needs and their families.
- Identify and respond to emerging priority needs associated with public health emergencies and their effects on the maternal and child populations.

Washington State also included the following additional state performance measures:

- Reducing depression and increasing access to mental health care
- Positive adult mentors for teens
- Preventing teenage alcohol use
- Affordability of health care services
- Preparation for the next MCHBG needs assessment

The needs assessment that AIHC is conducting is an important component of the "next MCHBG needs assessment" referenced above. We appreciate the opportunity to see how the needs and service/resource gaps identified by Tribal and UIHO leaders and members of Tribal and Urban Indian communities are distinct from and compare to the current Washington State priorities.

Overview of American Indian Health Commission

AIHC is a unique model of Tribal-state collaboration on health care issues in Washington State and nationally, and is a recognized Indian Tribal organization formed by Tribes and UIHO leaders in 1994 with the mission to improve the health status of AI/AN people in Washington State. AIHC membership is comprised of delegates, formally designated by Tribal/UIHO resolutions, to represent, and vote on behalf of their Tribe/organization. Tribal and UIHO leaders recognized the need for coordinated and ongoing policy, program, and funding decisions regarding AI/AN health to include the wisdom and expertise of Tribal and UIHO leaders at the state level; this knowledge led to the formation of AIHC over 30 years ago.

AIHC holds quarterly delegate meetings to discuss new and ongoing business, establish and vote on strategies and proposals, and receive updates from state agencies and other partners. AIHC also convenes the triannual Governor's Indian Health Policy Council (GIHAC) meetings in partnership with the Washington State Health Care Authority (HCA) and the Washington State DOH. AIHC also partners with HCA to convene the Monthly Tribal Meetings (MTM) and is on the standing agenda. The Governor's Office of Indian Affairs (GOIA) also partners with the AIHC to convene statewide Tribal Liaison meetings. AIHC is known as a trusted organization intentionally formed to be governed by Tribal and UIHO leaders.

Therefore, AIHC's structure is designed to ensure project, policy, and legislative work is always Tribally driven and led. AIHC is also trusted due to its success in serving AI/AN individuals and communities based on Tribal/UIHO priorities and strategies, and how the work is conducted, updated, and prioritized over time. It is a trusted and known organization by Tribes, UIHOs, Tribal organizations, and Tribal Health and Social Service departments. AIHC has well established partnerships and trusting relationships with Tribes and UIHOs; in fact, the Tribes/UIHOs lead the work of AIHC.

As AI/AN and Indigenous people, we are knowledgeable in public health systems, processes and strategies; this includes development, administration, and analysis of community health needs and other

health assessments. We also have first-hand knowledge of medical and structural racism and discrimination through personal experiences and the experiences of our families, communities, and Tribes across generations. The work of AIHC leadership, staff, and consultants has been to address structural, institutional, interpersonal racism, and discrimination for the past 30 years. It is one of the reasons that Tribal and UIHO leaders formed AIHC.

In the last 30 years, the Tribal and UIHO leaders' certainty and AIHC's values of sovereignty, shared responsibility for the health of our communities, and honoring our ways, our culture, as a key to health and wellness has been the impetus and the foundation of the Tribally led policy, public health, program and legislative work of the AIHC. (https://aihc-wa.com/about/aihc-story/)

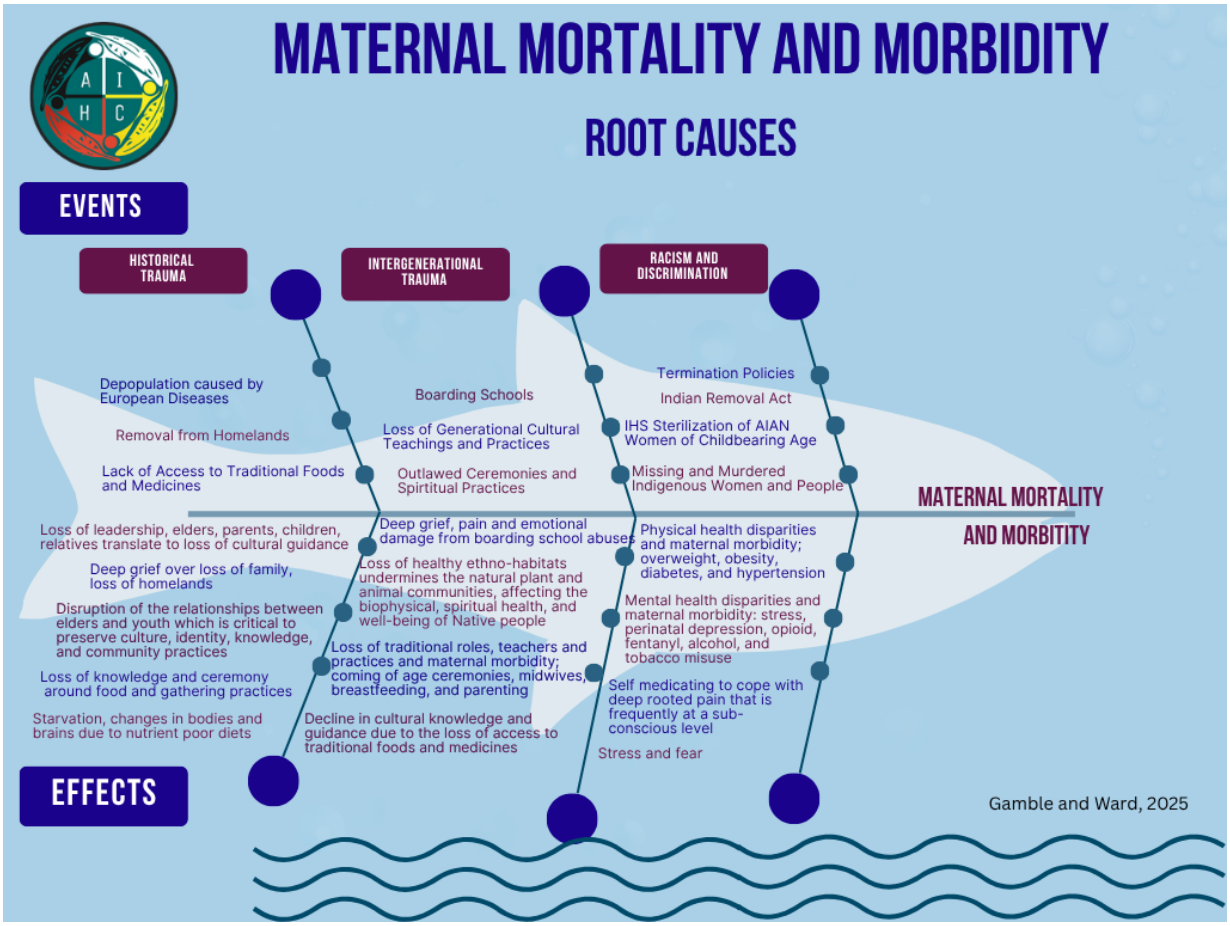
Maternal and Infant Health is foundational work of AIHC which resulted in the publication of the Healthy Communities: A Tribal Maternal and Infant Health Strategic Plan in 2010. This document does need to be updated to reflect the current creative and innovative work happening in Tribal and UIHO programs and grass roots indigenous organizations. However, most recommendations were left unfunded and many of the original, unfunded recommendations still need to be addressed today.

Statement of Need

Any discussion of modern issues and status of physical, social, and behavioral health of AI/AN people is complex. AI/AN people have some of the highest health status disparities when compared to other racial and ethnic groups. Yet, the current health status of AI/AN people conflicts with their history, traditional practices, and knowledge of their health, strength, and longevity in traditional times.

Graph 1 reveals examples of historical to current day events; a history of genocidal events, intergenerational traumas, and other factors that explain the root causes of the modern chronic disease rates and the physical, social, and behavioral health disparities of AI/AN people. To further understand the effects of AI/AN Historical Trauma reference the work of Native scholars: Brave Heart & DeBruyn, 1998[v]; Duran, E., Duran, B., Heart, M.Y.H.B, Horse-Davis, S.Y. (1998)[vi]; Brave Heart, Chase, Elkins, & Altschul, 2011[vii], and Walters KL, Mohammed, S., Evans-Campbell, T. Beltran, R.E., Chae, D.H. and Duran, B. (2011)[viii].

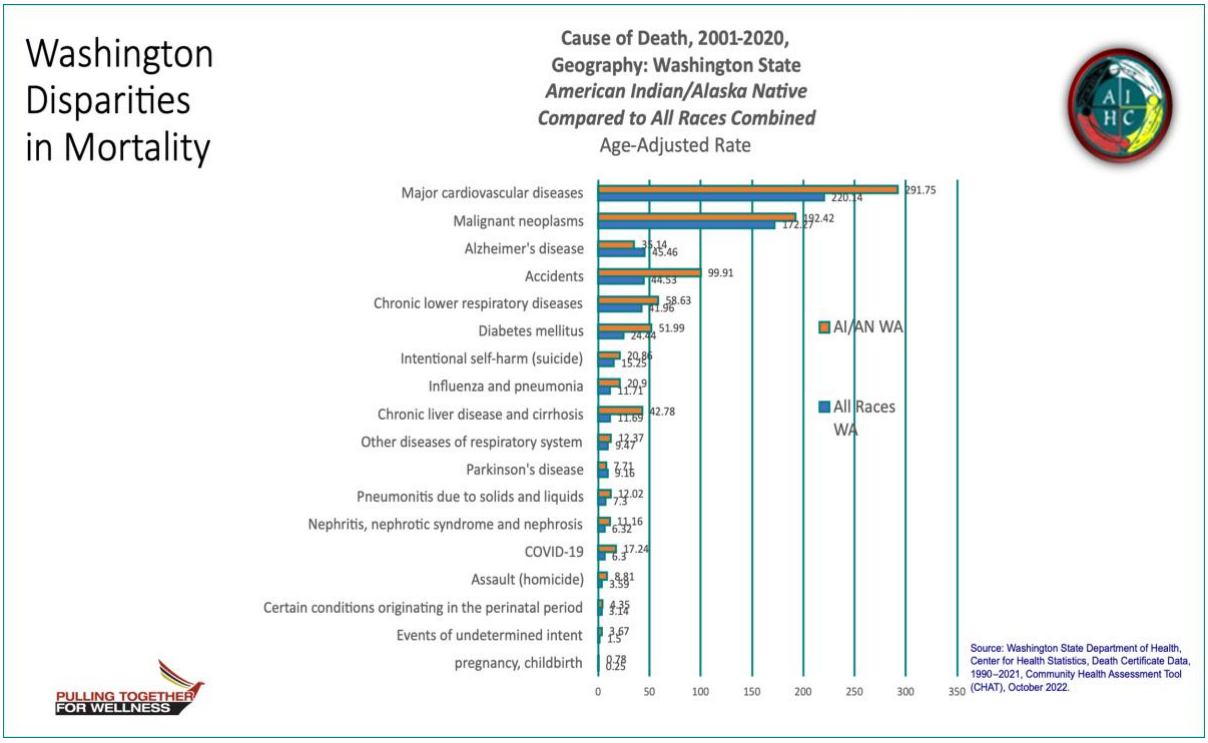
Graph 1



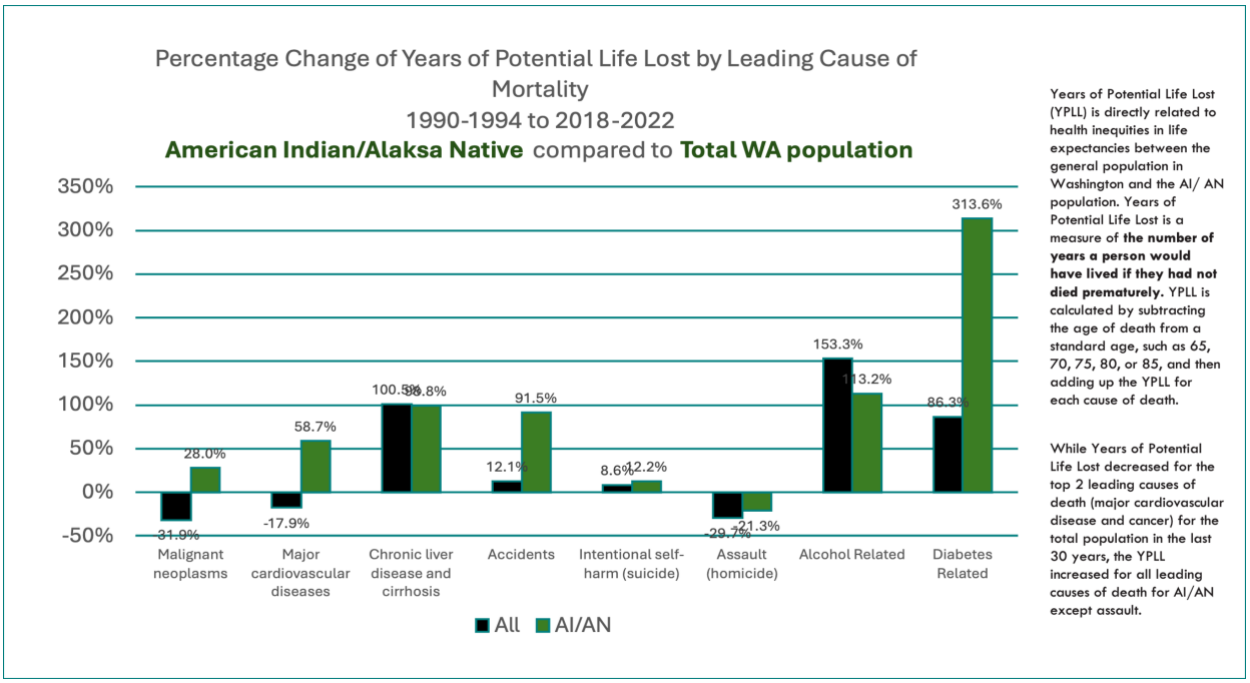
As noted by the Environmental Protection Agency, measures of health status are defined as the health outcomes of a group of individuals, and the Centers for Disease Control and Prevention (CDC) and other global health agencies view life expectancy and mortality data '…as indicators of overall population health because they represent the cumulative effects of social and physical environmental factors, behavioral and genetic risk factors, and the level and quality of health care.' [ix]

The following graphs (2, 3, 4, and 5) demonstrate the Mortality Disparity rates between AI/AN people compared to all races in WA State (2) and Years of Potential Life Lost rates of AI/AN people compared to Total WA State Population (3), Percentage Change of Years of Potential Life Lost by Leading Cause of Mortality (4), and Mortality comparison of AI/AN populations and White populations for those born between 2006 and 2023 (5).

Graph 2



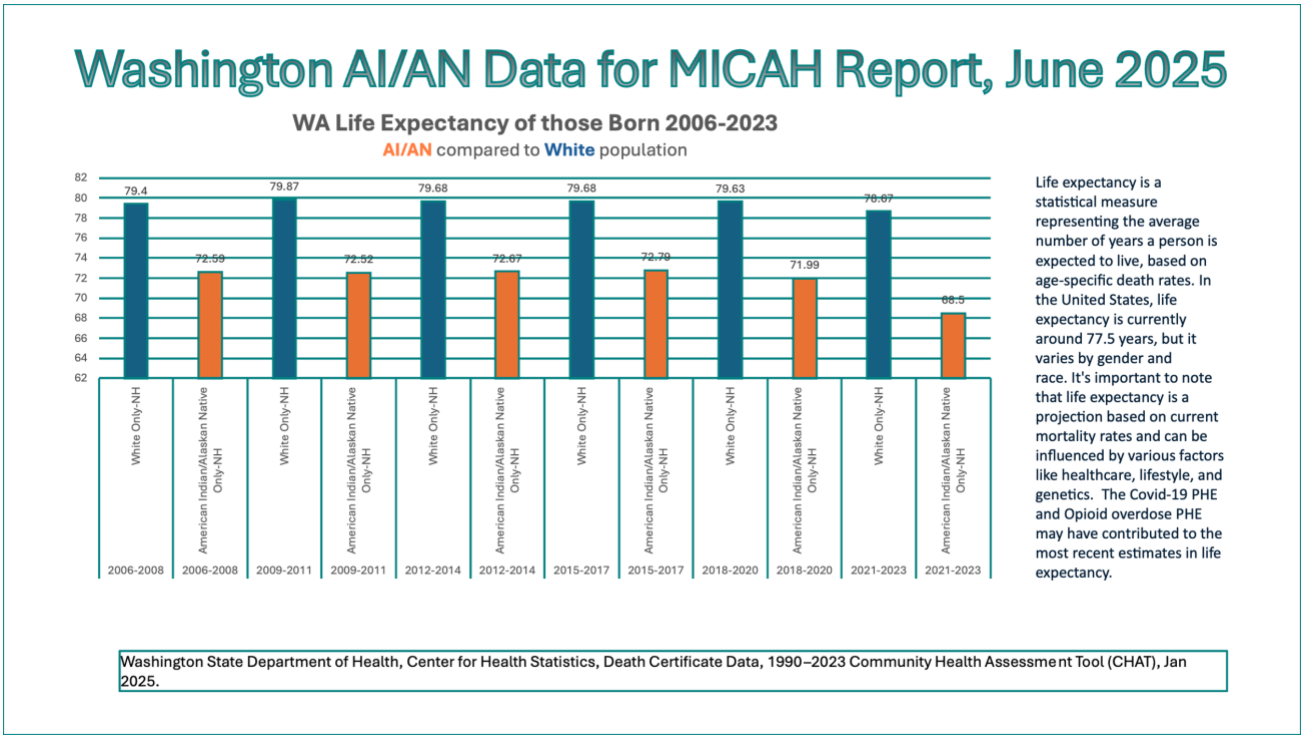
Graph 3



Years of Potential Life Lost (YPLL) is directly related to health inequities in life expectancies between the general population in Washington and the AI/ AN population. Years of Potential Life Lost is a measure of **the number of years a person would have lived if they had not died prematurely.** YPLL is calculated by subtracting the age of death from a standard age, such as 65, 70, 75, 80, or 85, and then adding up the YPLL for each cause of death.

While Years of Potential Life Lost decreased for the top 2 leading causes of death (major cardiovascular disease and cancer) for the total population in the last 30 years, the YPLL increased for all leading causes of death for AI/AN except assault.

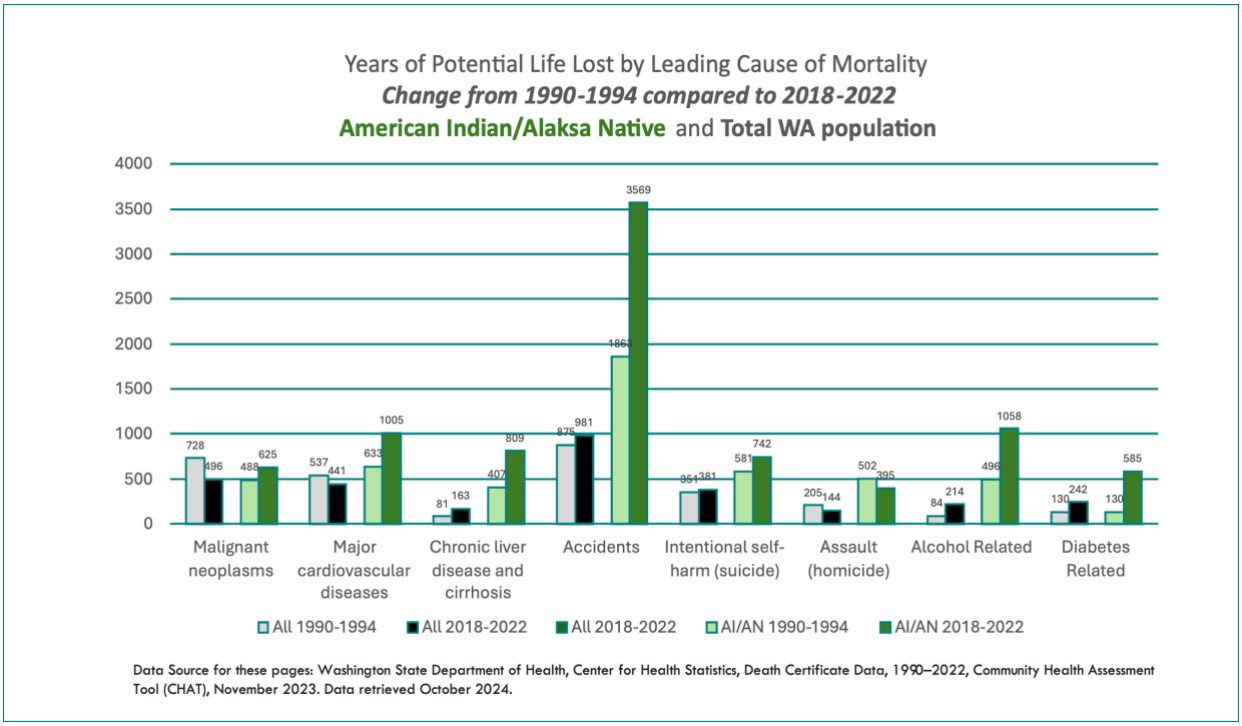
Graph 4



Life expectancy is a statistical measure representing the average number of years a person is expected to live, based on age-specific death rates. In the United States, life expectancy is currently around 77.5 years, but it varies by gender and race. It's important to note that life expectancy is a projection based on current mortality rates and can be influenced by various factors like healthcare, lifestyle, and genetics. The Covid-19 PHE and Opioid overdose PHE may have contributed to the most recent estimates in life expectancy.

Washington State Department of Health, Center for Health Statistics, Death Certificate Data, 1990–2023 Community Health Assessment Tool (CHAT), Jan 2025.

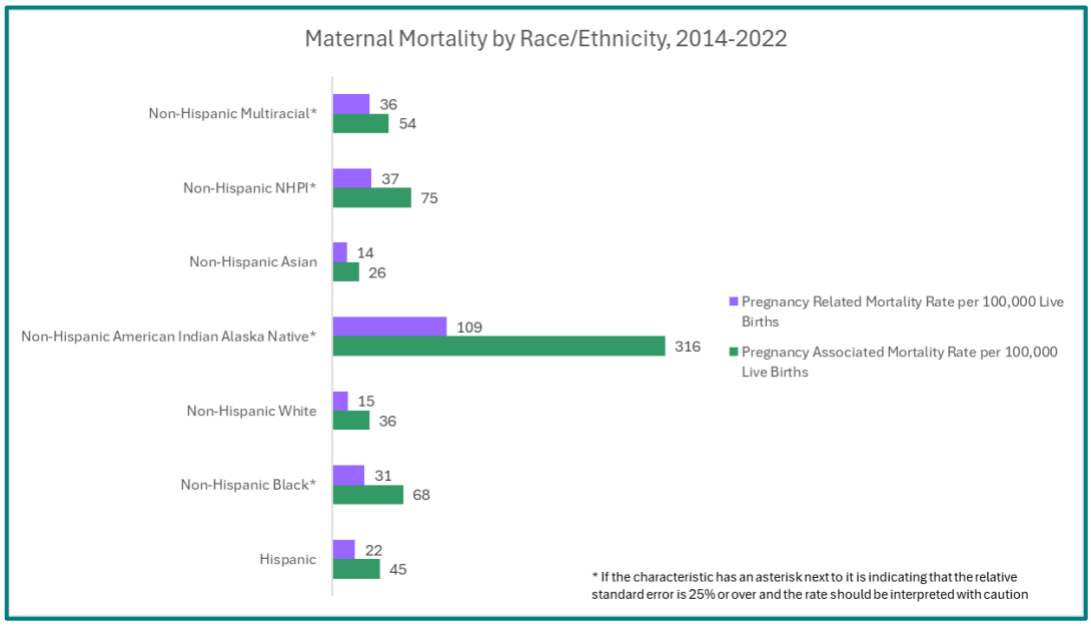
Graph 5



Other Important population health indicators are Maternal and Infant Mortality, shown below in Graphs 6, 7, and 8.

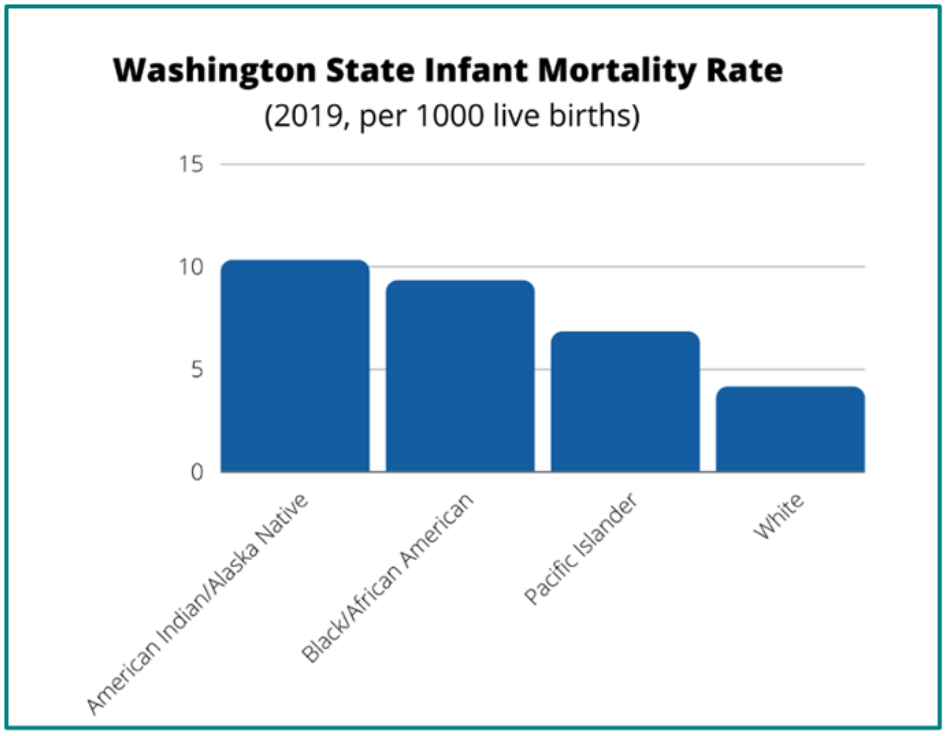
Graph 6

Maternal Mortality by Race/Ethnicity, (2014-2022) shows that the AI/AN population has much higher rates of maternal mortality for both pregnancy associated and pregnancy related deaths in WA State.



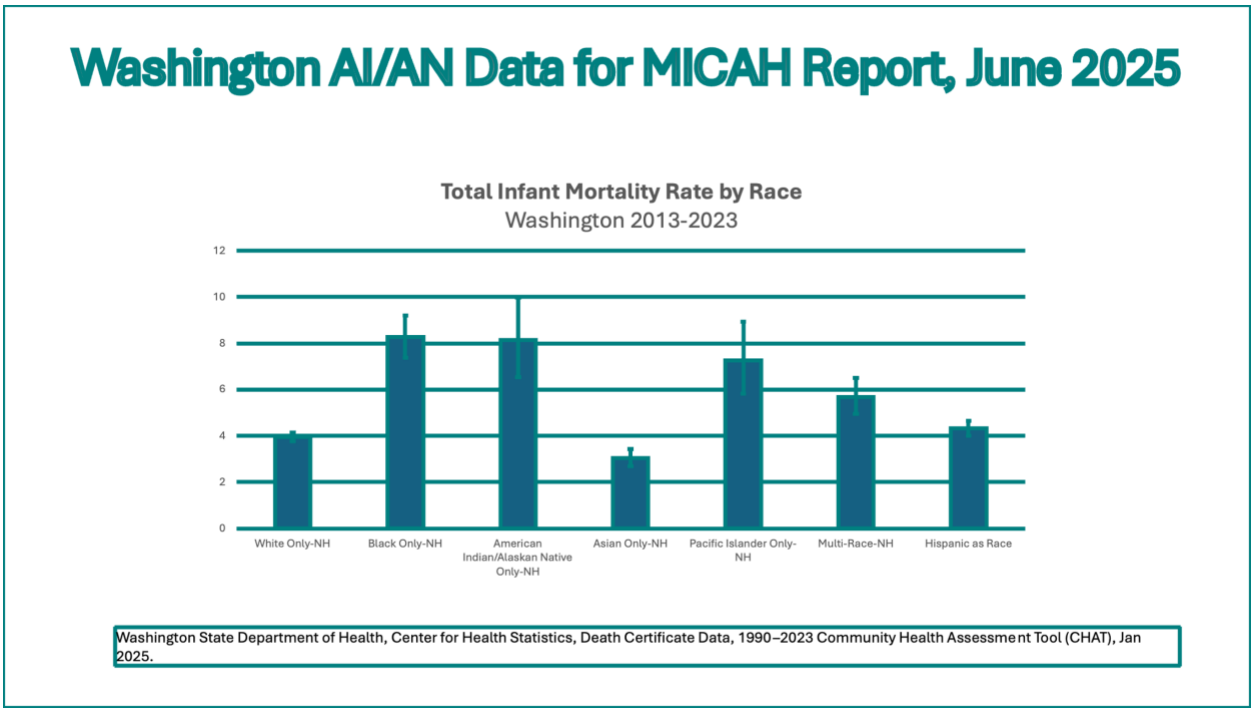
Graph 7

Washington State Infant Mortality Rates show that the AI/AN rate I higher than the rates for Black/African American, Pacific Islander, or White in 2019.



Graph 8

Washington AI/AN Data for MICAH Report-Total Infant Mortality by Race, June 2025



Graphs 1-8 definitively confirm the significant health disparities for AI/AN people when looking at chronic disease disparities, years potential of lives lost, life expectancy projections, maternal mortality, and infant mortality rates in our state.

In addition to population health, statisticians also measure health status which the CDC defines as 'health status is a measure of how people perceive their health—rating it as excellent, very good, good, fair, or poor. Reported health status is a predictor of important health outcomes including mortality, morbidity, and functional status. It is considered a good global assessment of a person's well-being.'[x]

AIHC consultants did not center our methods and approach on gathering perspectives of how individuals perceived their own status of health and well-being. Consultants focused on applying indigenous methods on the topic areas required by the MCHBG process. A strategy to engage Tribal and urban Indian community members was used to invite conversations about the health and well-being of each of the MCHBG affected population groups, i.e., women and mothers, infants, children, adolescents, and children and youth with special health care needs within their Tribal and urban Indian communities. This strategy was designed by AIHC consultants to ensure intentional use of culturally ethical and relevant approaches that acknowledge the wisdom of community members and leaders and are aligned with public health practice.

MATERNAL, INFANT, CHILD, ADOLESCENT HEALTH (MICAH) PROJECT

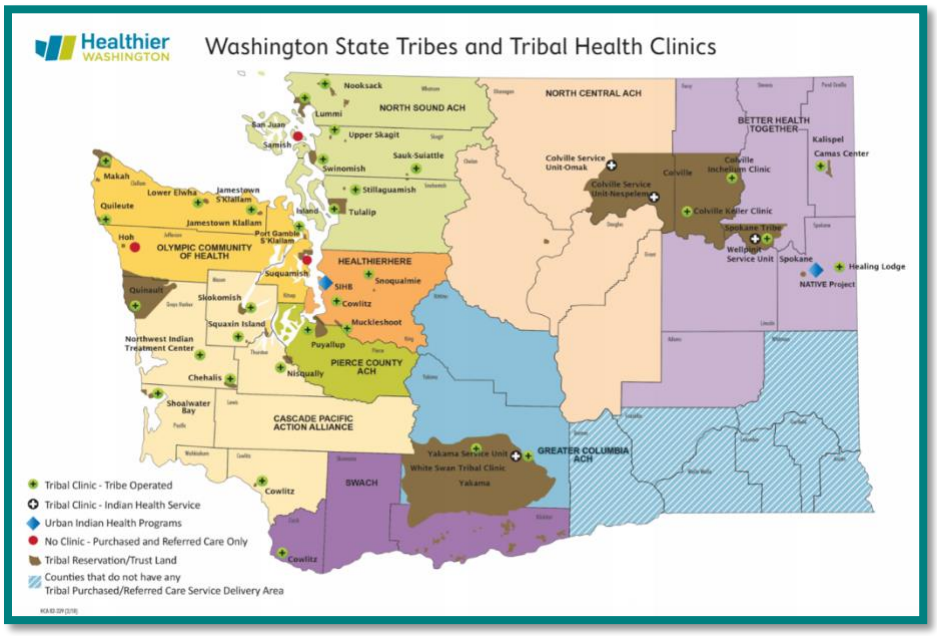
Early in the planning and strategy sessions, AIHC began referring to the MCHBG Needs Assessment as the MICAH Project which captured the essence of the Maternal, Infant, Child, and Adolescent Health focus and is a friendlier term to bring into communities. This report will use the terms "MCHBG" and "MICAH" interchangeably from this point on.

MICAH STRATEGY

The AIHC MICAH Project began with a focus on applying community engagement strategies while ensuring AIHC delegates and leadership continued to be informed and provide input to our process. Four key questions were critical to our planning process:

- How to ensure representation from the 29 Tribes, 2UIHOs, and 1 Urban Indian Community Center in our state within a few months' time
- How to structure the gatherings and the agenda
- What approach to use for promotion and engagement
- How to ensure a welcoming and supportive gathering on the day of the event

One of the first decisions was made in acknowledgement that it would be difficult to impossible to plan and execute community gatherings in the 29 Tribal and 3 Urban Indian communities. We had limited amount of time from funding to closure. Planning for community events in person required extensive direct outreach and networking prior to promotion and scheduling of the event. Data gathering, and time needed at the back end of the grant period to analyze the data and prepare the final report is also time intensive. Given the short period to accomplish the project, the most efficient plan to gather AI/AN community input was to schedule regional gatherings. A map of Washington State was consulted which showed both Accountable Communities of Health (ACH) regions and Tribal Homelands; using the ACH regions as a template, the state was divided into 6 regions with natural groupings of Tribes and Urban Indian communities. The goal was to conduct 6 regional gatherings with Tribal community members in each defined region.



1. King and Pierce County Area Tribes/UIHO (orange and green)
2. Northeast Tribes and UIHO (salmon & lavender)
3. Northwest Tribes (light green)
4. Peninsula Tribes (Gold, including Quinault)
5. Southwest Tribes (light gold)
6. Yakama

A great amount of thought went into the outreach and promotion. Once the regional approach was determined, the next order of business was to determine what information we wanted to gather and the best methods to gather it. Planning and strategy meetings continued to shape the questions and strategies with a plan for a supportive agenda. The approach was to draft the questions for individual thought and reflection, move into small group work, and then follow up with large group discussion. The draft agenda was developed to support this approach.

Although we felt confident with the developed drafts, we wanted to confirm that we were on the right track. Several key informants were invited to participate in a mock "focus group" discussion to test the questions and offer their opinions, critiques, and edits. Key informants ranged from young parents to grandparents, Tribal leaders and cultural leaders, participants from across the state, and both mothers and fathers were represented. The key informant sessions went well; they were glad to contribute to the plan. We learned that everyone thought that the draft questions and the proposed agenda were good and would be relatable to communities. We added the suggested edits and changes and were ready to move forward with the finalized questions and agenda.

The guide to our question development was to align the individual and small group questions and were determined by the 5 stated population domains of the MCHBG requirements: women and mothers, infants, children, adolescents, and children with special health care needs. We added a 6th question in acknowledgement of the opioid and fentanyl crisis experienced by AI/AN communities in Washington State. The 6 two-part questions for the individual and small group work are as follows:

Focus Group Questions:

1. What are important issues around women's and maternal health in your community?
2. What are important issues around perinatal and infant health in your community?
3. What are important issues around child health in your community?
4. What are the important issues around adolescent health in your community?
5. What are important issues around children with special health care needs in your community?
6. The impacts of the opioid/fentanyl epidemic are hitting Tribal and urban Indian communities in our state hard. What are the specific impacts of this epidemic on women, infants, children and adolescents in your community?

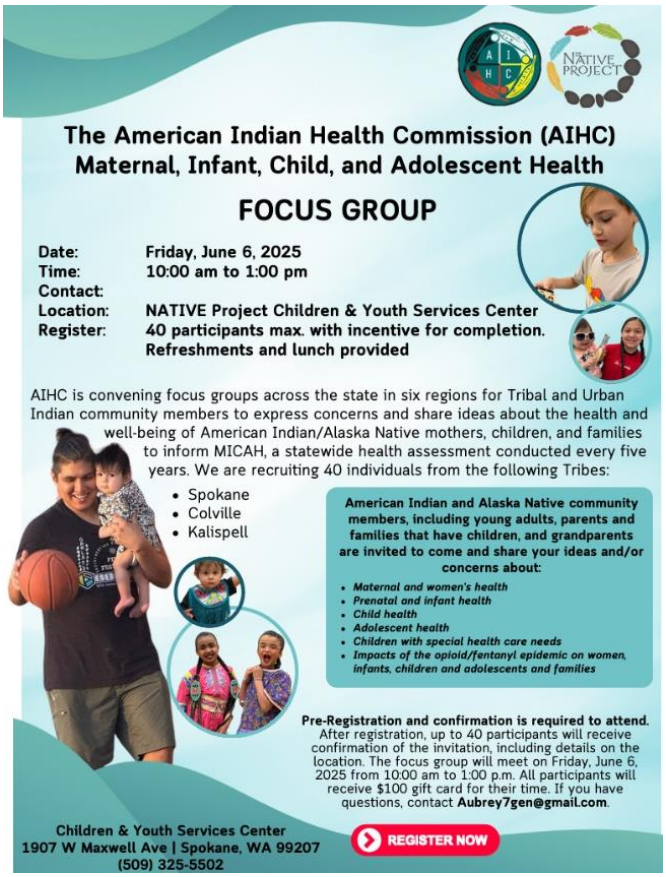
Additionally, each question had a similar follow-up question about what support is needed to help meet the needs in each of the six categories.

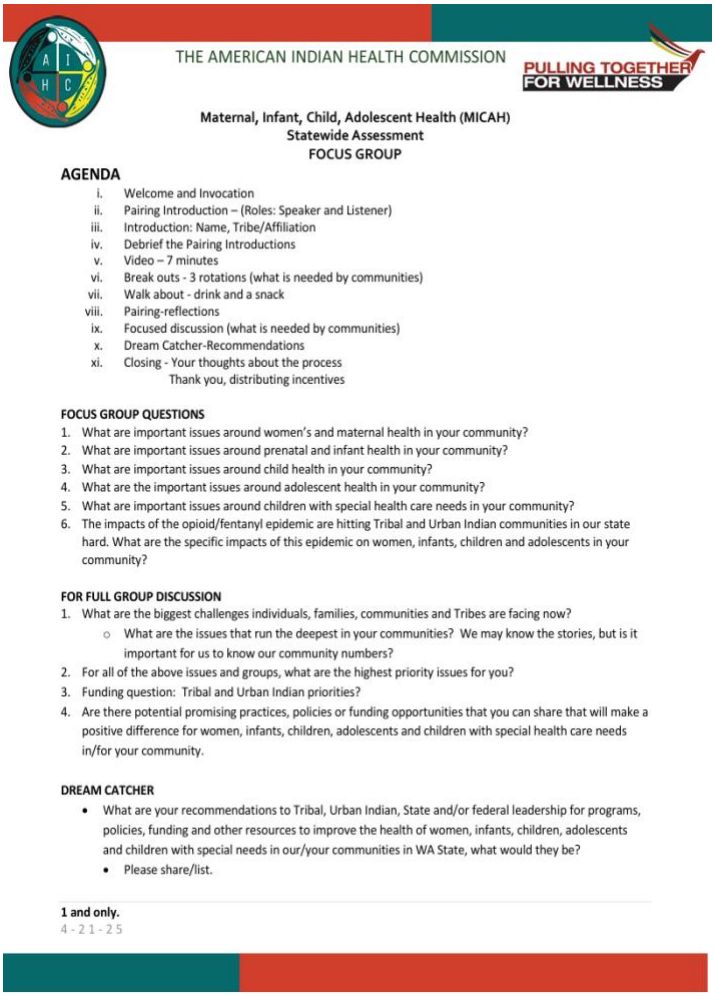
The full group discussion at the end of the agenda centered on four questions:

1. What are the biggest challenges individuals, families, communities, and Tribes are facing now?
2. For all the above issues and groups, what are the highest priority issues for you?
3. Funding question: What are Tribal and Urban Indian priorities?
4. Are there potential promising practices, policies or funding opportunities that you can share that will make a positive difference for women, infants, children, adolescents and children with special health care needs in/for your community?

Once the questions and the agenda were vetted and approved by the Key Informants, full attention was given to the promotion and scheduling of the gatherings. Passive promotion started prior to this with informing and updating at various meetings, such as the AIHC Quarterly Delegates meetings and the monthly MIH Work Group meetings. Once active promotion and scheduling began, it was a time intensive process of informing AIHC delegates, contacting the appropriate representatives to plan dates and places, and once an event site was determined, to begin promotion of the gathering.

In alignment with the PTW framework, our engagement strategy focused on ethical and culturally grounded methods to intentionally inform AIHC's delegates, inform and invite elders, inform and invite Tribal and UIHO leaders, inform and invite community members utilizing AIHC networks and contacts, and personal networks and contacts to inform them and promote the event. Ensuring that elders are treated with respect is a traditional practice that reflects the value that AI/AN people place on the wisdom, experience, and expertise of those who have lived to an age of elderhood. The next steps were to develop flyers, registration pages and social media posts; see example on the right. Once dates were set, the next phase of planning food, drinks and supplies were done, and travel plans were also made. Finally, the date of the first gathering arrived, and the process began. We were excited to see how our plans, agenda, and questions would be received.





THE AMERICAN INDIAN HEALTH COMMISSION

PULLING TOGETHER FOR WELLNESS

Maternal, Infant, Child, Adolescent Health (MICAH)
Statewide Assessment
FOCUS GROUP

AGENDA

i. Welcome and Invocation
ii. Pairing Introduction – (Roles: Speaker and Listener)
iii. Introduction: Name, Tribe/Affiliation
iv. Debrief the Pairing Introductions
v. Video – 7 minutes
vi. Break outs - 3 rotations (what is needed by communities)
vii. Walk about - drink and a snack
viii. Pairing-reflections
ix. Focused discussion (what is needed by communities)
x. Dream Catcher-Recommendations
xi. Closing - Your thoughts about the process
Thank you, distributing incentives

FOCUS GROUP QUESTIONS

1. What are important issues around women's and maternal health in your community?
2. What are important issues around prenatal and infant health in your community?
3. What are important issues around child health in your community?
4. What are the important issues around adolescent health in your community?
5. What are important issues around children with special health care needs in your community?
6. The impacts of the opioid/fentanyl epidemic are hitting Tribal and Urban Indian communities in our state hard. What are the specific impacts of this epidemic on women, infants, children and adolescents in your community?

FOR FULL GROUP DISCUSSION

1. What are the biggest challenges individuals, families, communities and Tribes are facing now?
   - What are the issues that run the deepest in your communities? We may know the stories, but is it important for us to know our community numbers?
2. For all of the above issues and groups, what are the highest priority issues for you?
3. Funding question: Tribal and Urban Indian priorities?
4. Are there potential promising practices, policies or funding opportunities that you can share that will make a positive difference for women, infants, children, adolescents and children with special health care needs in/for your community.

DREAM CATCHER

- What are your recommendations to Tribal, Urban Indian, State and/or federal leadership for programs, policies, funding and other resources to improve the health of women, infants, children, adolescents and children with special needs in our/your communities in WA State, what would they be?
  - Please share/list.

1 and only.
4-21-25

As stated above, it was important that the agenda be thoughtfully and strategically developed. The goal was for participants to feel comfortable with the gathering and the process of sharing their thoughts, concerns and creative ideas. Participants started out sharing in groups of 2, then in small groups and finally the full group. Opportunities for debriefs and check-ins were built in. This was a successful plan as people participated fully and enthusiastically. This was also very strategic. The paired introduction at the beginning of the agenda was to help people gain comfort and create a trusting environment by talking, listening and sharing. In addition, the topic for the pair and share was also strategic and led to participants being comfortable to open up and share even more. They were primed and open to thinking about and giving thoughtful answers to the small group questions.

To begin each session, AIHC consultants provided a brief overview of the MICAH project and shared the 7-minute video about the history of Title V and the MCHBG,[xi] which gave a clear and concise overview of the purpose and focus of the MCHBG funding, before beginning the individual and small group work on the questions.

We began the small group work on the questions. The 6 questions were all singly printed on a large poster size sheet of paper. Each question was clearly numbered and the population group clearly printed on each paper. In the center of each sheet was a large light blue circle. Each blue circle had a question labeled "A" and a question labeled 'B" in the white space.

Questions A: "What are the most important issues around (the affected population group) health in your community?" for each population group for questions 1-5. For example,

Question B: "What support is needed to help meet the (affected population group) care needs in your community?" for each of the population groups mentioned for the A questions listed above.

Question 6B: "What support would help to meet needs of women, infants, children, and adolescents regarding this (the opioid fentanyl epidemic) in your community?"

There were multiple copies of each question, and each question was placed on a table; there were 6-12 tables set up, depending on the space, with chairs and pens available. In the proposed agenda, for time constraint purposes, the plan was for each person to choose3 of the six 6 questions to give responses to, working individually or with others at the table. We had a set amount of time allotted for this activity.

The individual and small group activities were exciting for us as facilitators to see enthusiastic engagement of participants and to see and hear the discussions at each table. These were serious issues for the participants, and they had comments that they wanted to share. Of course, there were questions asked, and clarifications needed, but once the process started, it flowed easily and energetically.

We were surprised to see that the majority of participants chose to answer all 6 questions, not just the 3 as we had planned. This was amazing confirmation that all these MICAH population groups, and all 6 questions were important to the community participants and that they had concerns and creative solutions that they wanted to share. In one of the gatherings, as one of the participants was moving between tables, she said, “I can’t wait to get to questions 5 and 6! I have a lot to say.” In total, we have over 1500 individual responses from participants attending the gatherings.

Upon completion of the 6-question table activity, all of the posters were hung up and we invited participants to get up, walk about the room, get a snack and a drink and review all the issues and recommendations on the posters. Folks were invited to add any last-minute thoughts or comments that may have been sparked by reviewing all the participant ideas shared. Following the walk about, there was another opportunity for a pair and share. The same rules and sharing of time as the first round applied. Folks jumped right in, and the room always filled quickly with conversation in the second round.

After the second pair and share, the full group came together to answer 4 questions listed above. In the 3 gatherings that we were able to conduct the full agenda, this proved to be an interesting process. There was always a silence as the questions were asked in the full group; it may be that participants were forming a reply to the question while deciding if they trusted the process enough to share their thoughts openly or were shy in the full group. We believe that the flow of the agenda helped to ensure that we always received responses to the first 3 questions about priorities.

The fourth question – "Are there potential promising practices, policies or funding opportunities that you can share that will make a positive difference for women, infants, children, adolescents and children with special health care needs for your community?" – was not fully answered. This is an area where we recommend further work; it would be wise to seek additional opportunities to convene groups centered on this focused question. It was clear that there wasn't enough time for participants to process and respond in the limited amount of time we had together.

The final activity, prior to closing, is a favorite of many and very colorful —the Dream Catcher activity. At the setup of the room, prior to participants arriving, we had attached 2 preprinted colorful dream catchers to the walls. We also had pre-cut paper feathers in a myriad of colors. A handful of colorful feathers were distributed to each participant. The directions shared were to fill up the feathers with their hopes and dreams – 1 per feather. We encouraged everyone to fill out at least 1 feather; however, they could fill out as many as they wanted. After the heaviness of the day and the hard work everyone put in, it was enjoyable to end on a positive note to think about how we would like it to be. We received many positive comments about this activity, such as "I love this!" We even had a few young children who had accompanied family members wanting to fill out a feather, with words, a drawing, their names, or even stickers! To the right is a picture of one of the dream catcher posters filled with colorful hopes and dreams.

The last activity was closing remarks. We thanked everyone for their participation and hard work and asked them for their closing remarks. Many positive comments were made about their experience and words of appreciation for coming to their community to ask for their input.

MICAH DATA

The goal was to convene 6 regional gatherings. We ended up conducting 4 regional gatherings with multiple Tribes and UIHO community members invited, 1 Tribal gathering with community members from a single Tribe, and seven 7 small group virtual gatherings. Despite requests for rescheduling due to Tribal priorities and/or conflicts with community events, including ceremonies, funerals, and Tribal holidays; we had 110 total participants and over 1500 individual responses for the identified issues and recommendations. We also had over 225 feather hopes and dreams responses. We were able to complete the full agenda in 3 of the gatherings; in 2 of the MICAH gatherings, we had to be flexible to accommodate the needs and schedules of the people as they arrived and wanted to participate in answering all of the questions.

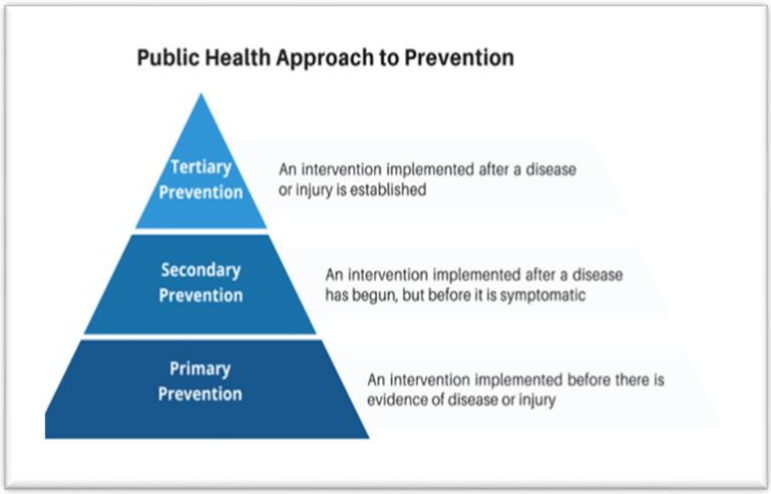
At one gathering, people kept arriving who had “just heard about it” on social media and we ended up staying over an hour later than planned or advertised. We could have stayed longer as additional people continued to arrive. This is a lesson learned for future gatherings. However, we were pleased with the outcomes, participation level, and the enthusiasm with which communities contributed to the needs assessment questions and additionally enhanced our learnings.

The number of unique responses was remarkable making the thematic analysis robust. The major themes for each question were consistent across all the convenings, however there were age-appropriate and community differences. The first notable take away is that participants came, engaged and stayed through the entire MICAH project process because they had something to say. They have serious concerns and serious recommendations. They want to be heard, and they want things to change for the better as they are worried about the future of the next generation and of their community.

- “It actually means a lot to include community voice and makes a difference.”
- “Community members’ voices have a chance to be heard, and we can make a change.”
- “This gets more people thinking about our needs and issues around these specific topics!!”

From traditional times to present day, AI/AN people have recognized the importance of considering the whole and the interconnectedness of systems – holistic approaches – whether considering large environments or small. When looking at individual health, we know it is essential to look at the whole person, not just the singular symptom or body part affected. Healing does not happen in isolation or when only certain systems are evaluated. Healing happens when we work to heal completely and address all the hurts at the same time. This is also true for community health; we must consider the whole community when designing healing strategies. The healing strategies will be different for each community member, depending on their age, gender, clan, Tribe, cultural values, family values, mental, emotional, physical and spiritual health status. In public health, this is a strategy called “meeting people where they are at.”

Another public health strategy is to look strategically at the levels of healing needed and design appropriate responses for what is trying to be accomplished. These levels are referred to as primary, secondary and tertiary prevention.



Primary prevention focuses on preventing the onset of disease (injury or condition) before it occurs, secondary prevention aims at early detection and prompt intervention to halt the progression of disease (or condition), and tertiary prevention seeks to manage and reduce the complications of established diseases (or conditions). See image at left.

Therefore, the AIHC MICAH data is presented in a way to show the recommendations aligned with the principles of Primary, Secondary, and Tertiary Prevention in the following table.

Table I is a table of highlights from the discussions. Participant comments are listed in the comments box under the numbered questions.

- "We need to heal the root of the problem."
- "…people choose vices as a way of coping."
- "We learn to grieve people who are still "with us" and those that aren't.
- "…grief is too much in our community."

Table I: Recommendations

Question 1A: What are important issues around maternal and women's health in your community? Question 1B: What support is needed to help meet the maternal and women's health care needs in your community?
The major themes and issues around maternal and women's health expressed by participants include the following: • Need for Indigenous healers and Indigenous systems of care • Need access to culturally appropriate, compassionate, and non-judgmental care, including specialty care. It is important for people to feel trusted and to trust and be comfortable with providers; this requires enough providers for all • Need access to culturally relevant, compassionate and non-judgmental mental health, behavioral health, substance use disorder and MOUD services, including access to traditional teachings about mental health • Need for supportive resources
Question 2A: What are important issues around perinatal and infant health in your community? Question 2B: What support is needed to help meet the perinatal and infant health care needs in your community?
The major themes and issues around perinatal and infant health expressed by participants include the following: • The need for Indigenous and/or trusted, non-judgmental providers

- The need for Indigenous mental health providers offering culturally-focused care
- The need for trusted supports
- The need for education

Question 3A: What are important issues around child health in your community?

Question 3B: What support is needed to help meet the children's health care needs in your community?

The major themes and issues around child health expressed by participants include the following:

- Need for on time, immediate access to services for physical, mental and emotional health for children, including dental health
- Need to keep children safe: at home, in their public and community environment, at school, and online
- Lack of understanding and support regarding the trauma children face in their everyday lives
- Lack of support and intervention results in labeling and a missed opportunity to change a child's trajectory
- Concern about too many children in foster care; sometimes when systems are not a safe place, parents don't ask for help and give up, so children stay in the system
- Need for community-based supports, including cultural and social activities for all age groups

4A: What are the important issues around adolescent health in your community?

4B: What support is needed to help meet adolescent health care needs in your community?

The major themes and issues around adolescent health care needs expressed by participants include the following:

- Lack of education for adolescents and families of what adolescent minds and bodies are going through and not knowing how to express themselves
- Need on-call mental health services in our community to provide full spectrum adolescent mental health care, from personal growth to substance misuse prevention to depression and suicidal ideation screening, prevention, and treatment
- Adolescents need support for issues such as emotional support, confidence building, skill building, to respect and accept their own bodies, minds, ideas, and values
- Adolescents need community-based supports to be more involved in sports/school, cultural and social activities

5A: What are important issues around children with special health care needs in your community?

5B: What support is needed to help meet children with special health care needs in your community?

The major themes around children with special health care needs expressed by participants included the following:

- Lack of knowledge around special health care needs children:
  - Parents don't know what resources are available
  - Providers/clinics don't have information
  - Lack of correct terminology
  - Lack of community understanding
- Tribes and families are not connected to CSHCN resources
- Autism concerns: diagnosis, treatments, resources
- Lack of money and resources for CSHCN
- Concerns about school support

6A: The impacts of the opioid/fentanyl epidemic are hitting Tribal and Urban Indian communities in our state hard. What are the specific impacts of this epidemic on women, infants, children and adolescents in your community?

6B: What support is needed to help address the impacts of the opioid/fentanyl epidemic on women, infants, children, and adolescents?

The major themes around specific impacts of the opioid/fentanyl epidemic on women, infants, children and adolescents expressed by participants included the following:

- Concerns about generational cycles of addiction. ("In a vicious cycle of addicted parents/families, the children end up so broken, may pick up the addiction too.")
- Concerns that services and response are not meeting the needs
- Concerns about the initial and long-term health of babies born to mothers who are using substances.
  - Premature babies and NICU Stays; born addicted
  - Children w/emotional and learning differences
  - Birth defect/complications
  - Abandonment
  - Mental health damages
  - Kids being born addicted
  - No one wants to watch them, lack of support for addicted babies and families
- Concerns about the long-term impacts of parents using substances, on children born exposed to substances, and broken families in the community
  - Broken homes/families
  - Shame and Stigma
  - The normalization of drug use
  - Higher ACE'S numbers
  - More at risk youth
  - Loss of family members

- Concerns about infants, children and adolescents living in homes where drugs are actively being used and observing traumatic events
  - Being unaware of exposure to trauma
  - Being (un)able to label what/how they are feeling
  - Conflicts with expectations around school—attendance, homework, behavior
- Lack of research translates into lack of understanding of the immediate and long-term impacts resulting in a lack of funding and resources to address all these issues

The Critical Importance of Tribally Developed and Led Work

Pulling Together for Wellness

AIHC's Pulling Together for Wellness (PTW) framework exemplifies the power of Tribally led and community-driven health initiatives. Developed under the guidance of Washington Tribal and Urban Indian Leaders, this comprehensive approach blends Indigenous wisdom with Western public health science, creating a unique model for wellness that resonates deeply with tribal communities.

At the heart of the PTW framework lies a profound respect for cultural context. The model recognizes that true health and wellness cannot be achieved without honoring the traditions, values, and experiences of Indigenous peoples. This cultural grounding forms the foundation upon which the entire framework is built. An important tenet of the framework is the deliberate inclusion and engagement of all levels of community and leadership in Tribal and community driven initiatives and solutions. Engagement with natural community leaders of all ages, who tend to know what the community needs are, where there is interest in culturally grounded collaborative initiatives, and who is working and doing what in their communities to address them. Tribal and Urban Indian Leaders, with a strong passion for the health of their people, can be the most significant champions in opening avenues of opportunity, sustainability, and motivation for change.

The PTW framework development was a collaborative effort, bringing together Tribal and urban leaders, elders, youth, community members, cultural knowledge keepers, program staff, and public health specialists. This holistic vision from various viewpoints was composed through the guidance of AIHC's PTW Leadership Advisory Council (PTW LAC), which played a crucial role in shaping the final model. The PTW framework was established as a cornerstone of AIHC work through the passage of a resolution in 2015. The Affiliated Tribes of Northwest Indians (ATNI)[1] passed the PTW framework and the 21 competencies by resolution as the policy of ATNI at the 2025 Annual Spring Convention in May 2025.

[1] ATNI is organized and chartered as a non-profit 501(c)3 corporation under the laws of the State of Oregon. The organization sets out its membership and operating policies within its Constitution and Bylaws and ATNI Policies & Procedures Manual. Authority for management of the affairs of ATNI are delegated to the Executive Council by the members and further delegated to the Executive Board, Committees, and Executive Director.

The framework guides us to apply our values and balance Native and Western science in our processes. It raises the significance of Native epistemology 'ways of knowing' and practice-based knowledge. It guides us to embrace the Seven Generation thinking as defined by our ancestors to honor the Seven Generation Principle as standing in the present, while looking back three generations to the wisdom and experiences of our ancestors to address issues in their current context while we embrace the strength of our ancestors in our planning for three generations forward for the benefit of our children, grandchildren, great grandchildren and the generations to come. This is a traditional way of being, a natural way to honor our ancestors and protect our children and the future generations in our daily lives.

National Indian Health Board

Further, the National Indian Health Board[2] has also emphasized the importance of Tribally led initiatives as recently stated, "Despite these innovative efforts, sustained funding and policy support remain critical in addressing maternal health disparities for AI/AN communities. There is an urgent need to invest in Tribal maternal health and build sustainable partnerships. Philanthropy is a critical component to supporting the health of AI/AN communities. Grantmakers could consider investing in the following:

Tribal-led initiatives are one of the most impactful ways to reduce disparities. Tribal health programs and grassroots organizations are deeply rooted in their communities and are better equipped to address local needs. Flexible, long-term funding can allow these programs to expand their reach and improve their sustainability.

Workforce development is another crucial area for philanthropic engagement. By increasing funding for training programs for Indigenous doulas, midwives, and health care providers, philanthropy can help build a culturally competent workforce that understands the unique needs of Native mothers. Scholarships for Native students pursuing careers in obstetrics, gynecology, and public health can further strengthen this effort.

Policy advocacy to increase federal funding for Tribal healthcare systems, improve data collection on maternal health disparities, and ensure that Native voices are represented in policymaking. Collaborating with Tribal leaders and organizations can amplify these efforts, creating systemic changes that benefit Native mothers and their communities." (Alexander and Raj)[xii]

[2] The National Indian Health Board (NIHB) stands as the united voice of federally recognized Tribes, dedicated to advancing health and well-being in Indian Country. Since 1972, NIHB has provided critical advocacy, policy analysis, and education to support Tribal sovereignty and strengthen Tribal health systems. Based in Washington, DC, NIHB offers a wide range of services—from legislative tracking to training and technical assistance—ensuring that Tribes have the resources and information they need to navigate the complexities of health care policy and public health. Rooted in its mission, NIHB collaborates with Tribal leaders, federal agencies, and partners to fulfill the trust responsibility and secure quality health care for American Indian and Alaska Native communities.

Leadership Comments

The MICAH Project is well vetted. As noted in Section 5: AIHC MICAH Project, key informants including Tribal and cultural leaders, gave their approval of the proposed questions, agenda and approach. This was an important endorsement and confirmation that the needs assessment would ask questions that are meaningful to AI/AN people with an approach that would elicit thoughtful answers that reflect the issues, gaps and needs of their community.

In the meetings with AI/AN leadership to share the results of the MICAH Project needs assessment, it was affirming to hear that the leaders recognized the issues that were listed. The results were in alignment with what they know and hear as Tribal and urban Indian leaders. The AI/AN leaders were also in favor of how the needs assessment results were laid out with the recommendations divided into primary, secondary and tertiary prevention categories. One Tribal leader stated, "I can relate to this, how it is laid out. Another agreed by saying, "This is a great opportunity. I like this public health model." The leaders agreed that this was important work and significant data results, and that we should continue to share the results with Tribal and urban Indian leadership.

In discussion with the leaders about the non-response to the fourth question regarding identifying potential promising practices, policies or funding opportunities that will make a positive difference for women, infants, children, adolescents, and children with special health care needs, they agreed that it was a lot to cover in one session and that further work would be necessary and require additional strategies to ensure the right people are involved in responding to this particular question.

AI/AN leaders also heard about the MICAH needs assessment from their constituents, and they wanted to be sure that AIHC knew that the experience was positive for the MICAH participants. They were very comfortable to have gone through this experience "with people who looked like them." This is a significant confirmation of the importance of Tribal developed and led work.

Final Recommendations

As stated in Section 6: MICAH Data, there were over 1500 individual responses to the 6 A and B questions (12 total questions). While answers reflected what was happening in individual participant communities, there were also remarkable similarities across communities. These common themes are to be expected, as AI/AN people, their relatives and ancestors, have survived common traumatic historical and current events.

Understanding Profound Disparities Experienced by AI/AN People

It is critical for state agencies, decision makers and funders to fully understand and accept the profound disparities that AI/AN people face today; the reality of the traumatic history and ongoing institutional, systemic, and interpersonal racism prevailing; resulting in the current AI/AN physical, behavioral, and social disparities.[xiii] [xiv]

This is important for several reasons:

- AI/AN people are still recovering from the impacts of hundreds of years of attempted and realized genocide against Native people, their culture and their way of life.[xv] (Brown-Rice, 2013[xvi])
- AI/ANs are an oral tradition people; it is in our values and our DNA to hold our families', clan relatives, and Tribal members' stories, and experiences close to our heart, mind and spirit—we remember them and feel them. This is part of the seven-generation experience.
- The traditional cultures, values and life ways of the Indigenous people of North America were in vivid contrast to the values of the European visitors and Colonists. There were stark differences in beliefs of equality of men and women, the sacredness of children, spiritual values, the role of animals, plants, and nature in human lives, and land ownership, plus differences in diet, clothing, housing, and medicines. (Harper and Harris)[xvii]
- The colonists believed in human supremacy, with the white males at the top of this hierarchy, while the Indigenous people lived a life in balance with all of the beings around them and acknowledged their role in the life cycle of all.[xviii]
- This concept of human supremacy only pertained to the white colonists, and flavored all their judgement of Indigenous beliefs. This superior attitude has persisted for hundreds of years, with an intentional belief and judgement that other humans, especially non-white humans, and other beings, are inferior. When your people are considered inferior, and your values, traditions and lifeways are considered barbaric for hundreds of years, there is an impact. AI/AN people are still feeling that impact. (Brave Heart & DeBruyn, 1998)[xix]
- This long history of white and human supremacy has created extreme disparities in the physical health, mental health, emotional health, and social determinants of health experienced by AI/AN people today. (Alexander and Raj)[xx]
- The federal laws recognizing the sovereign rights of Tribal Nations and Tribal leaders to govern their own Tribal citizens were passed in the 1970's, only 50 years ago. From that point, Tribes were able to assume their rightful governance over AI/AN children, health care, education, land, community, etc. The healing path started then, and while there have been remarkable strides, there is much work still to be accomplished. Here are a few examples of the self-determination era that derive from federal law, legislation, policy, and events ranging from:
    - 1970 - President Nixon's delivery to Congress on Indian Affairs stating the importance of genuine Indian self-determination and empowerment
    - 1974 – the Boldt decision, United States v. State of Washington https://www.historylink.org/file/21084
    - 1976 – President Ford signs Indian Health Care Improvement Act https://www.congress.gov/bill/94th-congress/senate-bill/522
    - 1978 - Indian Self-Determination and Education Act, proposes the need for tribal-specific plans and solutions https://www.congress.gov/bill/93rd-congress/senate-bill/1017
    - 1978 - Indian Child Welfare Act https://www.congress.gov/bill/95th-congress/senate-bill/1214

- 1978 - American Indian Religious Act to protect and preserve for America Indians their inherent right and freedom to believe, express and exercise traditional https://www.nlm.nih.gov/nativevoices/timeline/545.html

For more information, see: Native Voice-Native Peoples' Concepts of Health and Illness

https://www.nlm.nih.gov/nativevoices/timeline/index.html

PARTICIPANTS' COMMON THEMES AND RECOMMENDATIONS

The MICAH participants have many comments about needing trusted providers who look like them, understand their history, and accept their culture, beliefs and values. They have comments about needing to be trusted and their ideas accepted by their providers.

- The need for Indigenous Healers and Indigenous Systems of Care for all health care and social service domains across all ages—physical, emotional, behavioral, birthing, postpartum, parenting and so on.
- AI/AN participants in the MICAH Project were also very clear that they want the services and resources they recommended to be available in their home community. They want resources like adequate number of providers and specialists to meet the needs of their communities, and they also want to be able to access the services and resources when they need them. They emphasized the critical importance of getting the care when it is needed to address immediate and urgent health issues.
- The request for educational classes and gatherings. These varied, but the following were mentioned frequently across all gatherings:
  - Prevention and information on drugs; opioids and fentanyl were specifically mentioned, as well as other drugs that are easily accessible.
  - Childbirth Education
  - Parenting Education
  - Lactation Support
  - Education about Drug Exposure
- There is a recognition of the role of the family and community. Support groups were mentioned multiple times for postpartum and parenting families, for postpartum women, for families with children with special health care needs, and for children and adolescents with appropriate age groups.
- There is great concern about infants being born drug exposed, and concerns about the impacts of substance misuse and generational trauma in the daily lives of children and adolescents.
- There was a strong understanding that culture and traditional activities need to be supported as they are vital to healing and wellness.
- Participants recognized the importance of bonding between infants and parents and the need for supportive longer paid family and sick leave.

LESSONS LEARNED

- It was a clear result that AI/AN people, for a variety of reasons, prefer to participate in events that are in their community and/or homelands. Although the plan for regional gatherings was necessary for the timeline, Tribal participation was much higher if the event was held at their Tribe or Urban Indian community.

- We did not have a paper evaluation; we only asked for verbal input at the end of the gathering which we did not document. This is a lesson learned for us; the next time, we will include a paper evaluation. The comments were so good and so positive, we are disappointed to have missed documenting them.

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[x] https://www.cdc.gov/nchs/hus/topics/health-status.htm, access July 14, 2025.

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