Maternal Health Leadership Council Meeting
July 19, 2022
12:00 – 4:00 PM
Montana Hospital Association Board Room - 2625 Winne Ave, Helena, MT 59601
Zoom: https://us02web.zoom.us/j/87488465476?pwd=ZitxcUFXZmU4TE5MMEYwNytYbkpNZz09
Meeting ID: 874 8846 5476  Passcode: 721941

Agenda
12:00 – 12:30 Working lunch – follow-up discussion on April presentation on American Indian Historical Trauma and Maternal Health

12:30 - 12:50 MOMS Year 4 Workplan
Input and approval requested

12:50 – 1:10 Overview of Cultural Safety by Amy Stiffarm, MPH (Aaniiih, Cree, Blackfeet)

1:10 – 1:30 Overview of Trauma-Informed Care by Sarah Reese, PhD, LCSW

1:30 – 1:40 Break/individual reflection (prepare thoughts on small group questions)

1:40 – 2:10 Discuss how to develop a Montana Cultural Safety and Trauma-Informed Care Training
Small group discussions

2:10 – 2:30 Report out from small groups

2:30 – 2:50 Synthesize input into an outline for developing and implementing training program
Small group discussions

2:50 – 3:10 Debrief in full group

3:10 – 3:20 Break

3:20 – 3:30 Supporting maternal health in primary and ancillary care settings
Report out from Olivia Riutta of the Montana Primary Care Association and discussion

3:30 – 3:40 Summary of projects funded by 2022 MOMS Rapid Response Mini Grants
University of Montana

3:40 – 3:50 Updates on MOMS and related projects and Y4 plans

3:50 – 3:55 Questions and discussion

3:55 – 4:00 Public comment

Next meeting – October 18
Members Present
Chair, Dr. Tersh McCracken, MOMS Medical Director & Ob-Gyn at Billings Clinic
Lisa Troyer, Wellness Consultant at Pacific Source Health Plans
Janie Quilici, Perinatal Behavioral Health Counselor at Community Physicians Group
Oliva Riutta, Outreach and Engagement Manager at MPCA
Brie MacLaurin, Executive Director of Healthy Mothers, Healthy Babies
Tami Schoen, RN at Hill County WIC Department
Jen Verhasselt, Senior Residential Services at Rimrock and Pathway to Parenting program
Mary LeMieux, Member Health Management Bureau Chief at Medicaid, and Perinatal Behavioral Health Initiative Director
Dina Kuchynka, Maternal and Newborn Health Manager at SCL Health-Holy Rosary
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

Members Absent
Dr. Jean-Pierre Pujol, Medical Director at Blue Cross Blue Shield of Montana
Vicki Birkeland, Nursing Director, Women’s Services at St. Vincent’s Montana Perinatal Quality Collaborative
Tressie White, Program Director with Montana Healthcare Foundation
Jennifer Wagner, Rural Hospital Improvement Coordinator with Montana FLEX Program at Montana Hospital Association

Program Staff Present
Dr. Annie Glover, Lead evaluator and PI for MOMS at University of Montana (UM)
Carly Holman, Program Evaluator at the UM Rural Institute for Inclusive Communities
Amanda Eby, MOMS Project Coordinator at DPHHS
Lacey Ronzheimer, Nurse consultant for Montana
Stephanie Fitch, MOMS Grant Manager at Billings Clinic

Public Attendees
Dr. Sarah Shannon, Dean of the Mark and Robyn Jones College of Nursing
Sarabeth Upson, DPHHS Medicaid, Perinatal Behavioral Health Initiative
Amy Stiffarm, Indigenous Public Health PhD Student
D’Swayne Barnett, Director of the Missoula City-County Public Health Department

Welcome and introductions
Dr. Tersh McCracken opened the meeting and lead roll call. Lacey Ronzheimer gave an introduction and overview of the work she does. Janie Quilici moved to approve the meeting minutes and Mary LeMieux seconded the motion.

Montana State University Investment for DNP Certified Nurse Midwifery Program
Dr. Sarah SCanon opened her presentation. The college was renamed the Mark and Robyn Jones college of Nursing. Dr Shannon gave an overview of the history of the college and explained the
distributed campus model. The undergraduate program is provided in person at each of the five locations. Enrollment has grown by 23% since 2017. They offer a traditional bachelor’s degree and an accelerated bachelor’s degree. The Graduate program works to allow students to complete their clinicals as close to their home as possible. They offer a Master of Nursing and a Doctor of Nursing Practice. 80% of the graduates stay in Montana and serve their communities.

The founders of Goosehead Insurance, Mark and Robyn Jones, donated $101 million to MSU in August of 2021. These funds aided in five new facilities with classrooms to accommodate increased enrollment and state of the art simulation labs, the creation of a DNP certified nurse-midwifery program, five endowed professorships, and an endowed student scholarship fund.

The goals for the program are to:
1. Increase the BSN-prepared nurse workforce in Montana from 300 to 400+ annually
2. Increase the DNP-prepared nurse practitioner workforce, particularly in rural Montana, graduating 50-60% more advanced practice nurses, particularly psych-mental health NPs and certified nurse midwives to decrease the number of counties in Montana classified as Health Provider Shortage Areas and to improve health outcomes.
3. Attract top nursing faculty talent via endowed professorships.
4. Increase student scholarships. The gift will provide $40,000 per year in new scholarships.

The Doctor of Nursing practice level will be the third option in the current DNP program. It will have an emphasis on serving rural Montana. They are working to develop and approve the curriculum. In 2023-2024 they will be obtaining the pre-accreditation approval from ACME. In the fall of 2024, they will be able to admit the first cohort. The Jones’ investment supports planning and implementation prior to revenue generation and supports extra student expenses necessary to live in rural Montana while traveling to larger settings to obtain practice experiences for intensive periods.

Q&A
Dr. Annie Glover commented how exciting it was, as they’ve been doing work in clinical quality improvement in the perinatal quality collaborative (PQC) and working directly with nurses. They are the ones who typically respond to the assessment surveys on facility capacity. Dr. Glover said she believes having a midwifery program in Montana will be a gamechanger. Dr. Shannon stated that critical access hospitals don’t want to offer OB services but would be able to identify women, so they are appropriately referred to a larger community. Dr. McCracken also commented that a midwifery service that can act as a physician extender would open many great possibilities.

Montana’s Emergency Obstetrics Survey
Dr. Annie Glover presented the results from the emergency obstetrics survey conducted through the University of Montana with the critical access hospitals in Montana that don’t have an obstetric unit, which was the brainchild of Carly Holman. Carly presented on the LOCAte survey at the January meeting and conducted that survey as well as this one. The goal was to assess the system of care that Montana has around Obstetric services. They wanted to have an emphasis on perinatal regionalization and risk-appropriate care, so it was important to make sure they were including these critical access hospitals in this assessment. The survey was built off a World Health Organization (WHO) framework as part of a larger maternal health system needs assessment that is ongoing. They used Montana clinicians’ feedback to make it more applicable to our circumstances. They added questions related to perceptions of care capacity, transport, training resource needs, and then also the facility’s participation and various MOMS interventions. The survey was done through RedCap and there was a 94% response rate. Dr. Glover gave an overview of the results.
**Q&A**

Dr. McCracken asked if the conduct blood transfusion module was based on if they have blood available or the ability to do blood transfers. Carly Holman clarified it is if they have blood available. Dr. McCracken asked if there was a common thread in the hospitals with ten or more emergency events? Dr. Glover said she had not done the crosstabs yet, but it would be a good line to look at. Tami Schoen commented that she wouldn’t be surprised if many of them were related to the tribal health not having OB services and the mother having to be transported. Dr. McCracken thanked Carly Holman and Dr. Glover for gathering the information. He thought the next step would be determining the recommendations based off the information.

Olivia Riutta commented that she is excited for the crosstabs. She is hoping to get more information on why people deliver in the emergency room versus closer locations. She thought engaging EMS and emergency workers would also be worthwhile. Dr. Glover stated there is an emergency services advisory council at DPHHS that would be a good partner to engage. Carly Holman stated they had some nurses from rural critical access hospitals that suggested looking at the community level EMS, firefighters, etc. who handle emergency obstetric services. They would benefit from these conversations and simulation training as well. Tami Schoen asked if the emergency room deliveries counted deliveries done in the ambulance in route. Dr. Glover was unsure if that was included. She said she wanted to include first responders in the brainstorming and discussions.

Sarabeth Upson commented that the Healthy Mothers Healthy Babies group has done crisis resource mapping and would have good connections beyond the state level. Dr. McCracken said he thought there was some resistance within Native Americans to leave the reservation for delivery and there are many factors that play into that. He believes that would be another area to look at.

**American Indian Historical Trauma and Maternal Health**

Dr. McCracken welcomed Dr. D’Shane Barnett and Amy Stiffarm and thanked them for presenting. Dr. Barnett opened the presentation. He spoke about traditional health practices and how it affects the American Indians today. Amy Stiffarm presented on Indigenous Maternal Health. She spoke on how understanding Indigenous worldview can affect maternal health and how to approach this work with a strength-based mindset. She also touched on ways to work with tribes and tribal leaders.

**Q&A**

Dr. McCracken asked Amy how she would counsel them to be more culturally safe. Amy Stiffarm stated it is more about understanding the power dynamics. It is seeing the people for their strengths and resiliencies instead of their disparities or stereotypes. She said to ask if there are any cultural practices they want to do in their birthing process. Dr. Barnett agreed that there are many trainings and workshops available, but simply ask the patient if there is anything you can do to make them feel safer or more comfortable.

Dr. McCracken also asked if an indigenous Doula is a substitute for having family in the birthing suite or if there is a role for them even with family present. Amy Stiffarm answered that an Indigenous Doula would still have a role. They support the mother and are more of an advocate than a family can be. Dr. McCracken touched on the fear felt by Indigenous parents that their children will be taken at birth. Dr. Barnett said there needs to be an opportunity for key stakeholders to come to the table to have those discussions create answers.
Amy Stiffarm said having a relationship where someone struggling with addiction can come forward with that information and be given the tools and treatment that align with their beliefs and ceremony would be very helpful. She also stated being transparent about information, who is being screened, and what is the process for that is important. She believes we need to be thinking more along the lines of prevention.

**Determine meeting format for July and October Public comment**
Amanda Eby brought up possibly meeting in person and opened the floor for discussion. They would be doing a hybrid meeting so people could join virtually as well. They can use grant funds to provide reimbursement for mileage, for lodging, and for per diem for meals as well.

Dr. McCracken thought having at least one in person meeting would be good. He said the virtual system has worked but it’s nice to have the sidebar conversations that can help propel an organization going forth and generate ideas. Janie Quilici said she would like to be in person as well.

Dr. Glover said there are hybrid options at the campuses so they could investigate that option. Tami Schoen thought meeting in person would be nice as well. Amanda Eby asked if they wanted to do the July meeting or October meeting in person. They settled on July due to better weather.

**Announcement**
Amanda Eby shared they received approval from HRSA to use carryover funds from year two to administer another mini-grant program this year. The program would be administered according to the same criteria that was approved by the council a year ago. She asked for volunteers to be on the review committee. Mary Lemieux asked when Amanda would be sending out the applications and when they would be returned. Amanda answered the timeframe will be the same as last year, over the month of May. Dr. Annie Glover stated they are updating the application system right now. They will get the timeframes out asap. Lisa Troyer commented that, as someone who reviewed applications last year, they are not very long or complicated.

Dr. McCracken asked Amanda who last year’s grant winners were. Amanda answered there was a patient referral system for the postpartum resource group in the Flathead area, there was one that funded the films that Healthy Mothers, Healthy Babies created about postpartum mental health in native populations, several went to training programs, and some went to simulation equipment to help with the simulation training in hospitals. Dr. Glover said she attended one simulation at St Luke’s Hospital in Ronan. The Rocky Boy Tribal Health Department used some of their funds to put together food packs for mothers during COVID as well as gas cards to help mothers and babies get to their appointments.

Meeting adjourned at 5:00 pm.
American Indian Historical Trauma: Understanding Health Impacts

D’Shane Barnett, MS, PhD(c)
Missoula Public Health

April 19, 2022
Traditional Practices
American Indian Freedom of Religion Act

Do you know anyone who is 45-years-old or older?
American Indian Freedom of Religion Act

1883
Laws Banning TCP

1964
Civil Rights Act

1978
AIFRA
Historical & Intergenerational Trauma

Maria Yellow Horse Brave Heart$^{1,2}$

- Colonization
- Attempted genocide
- Forced relocation
- Termination
- Boarding schools
- Separation from resources

- Poverty
- Violence
- Problem substance use
"Firewater Myth"

The “firewater myth” is a term that has been used to represent the notion that AI/ANs are more susceptible to the effects of alcohol and more vulnerable to alcohol problems due to biological or genetic differences. Although genetics play a clear role in the risk for an alcohol use disorder, there is little evidence that biological risk factors play a greater role in alcohol use disorders among AI/ANs compared to other racial groups.

-Gonzalez & Skewes³
Holistic Healing

Two-Eyed Seeing Blended Approach to Delivering Seeking Safety
Conceptualized in the Medicine Wheel


Figure 1 Two-Eyed Seeing blended approach to delivering Seeking Safety conceptualized in the medicine wheel. Adapted from an article, "Medicine Wheels: A Mystery in Stone," written by J. Rod Vickers [6].
<table>
<thead>
<tr>
<th>Year</th>
<th>Reservation/Urban</th>
<th>Sample Size</th>
<th>Type of Study</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021</td>
<td>Urban</td>
<td>N = 63</td>
<td>RCT</td>
<td>DARTNA participants reported fewer drinks per day (d = −0.39, 95% CI = −1.04, 0.27), and lower odds of marijuana use in past 30 days (odds ratio = 0.50, 95% CI = 0.10, 2.54) compared to usual care.</td>
</tr>
<tr>
<td>2014</td>
<td>Urban</td>
<td>N = 10</td>
<td>Pilot Study</td>
<td>Eighty percent (8/10) completed at least the 6-week (midpoint) assessments. Fifty percent (5/10) completed the 12-week DARTNA program 75% (6 of 8 participants) reported no alcohol or drug use at follow up. At follow up, IPs were drinking about 1.5 drinks less than before the intake data were collected (5.4 versus 6.8).</td>
</tr>
<tr>
<td>2008</td>
<td>Reservation</td>
<td>N = 190</td>
<td>Evaluation Study</td>
<td>Lower proportion of past-month drug use among respondents who participate in traditional ceremony: 16.1% and 25.5%, respectively (p = 0.044). Lower proportion of past-month marijuana use among respondents who participate in traditional ceremony: 10.5% and 17.4%, respectively (p = 0.079).</td>
</tr>
<tr>
<td>2016</td>
<td>Urban Reservation</td>
<td>N = 347</td>
<td>Cross-sectional</td>
<td>“More American Indian oriented” were less likely to report alcohol use than “bicultural” and “less American Indian oriented” (20.4%, 51.1%, and 58.6%, respectively; p &lt; 0.001), less likely to report heavy alcohol use (11.2%, 28.8%, and 39.9%, respectively; p &lt; 0.001); less likely to report illicit drug use (12.2%, 26.9%, and 27.9%, respectively; p &lt; 0.001). Lower proportion of past-month marijuana use among respondents who participate in traditional ceremony: 10.5% and 17.4%, respectively (p = 0.079).</td>
</tr>
<tr>
<td>2003</td>
<td>Urban</td>
<td>N = 2,449</td>
<td>Cross-sectional</td>
<td>Within the pre/post matched sample, alcohol use decreased 13% after six months and drinking alcohol to intoxication was reduced by 19%. Of those women who had used marijuana, non-prescription methadone, hallucinogens, uppers, downers, and inhalants at intake, none reported use at six months. Heroin use was down 93%.</td>
</tr>
<tr>
<td>2003</td>
<td>Urban</td>
<td>N = 742</td>
<td>Evaluation Study</td>
<td>Alcohol cessation was significantly and positively associated with participation in traditional spiritual activities (r = 0.23, p &lt; 0.01).</td>
</tr>
<tr>
<td>2020</td>
<td>Reservation</td>
<td>N = 980</td>
<td>Evaluation Study</td>
<td>AIANs who engaged in TCP reported significantly lower drinking frequency in past 30 days (Mean = 10.00 days vs 24.15 days, p = 0.009) as well as amount consumed in the last 30 days consumed (Mean = 10.34 vs 31.25, p = 0.017). Marginally significant difference in days of intoxication, with fewer days of intoxication among those who engaged in TCP (Mdn = 5.00 vs. Mdn = 28.50, p = 0.05).</td>
</tr>
<tr>
<td>2006</td>
<td>Urban</td>
<td>N = 61</td>
<td>Prospective Cohort</td>
<td>CA-AA participants reported an average of 6.49 drinks per drinking day compared to 6.72 for the AA-only participants.</td>
</tr>
<tr>
<td>2017</td>
<td>Urban</td>
<td>N = 52</td>
<td>Evaluation Study</td>
<td>An 80.2% decrease in alcohol or other drug use. Of the 490 participants, 116 (23.7%) reported using alcohol or drugs in the prior 30 days at baseline, with a decline to 23 (4.7%) six months later (p &lt; .001).</td>
</tr>
<tr>
<td>2011</td>
<td>Urban</td>
<td>N = 490</td>
<td>Evaluation Study</td>
<td></td>
</tr>
</tbody>
</table>
Table 2a. Crude and adjusted odds ratios for alcohol, marijuana, or other drug use by respondent knowledge, attitudes, and beliefs (KAB) regarding traditional ceremonial practices (TCP).

<table>
<thead>
<tr>
<th>SUBSTANCE USE WITHIN THE PREVIOUS 12 MONTHS</th>
<th>Alcohol</th>
<th>Marijuana</th>
<th>Other Drugs(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td><strong>CRUDE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less Positive KAB</td>
<td>Ref</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td>More Positive KAB</td>
<td>0.57 (0.31, 1.03)</td>
<td>0.70 (0.40, 1.24)</td>
<td>0.37 (0.14, 0.88)*</td>
</tr>
<tr>
<td><strong>ADJUSTED(^b)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More Positive KAB</td>
<td>0.49 (0.26, 0.93)*</td>
<td>0.65 (0.35, 1.18)</td>
<td>0.30 (0.11, 0.76)*</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young Adult (18-29)</td>
<td>1.98 (0.85, 4.70)</td>
<td>4.44 (1.95, 10.58)**</td>
<td>4.13 (1.07, 20.47)</td>
</tr>
<tr>
<td>Adult (30-55)</td>
<td>1.30 (0.61, 2.79)</td>
<td>2.52 (1.21, 5.43)*</td>
<td>7.15 (1.93, 55.71)*</td>
</tr>
<tr>
<td>Elder (56+)</td>
<td>Ref</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td>Annual Household Income(^c)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; $30,000</td>
<td>Ref</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td>$30,000 - $59,999</td>
<td>2.75 (1.31, 6.00)**</td>
<td>0.77 (0.38, 1.57)</td>
<td>0.24 (0.06, 0.74)*</td>
</tr>
<tr>
<td>$60,000 +</td>
<td>2.42 (1.09, 5.61)*</td>
<td>0.69 (0.32, 1.50)</td>
<td>0.18 (0.04, 0.65)*</td>
</tr>
</tbody>
</table>

\(^a\)Includes methamphetamine, inhalants, and prescription medications not used as directed by a medical provider

\(^b\)Adjusted for age and annual household income

\(^c\)Annual household income for all household members combined

*Significant at the 0.05 level; **Significant at the 0.01 level
Survey Results - Continued

Table 2b. Crude and adjusted odds ratios for alcohol, marijuana, or other drug use by respondent intent to participate in traditional ceremonial practices (TCP).

<table>
<thead>
<tr>
<th>SUBSTANCE USE WITHIN THE PREVIOUS 12 MONTHS</th>
<th>Alcohol</th>
<th>Marijuana</th>
<th>Other Drugs&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td><strong>CRUDE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less Intent</td>
<td>Ref</td>
<td>Ref</td>
<td></td>
</tr>
<tr>
<td>Greater Intent</td>
<td>0.68 (0.37, 1.25)</td>
<td>0.70 (0.39, 1.26)</td>
<td>0.31 (0.09, 0.86)*</td>
</tr>
<tr>
<td><strong>ADJUSTED&lt;sup&gt;b&lt;/sup&gt;</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater Intent</td>
<td>0.51 (0.26, 0.98)*</td>
<td>0.67 (0.36, 1.26)</td>
<td>0.31 (0.08, 0.91)*</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young Adult (18-29)</td>
<td>1.96 (0.85, 4.66)</td>
<td>4.38 (1.93, 10.39)**</td>
<td>4.16 (1.08, 20.47)*</td>
</tr>
<tr>
<td>Adult (30-55)</td>
<td>1.23 (0.58, 2.38)</td>
<td>2.41 (1.16, 5.14)*</td>
<td>6.26 (1.73, 30.41)**</td>
</tr>
<tr>
<td>Elder (56+)</td>
<td>Ref</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td><strong>Annual Household Income&lt;sup&gt;c&lt;/sup&gt;</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; $30,000</td>
<td>Ref</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td>$30,000 - $59,999</td>
<td>3.11 (1.45, 7.00)**</td>
<td>0.83 (0.40, 1.71)</td>
<td>0.29 (0.07, 0.88)*</td>
</tr>
<tr>
<td>$60,000 +</td>
<td>2.63 (1.17, 6.15)*</td>
<td>0.73 (0.33, 1.58)</td>
<td>0.20 (0.04, 0.72)*</td>
</tr>
</tbody>
</table>

*Significant at the 0.05 level; **Significant at the 0.01 level

<sup>a</sup>Includes methamphetamine, inhalants, and prescription medications not used as directed by a medical provider
<sup>b</sup>Adjusted for age and annual household income
<sup>c</sup>Annual household income for all household members combined
And I think we all know that we're urban and we all respect each other's tribal nations and their customs. And I think it... People do like to still learn of other tribal nations. And I think that would still be relevant for our community.

Yeah, I feel like we could, we have a lot of room for exploitation in this field, especially with those overnight shaman training classes. Um, and then people who kind of assert that they know the way but are not given the rights to do it from the community or elders that they come from.

Ceremonies could be tribally specific, so we need to have recognized elders from those tribes who can decide what is appropriate for whichever tribe they're from.

There also needs to be some teaching about the protocols behind the ceremony, what this ceremony is about, you know, basically kind of like some teaching about culture before you even get to the part about the ceremony.
Select References and Further Reading


Indigenous Maternal Health

MOMS Maternal Health Leadership Council Presentation
April 19, 2022
Amy Stiffarm, MPH, Indigenous Health PhD Student (Aaniiih)
Land Acknowledgement

I am presenting on the ancestral lands of the Ksanka, Selis, and Q'lispe peoples, on the present-day Flathead Reservation, located in what is now known as northwestern Montana.
I am enrolled Aaniiih of the Fort Belknap Indian Community and I also descend from the Chippewa Cree people of Rocky Boy and Blackfeet people of Browning, MT. All of this culture was all around me while growing up, but I never had the opportunity to learn very much about traditional practices related to pregnancy, birth, and motherhood. With my second child I experienced depression and anxiety. In my healing journey I’ve learned many things that could have been helpful to me then and prior. I’ve learned how I was considered at risk and how restoring balance in my social and physical aspects of life were healing for me.
Objectives

Describe Concept Map

Better understanding of Indigenous worldviews can affect maternal health

How to approach this work with strengths-based mindset

Help give ideas on how to engage and work with Tribes/Tribal Leaders
Introduction of Concept Map

The purpose of this concept map was to illustrate how maternal mental health looks for Indigenous women in the United States.

- A flower was utilized to represent the beauty of motherhood. Plants and humans have a sacred connection as we are in a reciprocal relationship with them.
- The sun is used to shine light on maternal mental health for Indigenous women and birthing people and our unique experiences and world views.
Indigenous Maternal Health Literature

- WOC at risk for preterm birth have stressful health care experiences. (MOD, 2022)
- NA women come second only to Black women in preterm birth rates and infant mortality. (McLemore, 2018)
- Tends to focus on disparities but no studies reported AIAN maternal mortality as a result of substance use (Heck, 2021)
- Limited literature and data (Kozhimannil, 2020)
- Lack of Indigenous authors/perspectives
"There is nothing wrong with Native Women. We are perfect just as we are and just like other moms, we all want the best for our children."

Camie Goldhammer, Co-founder of Native American Breastfeeding Coalition of Washington and Founder/Director of Hummingbird Doula Services
• The roots represent the macro level, where Traditional Knowledge, colonization and White supremacy merge to determine the health of the roots
• Cultural values recognize birth givers as sacred and birth is ceremony
• Historical trauma is not history
• Indigenous scholars and advocates have linked the removal of children from Indigenous communities to near erasure of traditional knowledge relevant to pregnancy and parenting
• We often only place value on Eurocentric ideals including western medicine and therapies
The Stem and Leaves

The stem represents the meso level, which encapsulates concepts of historical trauma and cultural safety in healthcare.

- Other strategies of colonization cause trauma such as removal from ancestral homelands
- Indigenous worldviews believe that healing is achieved through community and relationships
- Cultural safety seeks to achieve better care through being aware of power relationships, implementing reflective practice, and by allowing the patient to determine whether a clinical encounter is safe (Curtis, 2019)
The petals of the flower represent the micro level of maternal mental health issues and focus on the personal experiences of birthing people.

Protective factors of note here include cultural identity and support.

Historical trauma exposure alone builds a strong case for the need for more maternal mental health work in Indigenous communities.

Disclosure of signs and symptoms rely on trust.

Ceremony could be used to help with maternal health issues, but only if it is accessible to the birthing person.

Indigenous doulas can remedy these issues.
Relationships

• The health of the roots affects the stem and the flower.
• The stem and leaves support and nourish the flower.
• How strong is this support?
Planting Seeds

• Reclamation of Traditional Knowledge surrounding birth and parenting
• Indigenous Doulas
• Councils/Advisory boards of Indigenous birthing people and/or Elders
• Allow Tribes to tell you what they need/want
• Extra time and effort to work with tribal communities
References


Gineehayan
(Thank you)

Amy Stiffarm
amy.stiffarm@gmail.com
Objective A: Catalyze multidisciplinary collaboration in maternal health

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Activities</th>
<th>Timeframe: Milestones / Deliverables</th>
</tr>
</thead>
</table>
| Maintain the Maternal Health Leadership Council | • Facilitate conversations on planning cultural safety and trauma-informed care training for maternal health care providers and council and other related partners serving mothers.  
• In Y3-5, convene and facilitate quarterly meetings of the Council, alternating between in-person and zoom, to provide program implementation guidance, serve as a hub of information on maternal health, a platform for collaboration and partnership building among a variety of maternal health partners across the state  
• Become advisors on program and policymaking regarding rural maternal health at the local, state and national level.  
• Establish a distribution plan and protocol for the Montana Maternal Health Annual Report and other MOMS reports.  
• Continue to publicize the Leadership Council meetings open to the public | |
| Establish the Maternal Mortality Review Committee (MMRC) | • Establish consistent communication between ERASE MM program and MOMS program staff.  
• Support staff of the ERASE MM program in maintaining the MMRC and completing reviews of maternal deaths within 24 months of the date of death. | |
| Develop maternal health strategic plan through public input process | • Hold grant team strategic planning meetings June through August to prepare final strategic plan. | |
Conduct community education to have annual well-woman visit, initiate 1st trimester prenatal care, maintain prenatal care, seek insurance coverage, receive postpartum screening and care

- DPHHS will utilize the bureau’s existing contract with Windfall to conduct the public education campaign which must include consultation with a public health behavior change communications expert and focus groups for pilot testing of all materials.
- Billings Clinic will develop a documentary series highlighting maternal health disparities and cultural practices in tribal communities as well as a series telling the stories of agricultural and rural mothers.

Maintain Montana membership in AIM

- Engage and support the maternal track of the MPQC, with membership of 95% of facilities that identify as a birthing facility in the state by 2023.

Address the 2020-2025 Title V Needs Assessment identified National Performance Measure (NPM) 1: Well-Woman Visit – percent of women, ages 18-44, with a preventive medical visit in the past year, as the maternal health domain focus.

- UM will provide information from the Needs Assessment on the well-women visit with the Title V Project Director to inform related strategic work for CPHDs.

**Objective B: Measure maternal health in Montana**

**Responsible:** University of Montana Rural Institute (UMRI): Evaluation and Research Team

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Activities</th>
<th>Timeframe: Milestones / Deliverables</th>
</tr>
</thead>
</table>
| Collect and analyze maternal health data | Study Montana severe maternal morbidity (SMM) based on hospital discharge data | - Create two reports based on:  
  o Montana preparing for AIM using the SMM findings and  
  o Focus on rural and racial disparities based on data match between birth records and hospital discharge data (to be done in PQC grant program) |
|            | Provider postpartum survey based on ACOG clinical guidance | - Implement winter/spring of 2022 and share results in the summer 2022 |
|            | Patient survey on general pregnant and postpartum experience | - Implement summer of 2022 and share results in year 4 |
|            | Maternal Health Annual Report | - Annually publish report based on HRSA requirements through Y5 |
|            | Levels of Care Assessment Tool (LOCATe) | - Disseminate and apply results through participation in the ASTHO Risk Appropriate Care state team. |
| AIM enrollment                      | • Continue management and administration of AIM data platform for hospitals to submit data through UMRI to AIM quarterly.  
  • Serve as data manager role to help PQC hospitals submit data required for the AIM Severe Hypertension bundle to the AIM data center. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NORC data tracking tool</td>
<td>• Manage annual updating and tracking of data for submission to HRSA</td>
</tr>
</tbody>
</table>
| Needs Assessment                  | • Ongoing activity that regularly reports to inform all program activities and related maternal health initiatives  
  • Submit reports to MOMS grant team biannually according to the WHO systems of care building blocks                        |

**Objective C: Promote and execute innovation in maternal health service delivery**

**Responsible:** Billings Clinic Demonstration Project

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Activities</th>
<th>Timeframe: Milestones / Deliverables</th>
</tr>
</thead>
</table>
| Provide technical assistance and education to medical and public health    | Conduct professional development and maternal health grand rounds through Project ECHO. | • Continue Project ECHO clinics twice per month through Y4  
  • Continue recruitment efforts to increase physician and other health care  
  provider attendance  
  • Host twice yearly curriculum planning meetings with ECHO hub panel and  
  consider evaluation feedback to advise curriculum  
  • UM-Evaluation and Research Team continue to provide bi-annual reports for  
  Billings Clinic to review                                                                 |
| providers to improve maternal health interventions                         | Conduct listening sessions and research resources in local communities to inform the LIFTS platform. | • Community Resource Guides – LIFTS - ongoing  
  o Partnership with Healthy Mothers, Healthy Babies nonprofit and tribal  
  liaisons  
  o Eastern Montana and Tribal Communities  
  • Annual study reports on Empaths and Cuddling Cubs                        |
|                                                                            | Provide opportunities for healthcare professionals to participate in education, certification and licensing | • Simulation Leadership Academy  
  o Train 12-18 facilities in simulation design and facilitation (3 cohorts) |


| Opportunities to improve maternal health care delivery knowledge and competency across the state. | • Continue to offer a menu of training options for sponsorship on an individual basis including NRP, STABLE, PMH-C, RNC, parenting classes, doula trainings and others as requested.  
• Indigenous and Recovery Doula Training  
  o Sponsor annual doula training  
| Provide simulation training opportunities for non-birthing and birthing facilities of all levels in teamwork/communication and a variety of birthing scenarios | • SIM-MT  
  o Sponsor on-site, mobile obstetric simulations on as needed basis  
  o Topics include trauma in pregnancy and shoulder dystocia  
• Simulation Leadership Academy  
  o Continue offering courses that align with the quality improvement interventions of the MPQC  
| Conduct demonstration project to test telehealth interventions in maternal health in rural and American Indian/Alaskan Native (AI/AN) communities | Facilitate co-management of high-risk patients with urban-based specialists and rural-based generalists.  
| Establish access to visiting specialists, via live or telemedicine program in rural communities. | • Empaths  
  o Offer training and support to sites to implement screening for PMADs and suicide severity risk  
  o Partner with Meadowlark and the Montana Child and Family Services Division on implementing a uniform Plan of Safe Care and increase collaboration with local CPS offices  
  o Onboard additional states as capacity allows and dependent on outcome of the RMOMS grant application intended on supporting the Empaths program  
| Enable front-line health care providers to provide or receive real-time psychiatric and substance use disorder (SUD) consultation and care | • Empaths  
  o Partnership with Rimrock and the Mental Health Center  
• Partner with and promote the PRISM psychiatric consultation line  
• Project ECHO |
<table>
<thead>
<tr>
<th>Implement team-based approaches to perinatal care through the University of Montana</th>
<th>Establish linkages with and among community-based resources, including mental health resources, primary care resources and support groups</th>
</tr>
</thead>
</table>
| Support multidisciplinary networks of providers to expand service access in rural communities. | Establish and administer, with associated study and evaluation, a program to support a variety of non-medical, community-based roles that support pregnant and postpartum women, including:  
  - Home visitors  
  - Lactation consultants  
  - Doulas – recovery and indigenous  
  - Peer Support Specialists  
  - Community Health Workers |
| coordination support in treating pregnant and postpartum women. | • Project ECHO  
• Empaths |
Cultural Safety
Presented by: Amy Stiffarm (Aaniiih, Cree, and Blackfeet), MPH, Indigenous Health Ph.D. Student
MOMS Maternal Health Leadership Council Meeting | July 19, 2022
Positionality

As an Indigenous Researcher, I have acquired knowledge through both western and Indigenous Worldviews. As someone who has experienced depression and anxiety while pregnant and postpartum, I am deeply committed to this work.
I am presenting on common hunting grounds of many of the MT Tribes. Near the territories of Blackfeet, Aaniiih, Salish, and Pend d'Oreille Peoples.

I want to remind us all to acknowledge whose land we currently occupy and never forget the sacrifices or promises made around this occupation.
Overview

Why Cultural Safety & MOMS?
Terminology & Definitions
Social Determinants of Indigenous Health
Recommendations/Considerations
Resources
References
Q&A
Cultural safety seeks to achieve better care through being aware of power relationships, implementing reflective practice, and by allowing the patient to determine whether a clinical encounter is safe (Curtis, 2019).
Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition
Key Points

• Indigenous health inequities are driven by multiple and complex factors- including a violent colonial history
• Settler colonialism has impacted Indigenous Peoples to near extermination and the appropriation of Indigenous wealth and power
• This creates different exposures to the Social Determinants of Health (i.e. health access & quality of care)
“Framing ethnic health inequities as being predominantly driven by genetic, cultural or biological differences provides a limited platform for in-depth understanding” (Curtis et al., 2018)
"There is nothing wrong with Native Women. We are perfect just as we are and just like other moms, we all want the best for our children."

Camie Goldhammer, Co-founder of Native American Breastfeeding Coalition of Washington and Founder/Director of Hummingbird Reproductive Services
Inter-Generational Basis for Chronic Disease Disparities Among AIAN Peoples

Warne & Lajimodiere, 2015
Definitions

• **Cultural awareness** - acknowledgement of differences

• **Cultural sensitivity** - builds off of awareness and adds respecting other cultures

• **Cultural competence** - fusion of both awareness and sensitivity plus behaviors, attitudes, and policies that support working with diverse populations.

(Darroch et al., 2017)
Definitions – Cultural Competency

"Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations."

"The ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences by recognizing the importance of social and cultural influences on patients, considering how these factors interact, and devising interventions that take these issues into account."

"The ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients’ social, cultural, and linguistic needs."

Is cultural competency achievable?
Competency Does Not Acknowledge Power

Health equity is not possible without acknowledging and addressing power imbalances.

• Interactions
• Health Systems
• Social Structures
Why Focus on Power? - SDoH

The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. (WHO, 2022)
Social Determinants of Aboriginal People's Health (Reading & Wien, 2009)

Reading & Wien have outlined SDoH that are relevant to Aboriginal Peoples’ health at the distal, intermediate, and proximal levels.

- Distal – colonialism, racism, social exclusion, self-determination
- Intermediate- Healthcare systems, education systems, community resources, environmental stewardship, cultural continuity
- Proximal- health behaviors, physical environments, employment and income, and education
Recommended Cultural Safety Definition

“Cultural safety requires healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires individual healthcare professionals and healthcare organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided.

In doing so, cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity.

Cultural safety requires healthcare professionals and their associated healthcare organisations to influence healthcare to reduce bias and achieve equity within the workforce and working environment”.

Recommended Approach to Cultural Safety

1. Be clearly focused on achieving health equity, with measurable progress towards this endpoint;

2. Be centred on clarified concepts of cultural safety and critical consciousness rather than narrow based notions of cultural competency;

3. Be focused on the application of cultural safety within a healthcare systemic/organizational context in addition to the individual health provider-patient interface;

4. Focus on cultural safety activities that extend beyond acquiring knowledge about ‘other cultures’ and developing appropriate skills and attitudes and move to interventions that acknowledge and address biases and stereotypes;

5. Promote the framing of cultural safety as requiring a focus on power relationships and inequities within health care interactions that reflect historical and social dynamics;

6. Not be limited to formal training curricula but be aligned across all training/practice environments, systems, structures, and policies.
Steps to Consider for Healthcare Organizations

1. Mandate evidence of engagement and transformation in cultural safety activities as a part of vocational training and professional development;

2. Include evidence of cultural safety (of organisations and practitioners) as a requirement for accreditation and ongoing certification;

3. Ensure that cultural safety is assessed by the systematic monitoring and assessment of inequities (in health workforce and health outcomes);

4. Require cultural safety training and performance monitoring for staff, supervisors and assessors;

5. Acknowledge that cultural safety is an independent requirement that relates to, but is not restricted to, expectations for competency in ethnic or Indigenous health.
Resources

Centre for Remote Health- Cultural Safety Policy
BC Centre for Disease Control- Culturally Safe Care
Indigenous Cultural Safety Collaborative Learning Series- Webinar Series


Trauma-Informed Care

Sarah Reese, PhD, LCSW
Maternal Health Leadership Council Meeting
July 19, 2022
Questions to consider

1. How does trauma show up in the settings where you work?
2. What aspects of your work and organization are trauma-informed?
3. What aspects of trauma-informed care might you want to implement in the future?
What is trauma?

“Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual’s physical, social, emotional, and spiritual well-being” (SAMHSA, 2014, p. 7).
Examples of trauma (Menschner & Maul, 2016, p.2)

• Experiencing or observing physical, sexual, and emotional abuse
• Childhood neglect
• Having a family member with a mental health or substance use disorder
• Experiencing or witnessing violence in the community or while serving in the military
• Poverty and systemic discrimination
ACEs Study (Felitti, 1998)

• 1995-1997
• 17,000 patients

• Findings
  • Two thirds of participants reported one or more ACEs. One in five reported three or more ACEs.
  • People of low socio-economic status are at higher risk for ACEs.
  • ACEs and negative health outcomes are positively correlated.
How does trauma show up in the settings where you work?
Signs and Symptoms of Trauma (SAMHSA, 2014)

- Agitation
- Irritability, emotional swings
- Anxiety, depression, fear
- Outbursts of anger
- Easily startled by noise or touch
- Sudden sweating and/or heart palpitations
- Flashbacks – re-experiencing the trauma
- Difficulty concentrating
- Difficulty trusting
- Self-blame, guilt, or shame
- Feeling disconnected or numb
What is Trauma-Informed Care?

“a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that 
emphasizes physical, psychological, and emotional safety for both 
practitioners and survivors, and that creates opportunities for 
survivors to rebuild a sense of control and empowerment” (Hopper, 
2010).
Trauma-Informed Care Model (SAMHSA, 2014)

• **Realize** the widespread impact of trauma and understanding potential paths for recovery.

• **Recognize** the signs and symptoms of trauma in individual clients, families, and staff.

• **Respond** by integrating knowledge about trauma into policies, procedures, and practices.

• Seek actively to resist **re-traumatization**.
Six Key Principals (SAMHSA, 2014)

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues
Six Key Principals in OBGYN setting (ACOG, 2021)

1. Safety
   • Create a “safe, calm, comfortable, clean” environment
   • Reconsider the use of punitive polices around late or missed visits
   • Treat patients with respect and non-judgment
   • Interact with patients with compassion

2. Trustworthiness and transparency
   • Explain what will be happening and ask permission/consent
   • Offer options during care that can lessen anxiety

3. Peer support
   • Offer referrals to peer support groups.
Six Key Principals in OBGYN setting (ACOG, 2021)

1. Collaboration and mutuality
   • Engage in patient-centered communication and care
   • Invite patient involvement in care planning

2. Empowerment, voice, and choice
   • Offer care options when available
   • Encourage patients to ask questions

3. Cultural, historical, and gender issues
   • Practice self-reflection
   • Ask patients about cultural healing practices
   • Develop policies, protocols, and processes that are responsive to needs of those served (e.g., universal screening, collaboration with other organizations)
What aspects of your work are trauma-informed?
What aspects of trauma-informed care might you want to implement in the future?
Ten Implementation Domains
(Menschner & Maul, 2016)

1. Governance and leadership
2. Policy
3. Physical environment
4. Engagement and involvement
5. Cross sector collaboration
6. Screening, assessment, treatment services
7. Training and workforce development
8. Progress monitoring and quality assurance
9. Financing
10. Evaluation
**Exhibit 1. Key Ingredients for Creating a Trauma-Informed Approach to Care**

<table>
<thead>
<tr>
<th>Organizational</th>
<th>Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Leading and communicating about the transformation process</td>
<td>▪ Involving patients in the treatment process</td>
</tr>
<tr>
<td>▪ Engaging patients in organizational planning</td>
<td>▪ Screening for trauma</td>
</tr>
<tr>
<td>▪ Training clinical as well as non-clinical staff members</td>
<td>▪ Training staff in trauma-specific treatment approaches</td>
</tr>
<tr>
<td>▪ Creating a safe environment</td>
<td>▪ Engaging referral sources and partnering organizations</td>
</tr>
<tr>
<td>▪ Preventing secondary traumatic stress in staff</td>
<td></td>
</tr>
<tr>
<td>▪ Hiring a trauma-informed workforce</td>
<td></td>
</tr>
</tbody>
</table>
Key Take-aways

• Trauma is common and can have adverse impacts on health and well-being.

• Trauma-informed care is one approach to addressing the prevalence and impacts of trauma.

• Implementation of trauma-informed care involves change efforts on an organizational and individual level.
Questions?
Sarah.Reese@umontana.edu
References

MOMS Rapid Response Mini-Grant Program Update

July 18, 2022
Annie Glover, PhD, MPH, MPA
Molly Molloy, MSW
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.
Background

• Created to promote innovation in maternal health being conducted by local hospitals, health departments, and other community organizations

• Organizations invited to apply in May 2022 for grants up to $20,000

• Preference given to applicants in rural communities and who serve AI/AN populations

• Applications reviewed, scored and decided for awards by two council members and DPHHS and MOMS staff

• Where possible, unfunded applications forwarded to other programs
Overview

41 Applicants

13 Funded through MOMS Grant at UM Rural Institute ($172,922)
7 Funded through MOMS Demonstration Project ($41,609)
## Organizations receiving support through MOMS Mini-Grants

<table>
<thead>
<tr>
<th>MOMS Grant at UM RIIC</th>
<th>MOMS Program Support from Demonstration Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Big Horn County Public Health</td>
<td>Billings Clinic Family Birth Center</td>
</tr>
<tr>
<td>Blackfeet Early Childhood</td>
<td>Central Montana Medical Center</td>
</tr>
<tr>
<td>Community Hospital of Anaconda</td>
<td>Frances Mahon Deaconess</td>
</tr>
<tr>
<td>Dawson County Best Beginnings</td>
<td>Lewis and Clark County Public Health</td>
</tr>
<tr>
<td>Florence Crittenton</td>
<td>Northern Montana Hospital</td>
</tr>
<tr>
<td>Postpartum Resource Group</td>
<td>Park City-County Health Department</td>
</tr>
<tr>
<td>Gallatin County Health Department</td>
<td>St. Luke Healthcare Foundation</td>
</tr>
<tr>
<td>Mountain Home Montana</td>
<td></td>
</tr>
<tr>
<td>Richland County Health Department</td>
<td></td>
</tr>
<tr>
<td>Roosevelt Medical Center</td>
<td></td>
</tr>
<tr>
<td>St. James Healthcare Foundation</td>
<td></td>
</tr>
<tr>
<td>Valley County Health Department</td>
<td></td>
</tr>
<tr>
<td>YWCA Helena</td>
<td></td>
</tr>
<tr>
<td>Bitterroot Health Daly Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Types of programs funded

• Doula support for moms with higher risks and access to care barriers
• Postpartum depression screenings through lactation consultants
• HALO bassinets to enable access to infants for moms who had C-section
• Supplies and educational materials for birthing classes and postpartum outreach
• STABLE/NRP and other trainings for OB staff
• Quantified blood loss scales
Programs that MOMS could not fund

- Projects focused primarily on infant/child outcomes
- Projects eligible for other funding (such as some home visiting programs)

Progress reports from funded projects will be presented to Leadership Council later this year.