



Maternal Health Leadership Council Meeting

April 19, 2022

2:30 – 5:00 PM

Zoom Meeting <https://mtgov.zoom.us/j/88429847215?pwd=TTkwWUJQRlpNY1I3bFZEUUVKVFIQT09>

Meeting ID: 884 2984 7215 Password: 499747

Agenda

- 2:30 – 2:40** **Roll call, review agenda and approve minutes**
Introduce Nurse Abstractor/Coordinator for Enhancing Review and Surveillance to Eliminate Maternal Mortality (ERASE MM) grant
- 2:40 – 2:55** **Montana State University Investment for DNP Certified Nurse Midwifery Program**
Sarah E. Shannon, PhD, RN, FAAN - Dean and Professor
- 2:55 – 3:05** **Questions and discussion**
- 3:05 – 3:25** **Montana's Emergency Obstetrics Survey**
Annie Glover, PhD, MPH, MPA
Senior Research Scientist, Rural Institute for Inclusive Communities at UM
- 3:25 – 3:35** **Questions and discussion**
- 3:35 – 3:45** **Break**
- 3:45 – 4:45** **American Indian Historical Trauma and Maternal Health**
D'Shane Barnett, M.S. (Mandan/Arikara)
Health Officer/Department Director, Missoula City-County Health Department
Amy Stiffarm, MPH (Aaniiih, Cree, Blackfeet)
- 4:45 – 4:55** **Questions and discussion**
- 4:55 – 5:00** **Determine meeting format for July and October**
Public comment

Next meeting – July 19



Maternal Health Leadership Council

Meeting Minutes:

January 18, 2022:

3:30-5:00 PM:

Location: Zoom only

Members Present

Chair, Dr. Tersh McCracken, MOMS Medical Director & Ob-Gyn at Billings Clinic

Olivia Riutta, Outreach and Engagement Manager at MPCA

Tami Schoen, RN at Hill County WIC Department

Brie MacLaurin, Executive Director of Healthy Mothers, Healthy Babies

Lisa Troyer, Wellness Consultant at Pacific Source Health Plans

Jennifer Wagner, Rural Hospital Improvement Coordinator with Montana FLEX Program at Montana Hospital Association

Dr. Jean-Pierre Pujol, Medical Director at Blue Cross Blue Shield of Montana

Dr. Steve Williamson, Chief Medical Officer, Billings Area Indian Health Service

Ann Buss, Department of Public Health & Human Services (DPHHS) Maternal Child Health Section Supervisor/Title V Director

Vicki Birkeland, Nursing Director, Women's Services at St. Vincent's Montana Perinatal Quality Collaborative

Jen Verhasselt – Senior Residential Services at Rimrock and Pathway to Parenting program

Tressie White – Program Director with Montana Healthcare Foundation

Members Absent

Dr. Christina Marchion, Family Medicine/OB at Central Montana Medical Center

Dr. Bardett Fausett Maternal Fetal Medicine Specialist and President/Medical Director at Origin Health

Dr. Drew Malany, Ob-Gyn at Women's Health Care Center, PLLC and Chair of Montana American College of Obstetrics & Gynecology (ACOG)

Judge Mary Jane Knisely, 13th District Court Judge, Felony Impaired Driving Court (IDC), CAMO Court (Veterans Treatment Court)

Janie Quilici, Perinatal Behavioral Health Counselor at Community Physicians Group

Dina Kuchynka, Maternal and Newborn Health Manager at SCL Health-Holy Rosary

Mary LeMieux, Member Health Management Bureau Chief at Medicaid, and Perinatal Behavioral Health Initiative Director

Program Staff Present

Amanda Eby, MOMS Project Coordinator at DPHHS

Dr. Annie Glover, Lead evaluator and PI for MOMS at University of Montana (UM)

Stephanie Fitch, MOMS Grant Manager at Billings Clinic

Public Attendees

Carla DeSisto – Epidemiologist at the Division of Reproductive Health for the Centers for Disease Control and Prevention (CDC)

LeeAnn Bruised Head – Tribal Health Director for the Crow Tribe

Carly Holman – Program Evaluator at the UM Rural Institute for Inclusive Communities

Sarabeth Upson – DPHHS Medicaid, Perinatal Behavioral Health Initiative, standing in for Mary Lemieux

Dr. Kaitlin Fertaly – Evaluation Services Director at UM Rural Institute for Inclusive Communities



Welcome and introductions

Dr. Tersh McCracken opened the meeting and lead roll call. The minutes did not get sent out prior to the meeting. They will be sent out later this week for approval or comment.

Montana Levels of Care Assessment Tool (LOCATe)

Dr. Tersh McCracken thanked Carly Holman and her team for their work on the LOCATe project. Carly Holman opened the presentation, stating twenty-four states have used the LOCATe tool to evaluate the neonatal and maternal care available in Montana. Carla DeSisto went over the specifics of LOCATe and results gathered from Montana facilities. Carly Holman discussed the next steps for the Montana LOCATe initiative. A statewide report created from the LOCATe report will be distributed. Amanda shared the exciting next step: the CDC invited Montana to participate in The Association of State and Territorial Health Officials (ASTHO) Risk Appropriate Care (RAC) Learning Community, kicking off in April 2021. The RAC Learning Community leverages technical assistance and peer-to-peer learning to improve equitable risk-appropriate care practices in participating states by translating LOCATe data into policy and programmatic action. DPHHS is leading a multidisciplinary state for the project.

Q & A opportunity with presenter

Dr. Tersh McCracken asked for clarification on what was counted as ultrasound availability and access to a maternal-fetal medicine (MFM) specialist. He thought there was likely confusion when hospitals filled out reports, as just having an ultrasound machine should qualify them as at least a level one. Dr. McCracken also questioned how MFM availability was a stumbling block when they can be accessed via phone nationwide. Carla DeSisto answered regarding the ultrasound, there needed to be someone capable of making a final ultrasound reading and report. She said the way the MFM criteria is worded differentiates whether an MFM can be onsite at any given time.

Carly Holman followed up stating the facilities that did not meet level one, were called so clarification could be provided about the ultrasound requirements. The piece that prevented them from reaching level one was having someone available 24/7.

Vicki Birkland wondered if the information gathered could be made available for the Montana Perinatal Association meeting to promote awareness and give information on next steps. Carly Holman asked to be connected to the creators of the conference, Vicki will create an introduction email to assist.

Dr. McCracken asked if there is a plan to resurvey in a year or certain timeframe. Carla stated they do not have one specific recommendation. Some states reimplemented based on their rural hospital closures and mergers, others reimplant to track their progress on their quality improvement (QI) goals. McCracken said it should be used as a tool to see what the facilities need and if progress has been made.

Updates on MOMS

Amanda Eby stated the MOMS Grant team wants to recognize facilities across the state that have shown dedication to maternal health by participating in a variety of MOMs sponsored activities. They would like to create a subcommittee to determine criteria and awards for champions in maternal health care. The committee will be comprised of volunteers. Dr. Tersh McCracken said it was still open for discussions, and asked Amanda to send out an email for anyone interested. He asked for comments on the committee. Olivia Riutta thought it was a great idea to uplift everyone's hard work. Dina Kuchynka agreed that, with times as difficult as they are now, the show of appreciation would be an encouragement. Amanda said that anyone with ideas, even if they did not want to join the committee, should email her.



Overview of Montana American Indian Healthcare

LeeAnn Bruised Head introduced herself and gave a summary of her background. She presented on the health services available for the tribes and the challenges surrounding them.

Q & A on presentation

Mary Jane Knisely commented that she loved the presentation and expressed her desire to become culturally competent. Nikki Campbell has worked with LeeAnn and discussed how helpful the book she posted in the comments has helped her with her relations with tribes. She touched on the importance of asking if there is something you are unsure of, listen more than talk. She also offered other resources available to aid with the relationship between tribal and state governments. She said we need to be willing to learn and have those tough conversations with tribes. Amanda Eby thought it would be helpful if LeeAnn could do a presentation on historical trauma and how that relates to maternal health. Dr. Tersh McCracken asked how he, as a provider, could work better within the systems they have, how the Indian Health Services (IHS) and outside facilities can collaborate. LeeAnn answered that they can reach out to the Health Director of the Tribes, or the Tribal colleges to come do a presentation on their tribe, culture, and history. She gave some presentations to Riverstone and invited a group of the providers to come to the Crow Fair, to experience the culture and people. It helps to put things in perspective when providers can see people at their best and not only in crisis. Amanda Eby commented that she attends the local Pow Wow. She said working in healthcare you tend to hear and see only how bad things can be and attending events like those can be very encouraging. It's important to see the other side of people's lives.

Public comment/roundtable questions and discussion

Dr. Steve Williamson asked if the Blackfeet community hospital participated in LOCATe. Carly Holman answered that they did participate and thanked Dr. Williamson for his support in making the needed connections. Amanda said the Blackfeet community hospital is also participating in some simulation trainings and in the perinatal quality collaborative (PQC).

Amanda Eby stated the next meeting on April 19 may or may not be in person. The hope is to be in person and have a longer meeting to discuss the presentations and how the information can be applied to maternal health. The agenda will include hearing from Carly and the team at UM on the Emergency Obstetrics Survey data, and Amanda will be doing some research on potentially doing a Native American Historical Trauma presentation.

MSU Mark & Robyn Jones College of Nursing



Sarah E. Shannon, PhD RN FAAN Dean & Professor, College of Nursing

A history of serving Montana



MRJCON: Undergraduate Education

❖ **Delivered in-person on each CON campus**

23% enrollment growth since 2017

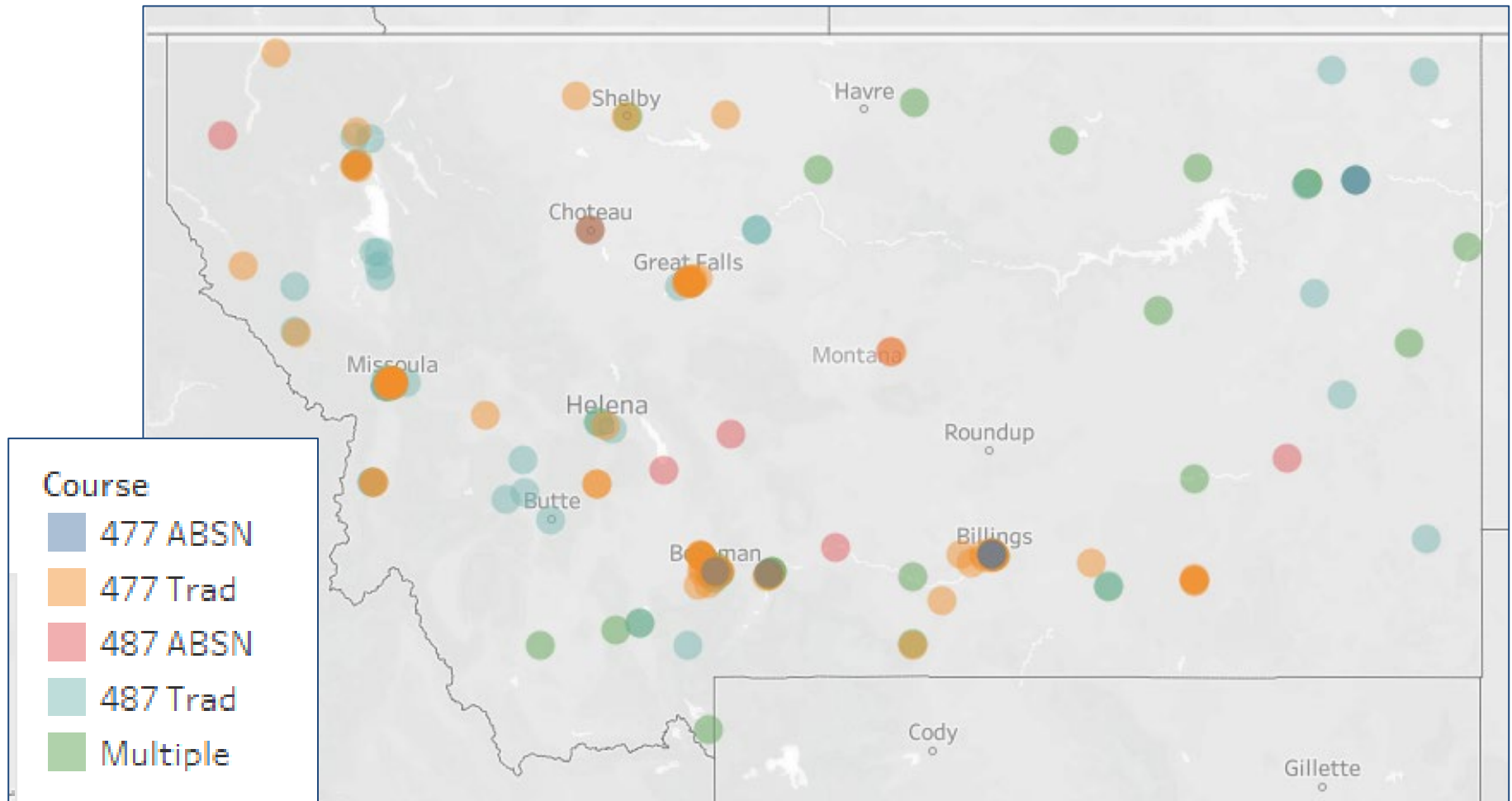
❖ **Traditional bachelor's degree (BSN)**

- 4-years (120 cr)
- 224 graduates per year; finish December & May

❖ **Accelerated bachelor's degree (ABSN)**

- 12-month program for applicants with prior bachelor's
- 80 graduates per year; finish in August

Locations of Senior BSN/ABSN Preceptors



MRJCON: Graduate Education

❖ **Coursework delivered online**

- Clinicals arranged as close to student's home as possible

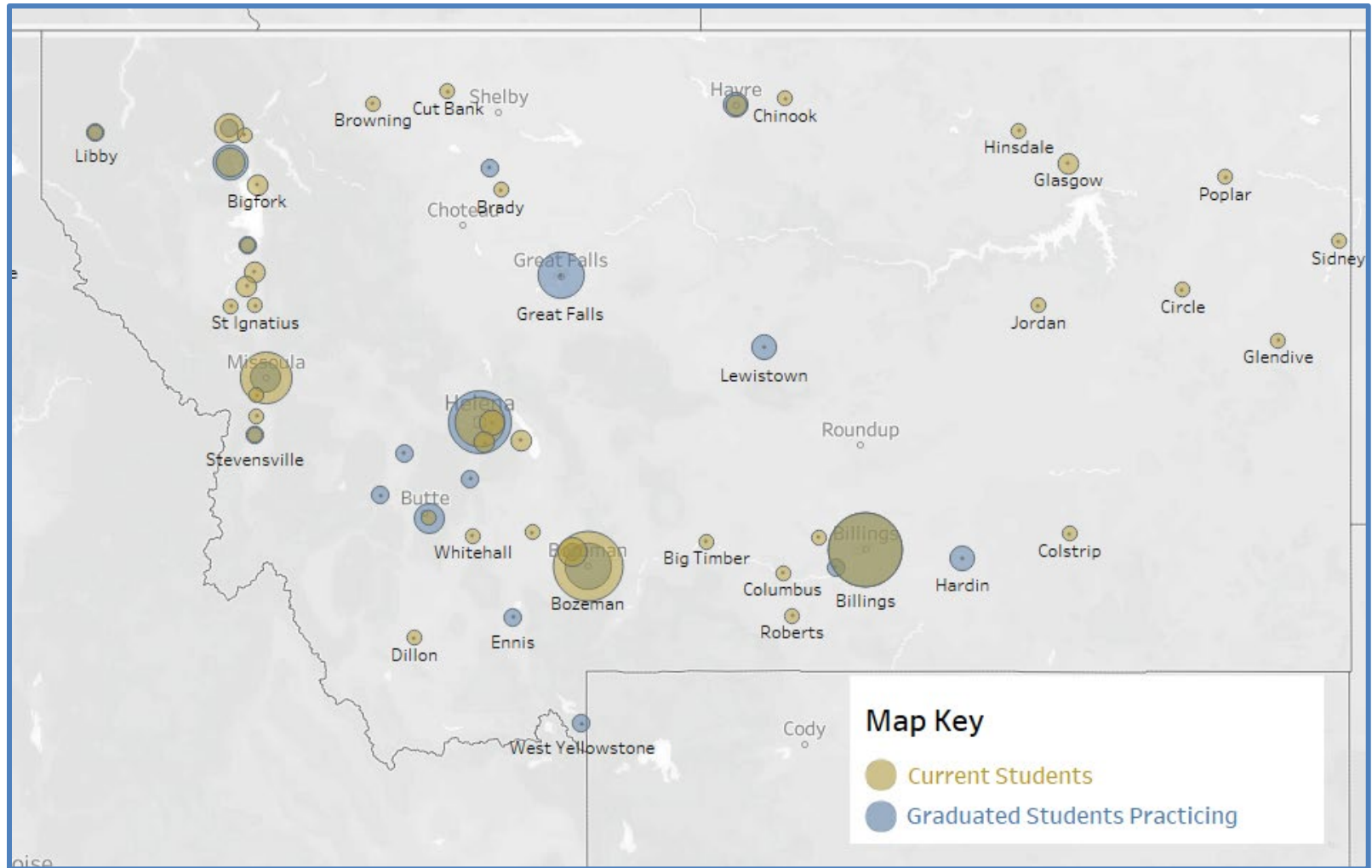
❖ **Master of Nursing (MN)**

- Focus on rural clinical nurse leadership
- Two years full time; 5-10 graduates/year

❖ **Doctor of Nursing Practice (DNP)**

- Family Nurse Practitioner (FNP) option
- Psych/Mental Health Nurse Practitioner (PMHNP) option
- Three years full-time; 20-30 graduates/year

Locations of Current and Completed DNP



'A day of new beginnings:' MSU nursing college receives \$101 million gift from founders of Goosehead Insurance



By Anne Cantrell, MSU News Service
AUGUST 31, 2021



Mark and Robyn Jones, founders of Goosehead Insurance, visit with Montana State University nursing students after the announcement of a \$101 million gift to the College of Nursing Monday, Aug. 30, 2021. The gift will support the MSU College of Nursing in meeting the future health care needs of Montana. MSU photo by Kelly Gorham

BOZEMAN — Friends of the Montana State University [College of Nursing](#) gathered at MSU Monday under blue skies to celebrate a transformative gift of \$101 million from Mark and Robyn Jones, founders of Goosehead Insurance Inc. The Joneses, who have a home in Whitefish, have said their intention is to help

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Jones Investment

- **Five new facilities located at each CON campus site**
 - Classrooms to accommodate increased enrollment
 - State-of-the-art simulation labs
- **DNP certified nurse midwifery program**
 - Goal to admit by fall 2024
 - Graduate 8 students annually
- **Five endowed professorships**
 - Recruit mid-career, research active tenure-track faculty
- **Endowed student scholarship fund**
 - Increased support for students

By 2030, ...

- **Increase BSN-prepared nurse workforce in Montana**
 - Increase production of graduates from current 300 to 400+ annually
- **Increase DNP-prepared nurse practitioner workforce particularly in rural Montana**
 - Graduate 50-60% more advance practice nurses, particularly psych-mental health NPs and **certified nurse midwives** to decrease number of counties in Montana classified as Health Provider Shortage Areas (HPSAs) and improve health outcomes
- **Attract top nursing faculty talent via endowed professorships**
 - Recruit and retain high caliber faculty
- **Increase student scholarships**
 - Gift will provide \$40,000 per year in new scholarships

Certified Nurse Midwife

- **Doctor of Nursing Practice level**
 - Will be the 3rd option in current DNP program
- **Emphasis on serving rural Montana**
 - Admit with preference for rurality
 - Recruit from former CO-OP graduates (\approx 130 AI/AN graduates)
 - Goal to admit 8-10 students annually
- **Timeline**
 - 2022-2023: develop and approve curriculum
 - 2023-2024: obtain pre-accreditation approval from ACME
 - Fall 2024: admit first cohort (graduate spring 2027)
- **How will the Jones' investment make the CNM possible?**
 - Supports planning and implementation prior to revenue generation (ACME, consultants, etc)
 - Supports extra student expenses necessary to live in rural Montana but travel to larger settings to obtain practice experiences for intensive periods

With incredible gratitude

Mark and Robyn Jones
donate \$101 million to the
MSU College of Nursing



Emergency Obstetric Care in Montana

Annie Glover, PhD, MPH, MPA

Carly Holman, MS

Diane Brown

Megan Nelson, MSW



Montana
Obstetrics &
Maternal
Support



This project is supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) as part of an award totaling \$9.6 million designed to improve maternal health outcomes with 0% financed with non-governmental sources. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by DPHHS, HRSA, HHS, or the US Government.



Outline

- Background
- Methods
- Results
- Next Steps

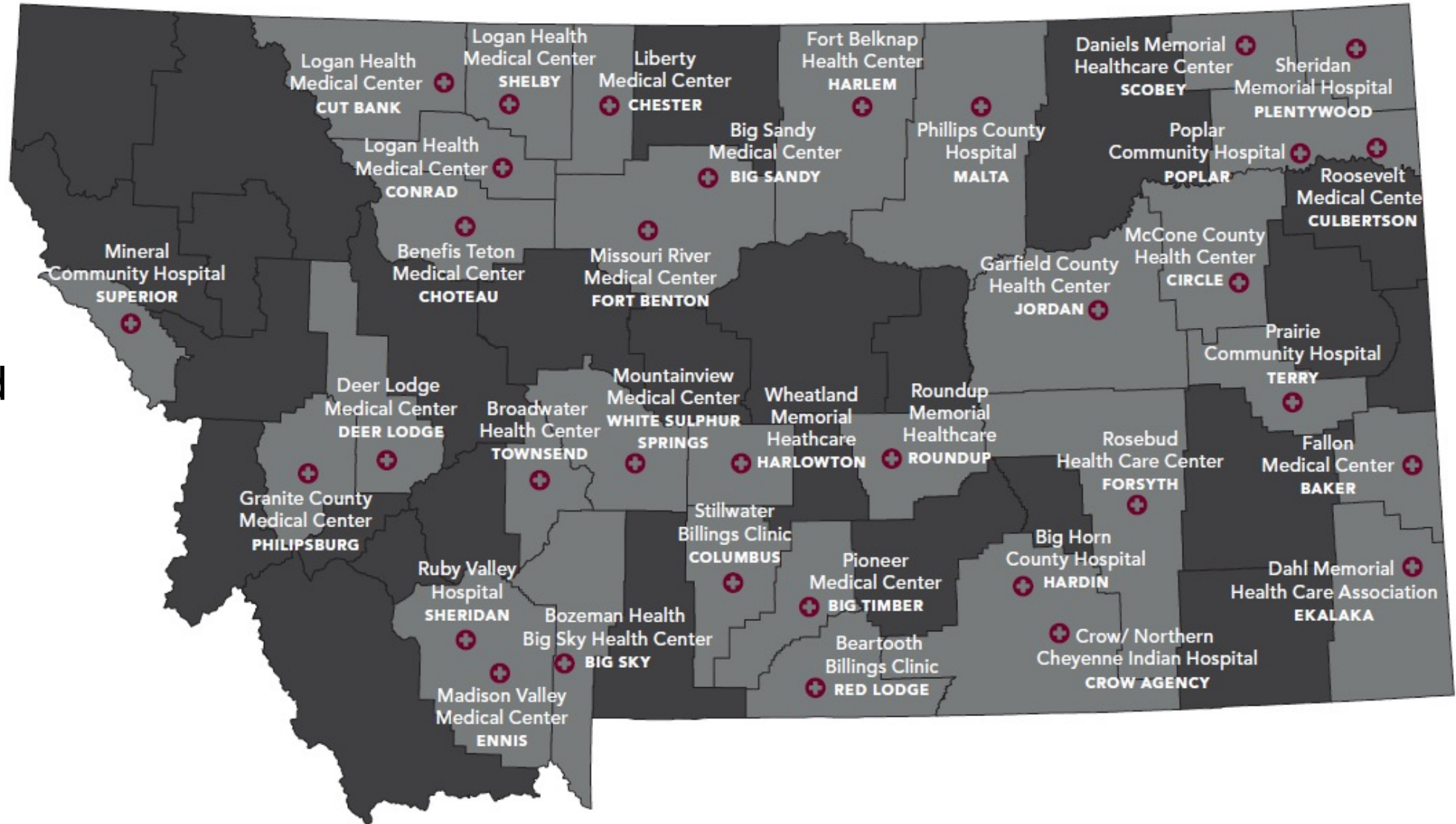




Background

- LOCATe assessed obstetric and neonatal levels of care for birthing hospitals
 - Emphasis on perinatal regionalization and risk-appropriate care
- Critical access hospitals (CAHs) without obstetrics (OB) provide emergency OB care (EmOC) services in emergencies
 - "Drive-by" delivery where mom is trying to get to a larger facility
- CAHs without OB unit should be prepared to perform key services
- Adapted WHO EmOC framework to assess Montana system

Montana hospitals without OB unit



- Over half previously had an obstetric unit.
- Closures follow national trend for rural hospitals.



Methods

Sample

Instrument

Methodology

- Instrument adapted from WHO EmOC Framework using Montana clinician feedback
- Additional questions related to perceptions of care capacity, transport, training/resource needs, participation in MOMS
- Email survey using RedCAP
- Data collection occurred from October 18, 2021, to December 10, 2021.
- 32/34 facilities ***without*** an obstetric unit (94%) participated.



Results

Capacity

Distance to birthing facilities

Emergency events

Staff concerns

Participation in MOMS

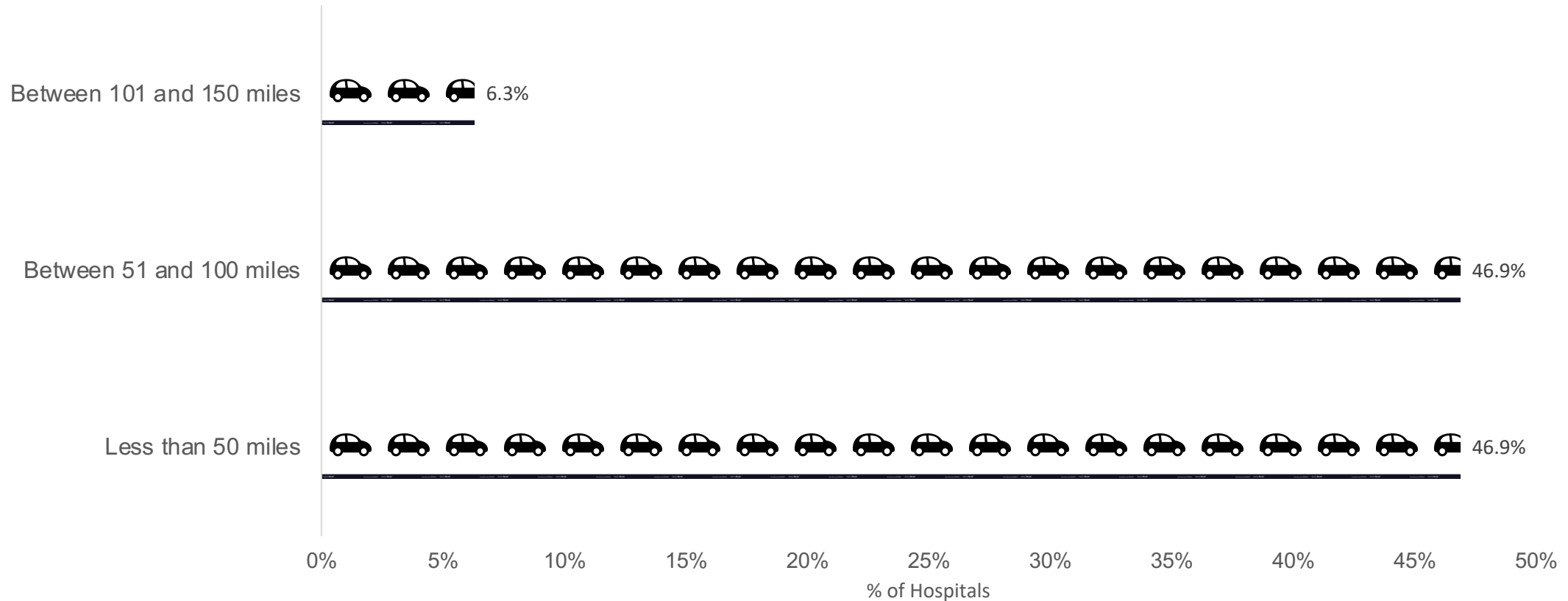
Capacity to provide emergency obstetric care

Emergency Obstetric Care Ability (N=30)	n (%)
Hospital has the capacity to...	
Administer magnesium sulfate for severe preeclampsia and eclampsia	26 (86.7)
Perform basic neonatal resuscitation	26 (86.7)
Conduct blood transfusion	23 (76.7)
Administer uterotonic drugs	16 (55.2)
Provide and interpret fetal heart tracing in an emergency setting	10 (34.5)
Perform assisted vaginal delivery with a soft cup vacuum extractor	4 (13.3)
Manually remove a placenta	4 (13.3)
Remove retained products of delivery	4 (13.3)
Hospital has a plan or policy for an emergency cesarean in the case of a life-threatening obstetric emergency	1 (3.3)

Emergency Obstetrics Services Results

Hospital Characteristics

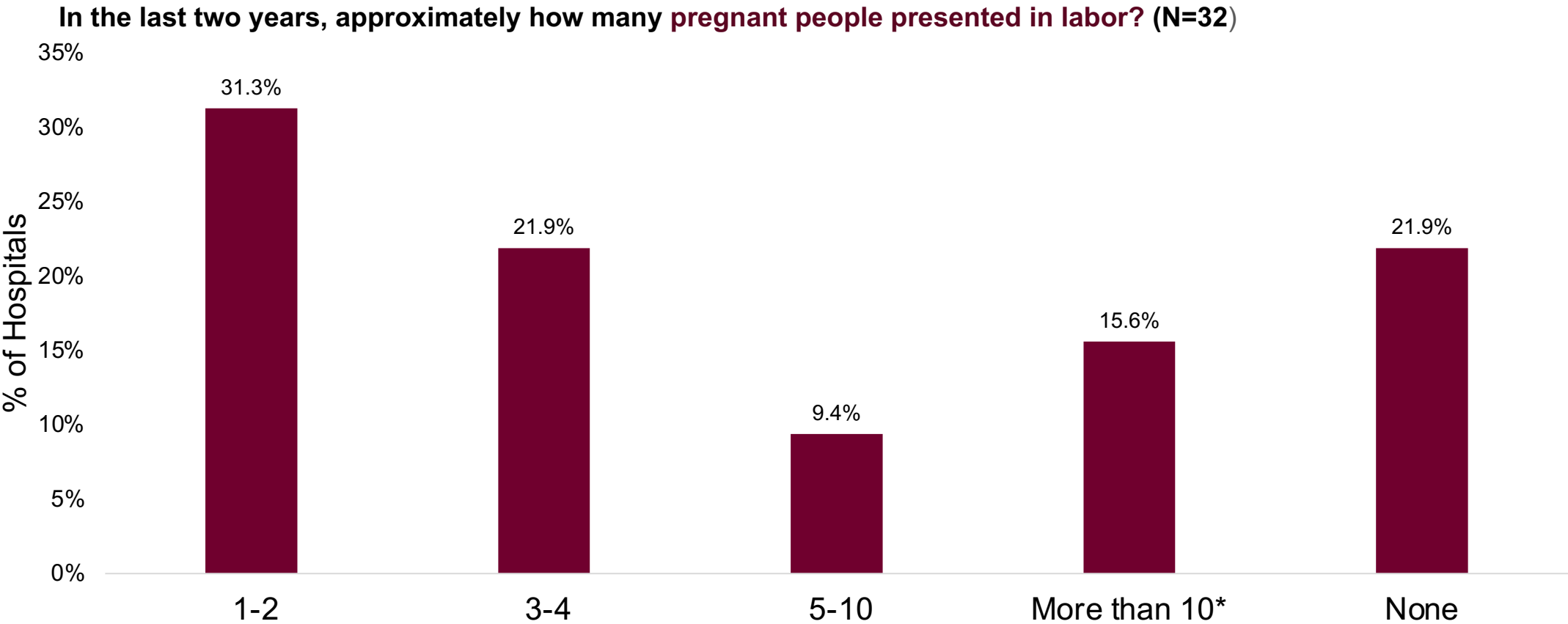
What is the driving distance to the closest hospital with OB services? (N=32)



Emergency Obstetrics Survey conducted October 18, 2021, to December 10, 2021.

Emergency Obstetrics Services Results

Emergency Events

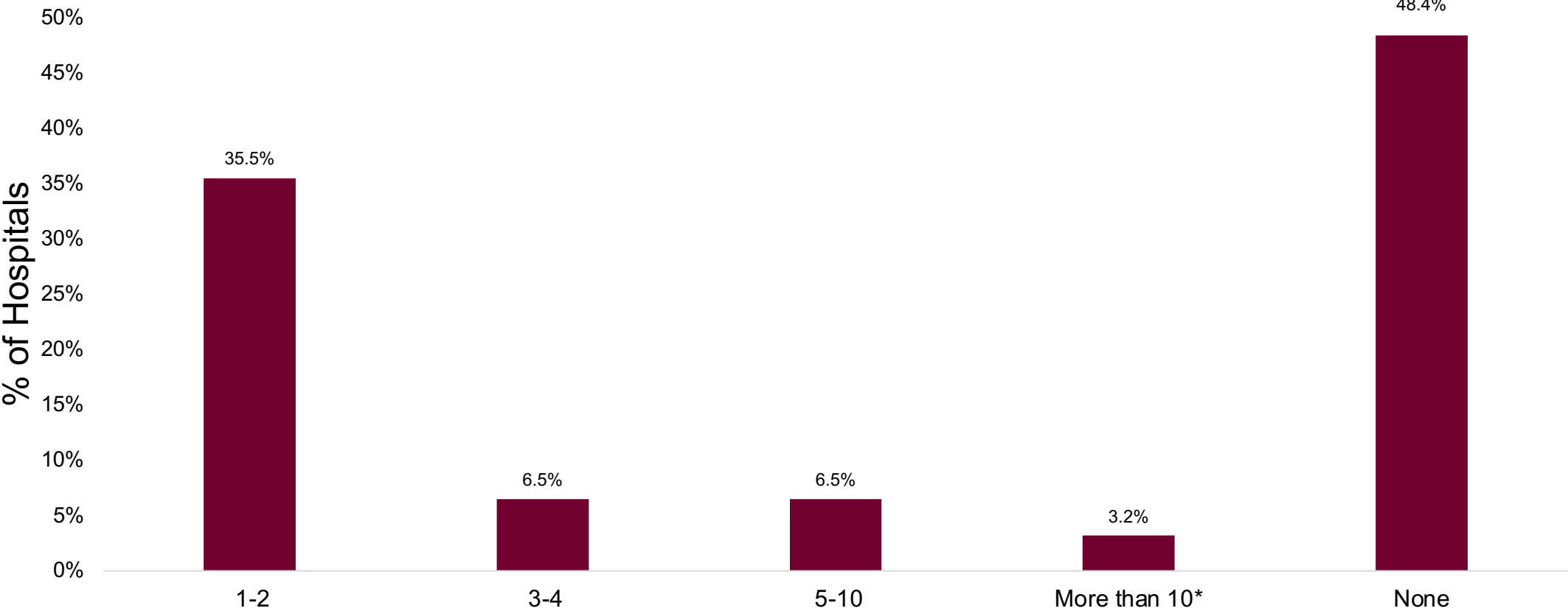


Emergency Obstetrics Survey conducted October 18, 2021, to December 10, 2021.

Emergency Obstetrics Services Results

Emergency Events

In the last two years, approximately how many **emergency room births** occurred? (N=31)

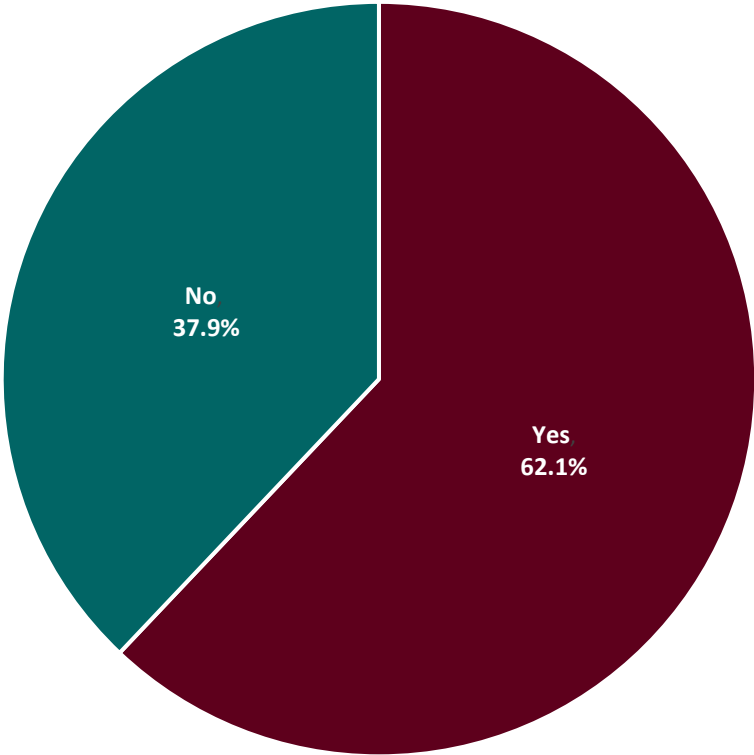


Emergency Obstetrics Survey conducted October 18, 2021, to December 10, 2021.

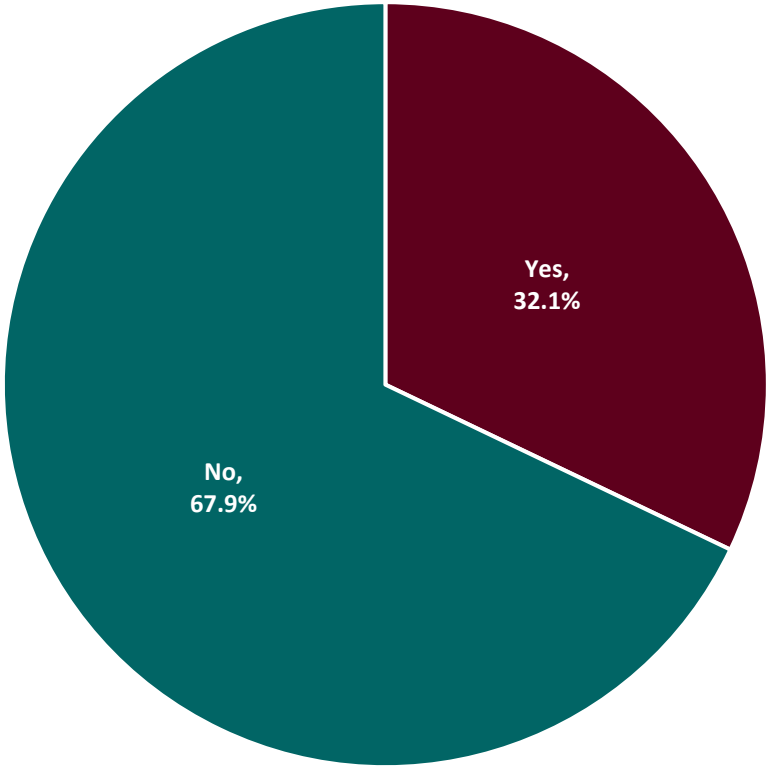
Emergency Obstetrics Services Results

Emergency Preparedness

Are per-diem staff oriented to policies/practices for obstetric emergencies? (N=29)



Does your hospital have a written protocol or formal policy describing under what circumstances transport of a pregnant patient should be arranged? (N=28)

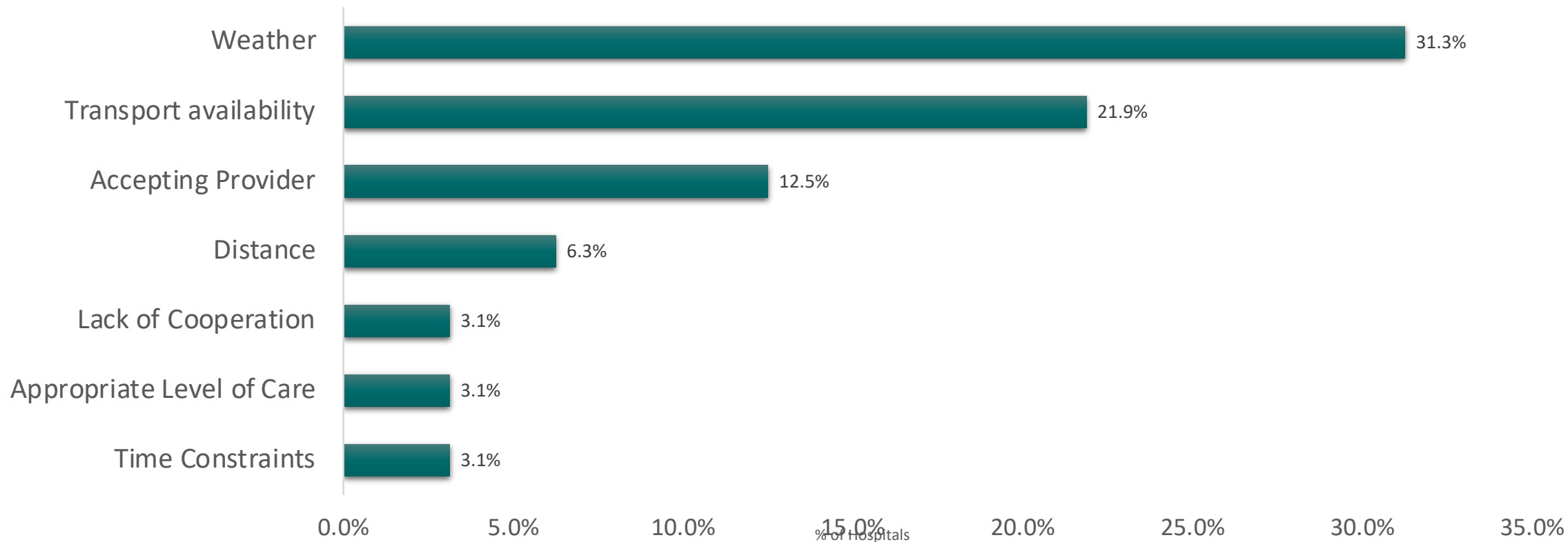


Emergency Obstetrics Services Results

Transport

Challenges Experienced by Hospital in Coordinating Urgent Transport of Pregnant Patients (N=32)

** multiple responses could be selected*



Emergency Obstetrics Services Results

Staff Preparedness

What best describes your hospital's position in regard to providing emergency obstetric services?

- They are of concern because of their frequency and our lack of experience in responding to them: **46.9%**
- They are extremely rare, and we have other priorities at our hospital: **46.9%**
- We are comfortable with our present level of experience and response to obstetric emergencies: **6.3%**

"I don't believe that anyone here has any experience in OB. It would be nice to spend a day on an OB ward and become familiar with the processes with a mentor with experience."

**multiple responses could be selected*

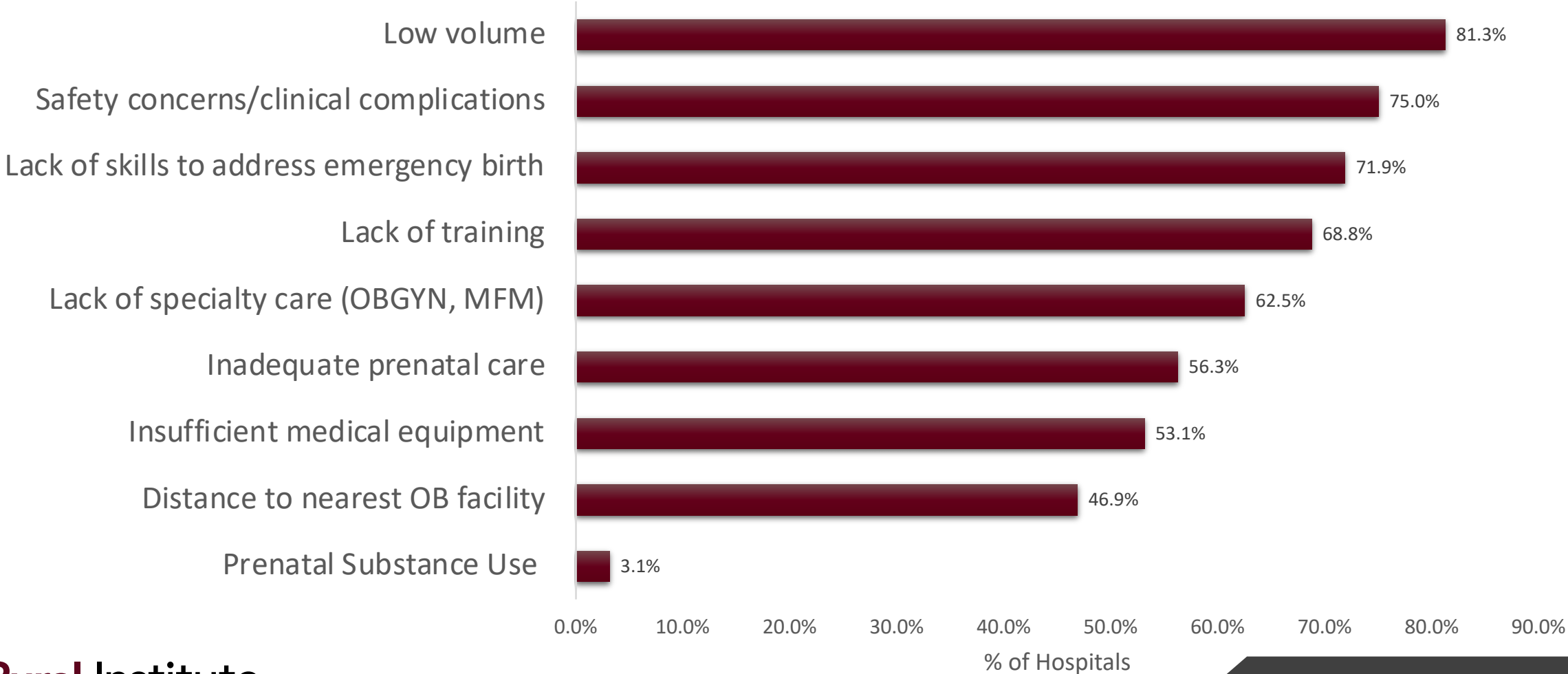
Emergency Obstetrics Survey conducted October 18, 2021, to December 10, 2021.

Emergency Obstetrics Services Results

Facility concerns with providing emergency obstetric care

What are your hospital's concerns about responding to local obstetric emergencies? (N=32)

**multiple responses could be selected*



Emergency Obstetrics Services Results

Participation with MOMS grant activities

Has your hospital participated in any activities coordinated by the Montana Obstetrics and Maternal Supports (MOMS) Program? (Select all that apply) (N=32)	n (%)
Obstetric Simulation Training	14 (43.8)
Project ECHO Virtual Case Presentations	1 (3.1)
Recipient of MOMS Mini-Grant	4 (12.5)
Nurse Certification Training	2 (6.3)
Unknown	1 (3.1)
None of the above	13 (40.6)

Next Steps

- Preparing full report for June publication and additional dissemination materials (presentations, manuscripts)
- Collecting data from survey on specific needs of hospitals for mini-grant and other MOMS programming outreach
- Recommendation alignment with LOCATe findings
 - Further promotion of perinatal regionalization
- Future work in emergency response, transport system strengthening

	Initials	Date
Prepared By		
Approved By		

[illegible]

Hello, my name is Rachel Twoteeth-Pichardo and I am Chippewa, Cree and Pend O'reille. I am currently a student at The University of Montana, which I am working towards my Bachelors in Art. I work with multiple mediums such as painting, drawing, beading, sewing, print making, dancing, Native American flute playing, and creating/teaching traditional indigenous games. The love and pride I have for my cultural heritage, drives my ambition and I couldn't imagine living a life without it. I titled this piece "A Mother's Love" for Mother's Day this past year. It meant a lot to me to create something so personal because it was my first actual Mother's Day, after become a new mom in 2020. My daughter really gave me a new found love, and respect to all mothers before me. I wanted to create something that really shows the beautiful bond between a mother and her baby and I mostly wanted to celebrate other indigenous mothers. This piece was also special to me because the ledger paper I used was from my grandmother's store in the 90's. Even though she is no longer here, I still get to craft and create with her and most importantly, carry her love with me.

The Indigenous Experience of Maternal Health & Wellness

Author: Amy Stiffarm, MPH (Aaniiih, Cree, Blackfeet)

Tribal Communities in Montana

There are over a dozen Tribal nations in what is now known as the state of Montana: The Blackfeet Nation, Chippewa Cree Tribes of Rocky Boy, Confederated Salish (Bitterroot Salish and Pend Oreille) and Kootenai Tribes of the Flathead Reservation, the Crow Nation, Assiniboine and Gros Ventre Tribes of Fort Belknap, Fort Peck Assiniboine and Sioux Tribes, Northern Cheyenne Tribe, and the Little Shell Tribe. Indigenous people have been birthing here long before this land became a state. To help better serve Indigenous people seeking maternal health care, we must acknowledge the difference in cultures and world views and recognize the strengths found in Indigenous societies. This strength-based perspective on Indigenous maternal health will draw attention away from deficit-based views that focus on negative issues affecting Indigenous people that further perpetuate harmful stereotypes. Instead, this report will demonstrate the beauty and healing potential of Indigenous world views of maternal health.

Inclusive Language Matters

It is important to note that when describing maternal health in Indian Country, the terms birthing people or person are used. Language is important and using incorrect words can cause harm. Before colonization efforts, many genders existed on this land. Eurocentric worldviews are based on physical traits and reflect a rigid dichotomy of boy or girl. An Indigenous worldview of gender is more fluid and is based on a person's spirit or gift. Two-spirit is often used to describe someone with both masculine and feminine spirits. In 2018, 2S was added to LGBTQ2S+ to be inclusive of Indigenous people (31).

The organizers who implemented the event formerly known as *Native Breastfeeding Week* provide an example of using inclusive language in maternal health. This event is held the second week of August, in conjunction with National Breastfeeding/Lactation Month. In 2021, the grassroots team

announced the name change to *Indigenous Milk Medicine Week* to be inclusive and considerate of the Indigenous populations they are serving (32).

Following these examples, birthing person or people will be used when describing Indigenous people who access maternal health care. If the term woman is used, it is respectfully meant to only identify sex, not gender. It is not the intention to cause further harm to birthing people but to illuminate topic areas that are rarely discussed.

Concept Map

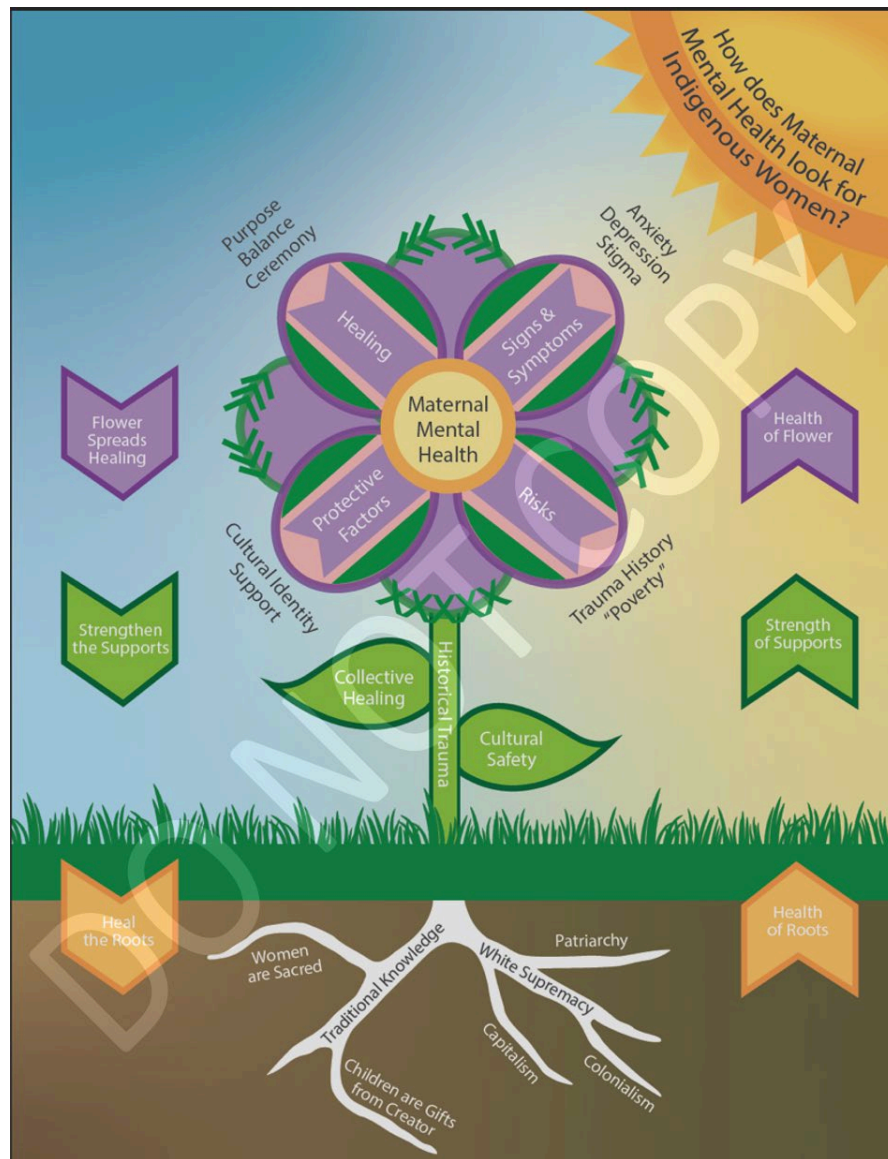


Figure 1. Indigenous Maternal Health Concept Map, developed by Amy Stiffarm, MPH (Aaniiih, Cree, Blackfeet)

To illustrate aspects of maternal health, I developed a concept map, shown here. This concept map was originally created to focus on maternal mental health for Indigenous birthing people. However, many of the topics presented align with maternal health in general. Furthermore, mental health is very relevant to maternal health as postpartum depression is the leading maternal health complication in the United States (33).

First and foremost, it's important to acknowledge that everyone's healing journey is different. This concept map presents ideas that may be true for some Indigenous people in Montana. It is not meant to represent every Native birthing person in the state. A flower represents the beauty of womanhood. Indigenous worldviews recognize the interconnectedness between all things. Plants and humans have a sacred connection as we are in a reciprocal relationship. Plants provide us nourishment and medicine and we honor them and help them spread and grow.

A flower is only as healthy as its roots. The health of the roots determines the strength of its stem which in turn aids the flower in blossoming to its full potential as a healthy thriving plant. The sun is used to shine a light on maternal mental health for Indigenous birthing people and our unique experiences and world views. Because the topics represented in the map are true for maternal health in general, this concept map will be used to help better understand the Indigenous experience.

Roots

The roots symbolize the macro level, or the larger scale view of the issues surrounding maternal health and well-being. How Indigenous people experience health is deeply influenced by Traditional knowledge. Many Indigenous cultures hold the belief that birthing people are sacred due to our ability to bring life into this world. With that knowledge is also the belief that our children are gifts from the Creator, and they travel from the Spirit World to us. Also within the Traditional knowledge realm is the fact that pre-colonization, our communities knew how to take care of birthing people in pregnancy and parenthood.

White supremacy is a rotten root of the flower of womanhood and birthing people's experiences. Colonization continues to disrupt our traditional teachings, including parenting. One of the most recently discussed tactics of the colonizers was the removal of children from Indigenous communities to attend boarding schools (United States) and residential schools (Canada). This topic has been widely discussed in

the media since the unearthing of 215 unmarked graves at the former Kamloops Indian Residential School in Kamloops, British Columbia (34).

Indigenous scholars and advocates such as Camie Goldhammer, Founder of Indigenous Breastfeeding Counselor Trainings and co-founder of Hummingbird Indigenous Doulas, have linked this removal of children to near erasure of traditional knowledge relevant to pregnancy and parenting. Montana had seventeen boarding schools throughout the state (35). These intentional efforts severely disrupted the passing on of Traditional Knowledge and introduced trauma into Indigenous communities. This occurred not just through taking children away from families, but from severe physical, emotional, and sexual abuse that had occurred at these “schools.”

White supremacy also only places value on Eurocentric ideals including western medicine and therapies. These models fail to recognize the power of traditional healing modalities that have allowed Indigenous people to survive despite the efforts of colonization. Also stemming from white supremacy is patriarchy. Residuals of patriarchy have been leftover in many Tribal communities after colonization and boarding schools (36). This can be seen in some communities in cultural revitalization efforts focusing on male-dominant teaching and ceremonies which are not conducive to a support system of collective healing. This not only affects the strength of cultural identity as a protective factor in a negative way but reduces the potential for healing through ceremony.

Stem and Leaves

The stem and leaves represent the community level. Connected from the experiences of the roots, the stem shows how historical trauma continues to impact Indigenous birthing people. Many Indigenous communities are suffering from disparities from the unhealed trauma stemming from colonization and genocide that occurred in Manifest Destiny’s name (37). Boarding schools caused a lot of this trauma for Indigenous communities, but other strategies of colonization, such as removal from ancestral homelands, cause trauma. Removal from ancestral homelands impacts spiritual connection to

place, gathering medicines, and nutrition from hunting and harvesting traditional plants. Because of our belief of being children of Mother earth, removal from our homelands is seen as the first separation of children from their mothers.

Branching off the stem is one leaf of collective healing to represent the Traditional Knowledge that remains and how it can still be utilized to heal Indigenous communities as a collective; this contrasts with western medicine which focuses mainly on individual healing. Indigenous worldviews believe that healing is achieved through community and relationships. Healthy birthing people and parents can be found in healthy communities. Before the medicalization of birth, Indigenous people birthed in ceremony and with the support and help of community.

This issue is especially relevant when we consider the protocols put in place due to the COVID-19 pandemic, where there were limitations regarding who was able to be present during birth. In some scenarios, birthing individuals were completely without their families. A study with Canadian Arctic Indigenous women recognized the stressors associated with needing to travel and be away from their communities to give birth. The authors stated that “for women who delivered away from home, [labor] was a traumatic event intensified by feelings of isolation and worry about their families” (38). Even before the pandemic, this was an issue for Indigenous birthing people in Montana, as most are expected to leave their communities to attend prenatal appointments and to give birth.

The other leaf is cultural safety. Cultural safety in health care is an important component of maternal health, as the care that a person receives during their pregnancy will impact them forever. Many studies demonstrate how implicit bias in maternal health care negatively relates to lower quality of care (39). Providing culturally safe care during pregnancy and for the baby and parent(s) afterward allows the mother/parent to feel supported and more secure in their cultural identity (40). This will also improve trust and communication, allowing the birthing person to speak openly about any potential physical or mental health issues (41). If a person is receiving western medical care, then that treatment needs to be

culturally safe as well. Indigenous people receiving these services should feel the freedom to receive care from both western medicine and Traditional healers if available. This should not be seen as a competition but an opportunity to further overall health and well-being.

Indigenous Doulas

The flower and its petals represent the individual experience of maternal health. There are four petals to represent the protective factors, the risks, the signs and symptoms, and the healing that are associated with maternal health and birthing for an Indigenous person. Indigenous doulas can help with each of these areas. They can be viewed like the essential, sacred water for the plant and aid in many of the issues relevant to maternal health for Indigenous women.

Research has shown that doulas are an important factor for helping pregnant people and parents during this impactful time of birthing people's lives and can aid in positive maternal health outcomes (42). Having access to Indigenous doulas can help restore supportive relationships, provide culturally safe care, and reclaim ceremony that combats the loss of Traditional knowledge (43). Indigenous doulas can serve as an additional layer of protection by helping birthing people identify risks they had not considered bringing up to their provider and aiding in recognition of warning signs and symptoms of potential maternal health issues, including mental health during pregnancy and after. Indigenous doulas can be the life force needed to address maternal health issues for Indigenous women by guiding mothers towards healing and restoring the sacred relationships between mothers and community.

When discussing Indigenous doulas, we must acknowledge the strengths already present within Indigenous communities and culture. Before colonization, aunties, moms, sisters, grandmothers, and two-spirit relatives had roles relevant to what are now called doulas. These roles were always present within Indigenous communities. When we advocate for Indigenous birthing people to have access to doulas, we are advocating for the resurgence of Indigenous doulas from within Indigenous communities, not for bringing outside, non-Indigenous doulas into communities. An example of this is work done by

Zaagi'idiwin, an Indigenous birth worker organization out of Manitoba, Canada that trains full-spectrum doulas. This past year, thirty participants from across Indian Country in Montana were able to attend this training.

Relationships

At the root level, we must consider the health of the roots and how this affects the stem and the flower. The stem and leaves support and nourish the flower. How strong is this support? This impacts the health of the flower. In looking closer at the petals, the protective factors and risks cancel one another out. Risks can lead to signs and symptoms. However, from an Indigenous perspective, signs and symptoms are only bad if they are not recognized and addressed. Signs and symptoms can lead to further healing. Healing can reduce these signs and symptoms and is represented by the two-way arrow between the petals. Healing may come easier for Indigenous women with more protective factors, and healing will further provide women with additional protective factors. Therefore, these petals also have two-way arrows.

Birth Justice

Once a flower is healthy, the flower can help spread this healing to others. By healing the individual, collective healing of the community can occur. This strengthens the support and sends healing back to the roots. Healing the roots is achieved by increasing Traditional Knowledge translation and reducing the impacts of colonization and white supremacy on Indigenous birthing people. For Indigenous birthing people, a healthy flower system translates to birth justice. This means there are safe, healthy options for where and how they choose to birth (44). These options should not conflict with but support Traditional Knowledge and ceremony and create a space where patients and their world views are respected. We need a healthcare system where all Indigenous birthing people can access Indigenous midwives, doulas, and lactation supports. This is birth justice.

Whenever an Indigenous birthing person seeks any type of care for themselves or their child, they are acting despite the wrongs done to the generations of birthing people before them. All birthing people deserve the best prenatal and birth care, where they are safe and respected. When an Indigenous birthing person is present at the doctor's office, they are holding the burden of the history of America and what has been done to their people. However, they also hold the amazing strength of their culture and the power of their ancestors' prayers. With hope for good health, they seek care.

This healthcare system has been failing Indigenous people for far too long. Let us work together to create a system that honors the ceremony of birth and provides the environment necessary for true healing. This environment is not only essential for Indigenous people, but for all birthing people. We must explore how cultural teachings of pregnancy, parenthood, and overall health can be combined with the current maternal healthcare system to improve outcomes for all birthing people. Healthy communities start with healthy birthing people.