



## 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>

[\[us02web.zoom.us\]](https://us02web.zoom.us)

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



## **Maternal Health Leadership Council**

Meeting Minutes:

April 19, 2022:

2:30-5:00 PM:

Location: Zoom only

### **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

**Olivia 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'Shane 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 Shannon 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

1978

AIFRA

1964  
Civil Rights  
Act



# Historical & Intergenerational Trauma

Maria Yellow Horse Brave Heart<sup>1,2</sup>

- Colonization
  - Attempted genocide
  - Forced relocation
  - Termination
  - Boarding schools
  - Separation from resources
- 
- Poverty
  - Violence
  - Problem substance use



# “Firewater” Myth

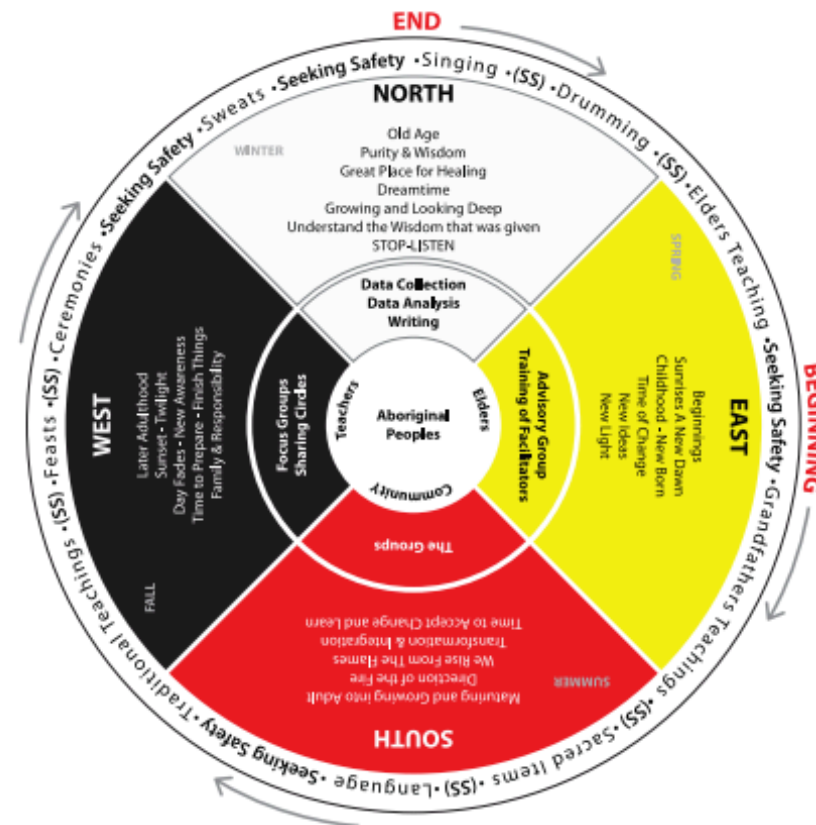
The “*firewater myth*” is a term that has been used to represent the notion that AI/ANs are more susceptible to the effects of alcohol and more vulnerable to alcohol problems due to biological or genetic differences. Although genetics play a clear role in the risk for an alcohol use disorder, there is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

-Gonzalez & Skewes<sup>3</sup>

# Holistic Healing

## 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 that appeared in *Alberta Past* 8(3): 6-7, Winter 1992-93.



**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 [86].

# Systematic Review (in preparation)

	Dickerson et al. 2021	Dickerson et al. 2014	Gossage et al. 2003	Greenfield et al. 2018	Herman-Stahl et al. 2003	Saylors 2003	Tonigan et al. 2020	Torres-Stone et al. 2006	Wendt et al. 2017	Wright et al. 2011
Year	2021	2014	2008	2016	2003	2003	2020	2006	2017	2011
Reservation/ Urban	Urban	Urban	Reservation	Urban	Reservation	Urban	Reservation	Urban	Urban	Urban
Sample Size	N = 63	N = 10	N = 190	N = 347	N = 2,449	N = 742	N = 980	N = 61	N = 52	N = 490
Type of Study	RCT	Pilot Study	Evaluation Study	Cross- sectional	Cross- sectional	Evaluation Study	Evaluation Study	Prospective Cohort	Evaluation Study	Evaluation Study
Results	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.	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).	Lower proportion of past-month drug use among respondents who participate in traditional ceremony: 16.1% and 25.5%, respectively (p = 0.041). Lower proportion of past-month marijuana use among respondents who participate in traditional ceremony: 10.5% and 17.4%, respectively (p = 0.079).	“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 = <0.001); less likely to report heavy alcohol use (11.2%, 28.8%, and 39.9%, respectively; p = <0.001); and less likely to report illicit drug use (12.2%, 26.9%, and 27.9%, respectively; p = <0.001).	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%.	Alcohol cessation was significantly and positively associated with participation in traditional spiritual activities (r = 0.23, p = <0.01).	CA-AA participants reported an average of 6.49 drinks per drinking day compared to 6.72 for the AA-only participants.	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 (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 = 29.50, p = 0.05).	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 < .001).

# Survey Results

**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).

	SUBSTANCE USE WITHIN THE PREVIOUS 12 MONTHS		
	Alcohol	Marijuana	Other Drugs <sup>a</sup>
	OR (95% CI)	OR (95% CI)	OR (95% CI)
<b>CRUDE</b>			
Less Positive KAB	Ref	Ref	Ref
More Positive KAB	0.57 (0.31, 1.03)	0.70 (0.40, 1.24)	0.37 (0.14, 0.88)*
<b>ADJUSTED<sup>b</sup></b>			
More Positive KAB	0.49 (0.26, 0.93)*	0.65 (0.35, 1.18)	0.30 (0.11, 0.76)*
<b>Age</b>			
Young Adult (18-29)	1.98 (0.85, 4.70)	4.44 (1.95, 10.58)**	4.13 (1.07, 20.47)
Adult (30-55)	1.30 (0.61, 2.79)	2.52 (1.21, 5.43)*	7.15 (1.93, 35.71)*
Elder (56+)	Ref	Ref	Ref
<b>Annual Household Income<sup>c</sup></b>			
< \$30,000	Ref	Ref	Ref
\$30,000 - \$59,999	2.75 (1.31, 6.00)**	0.77 (0.38, 1.57)	0.24 (0.06, 0.74)*
\$60,000 +	2.42 (1.09, 5.61)*	0.69 (0.32, 1.50)	0.18 (0.04, 0.65)*

\*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

# 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).

	SUBSTANCE USE WITHIN THE PREVIOUS 12 MONTHS		
	Alcohol	Marijuana	Other Drugs <sup>a</sup>
	OR (95% CI)	OR (95% CI)	OR (95% CI)
<b>CRUDE</b>			
Less Intent	Ref	Ref	Ref
Greater Intent	0.68 (0.37, 1.25)	0.70 (0.39, 1.26)	0.31 (0.09, 0.86)*
<b>ADJUSTED<sup>b</sup></b>			
Greater Intent	0.51 (0.26, 0.98)*	0.67 (0.36, 1.26)	0.31 (0.08, 0.91)*
<b>Age</b>			
Young Adult (18-29)	1.96 (0.85, 4.66)	4.38 (1.93, 10.39)**	4.16 (1.09, 20.47)*
Adult (30-55)	1.23 (0.58, 2.58)	2.41 (1.16, 5.14)*	6.26 (1.73, 30.41)**
Elder (56+)	Ref	Ref	Ref
<b>Annual Household Income<sup>c</sup></b>			
< \$30,000	Ref	Ref	Ref
\$30,000 - \$59,999	3.11 (1.45, 7.00)**	0.83 (0.40, 1.71)	0.29 (0.07, 0.88)*
\$60,000 +	2.63 (1.17, 6.15)*	0.73 (0.33, 1.58)	0.20 (0.04, 0.72)*

\*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

# TCP-Based Program Development

*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.*

Multi-Tribal

*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.*

Guided by Elders

*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.*

Learning Component

*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.*

Vetting of Traditional Practitioners

# Select References and Further Reading

- Gone JP. Indigenous Traditional Knowledge and Substance Abuse Treatment Outcomes: The Problem of Efficacy Evaluation. *Am J Drug Alcohol Abuse*. 2012;38(5):493-497.
- Gonzalez VM, Skewes MC. Association of Belief in the "Firewater Myth" With Strategies to Avoid Alcohol Consequences Among American Indian and Alaska Native College Students Who Drink. *Psychol Addict Behav*. 2018;32(4):401-409.
- Walters KL, Simoni JM, Evans-Campbell T. Substance Use Among American Indians and Alaska Natives: Incorporating Culture in an "Indigenist" Stress-Coping Paradigm. *Public Health Rep*. 2002;117(Suppl 1):S104-S117.
- Yellow Horse Brave Heart M. The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *J Psychoactive Drugs*. 2003;35(1):7-13.
- Yellow Horse Brave Heart M, Chase J, Elkins J, Altschul DB. Historical Trauma Among Indigenous Peoples of the Americas: Concepts, Research, and Clinical Considerations. *J Psychoactive Drugs*. 2011;43(4):282-290.

The background is a large, abstract Indigenous artwork. It features a warm, orange-brown color palette. There are several stylized, dark, branching shapes that resemble trees or reeds, some of which are filled with a red-to-orange gradient. The background is decorated with numerous concentric circles and dotted patterns in a lighter, golden-brown color, creating a textured, layered effect.

# Indigenous Maternal Health

MOMS Maternal Health Leadership Council Presentation

April 19, 2022

Amy Stiffarm, MPH, Indigenous Health PhD Student (Aaniiih)

An aerial photograph of a large, deep blue lake surrounded by dense green forests. Two small, tree-covered islands are visible in the upper portion of the lake. In the lower-left quadrant, a small cluster of buildings and a dock are situated on the shoreline. The text 'Land Acknowledgement' is overlaid in white, bold font across the center of the image.

# 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.

# Positionality Statement

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."***

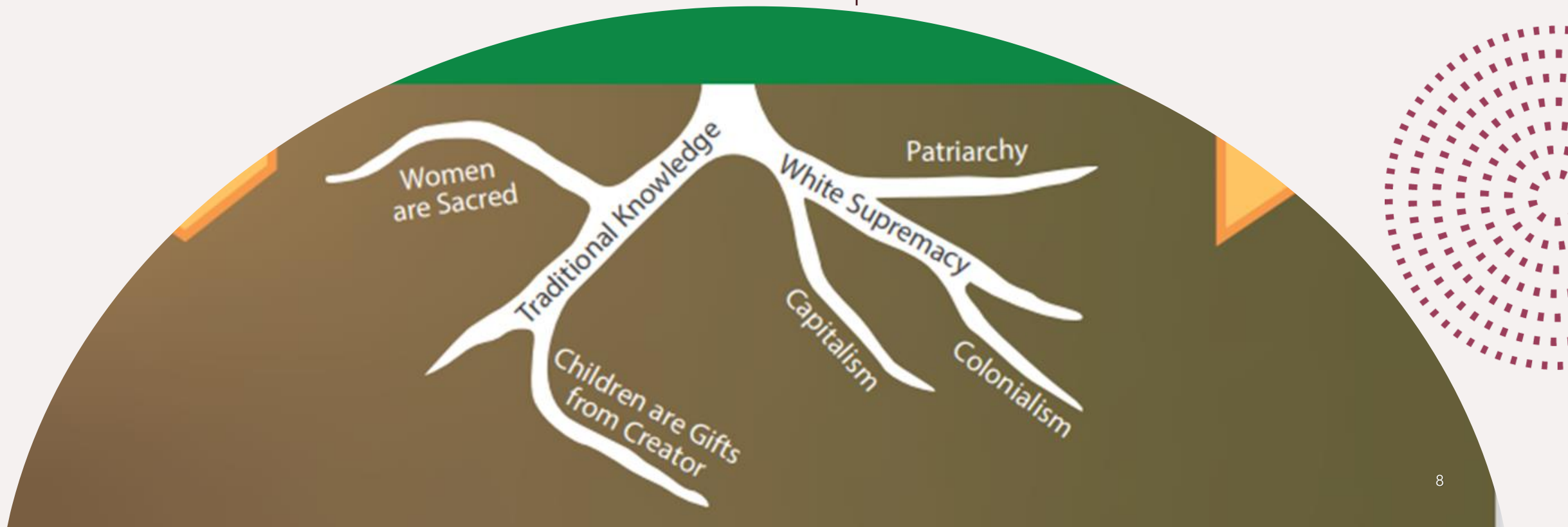
Camie Goldhammer, Co-founder of Native American Breastfeeding Coalition of Washington and Founder/Director of Hummingbird Doula Services





# The Roots

- 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



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.

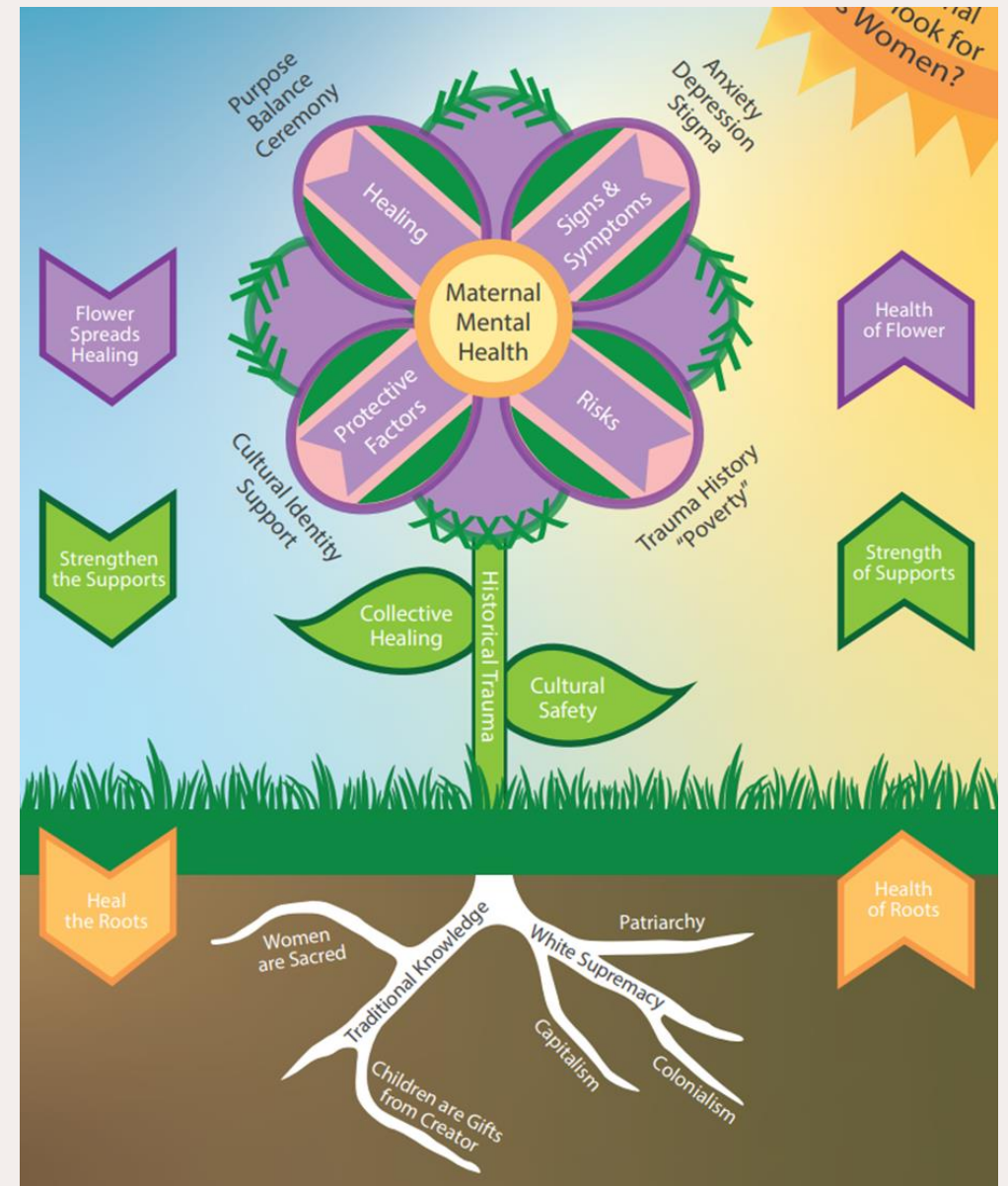
Disclosure of signs and symptoms rely on trust.

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

- Cidro J, Doenmez C, Phanlouvang A, Fontaine A. Being a good relative: Indigenous doulas reclaiming cultural knowledge to improve health and birth outcomes in Manitoba. *Front Women's Health*. 2018;3(4). doi:10.15761/FWH.1000157
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# Gineehayan (Thank you)

Amy Stiffarm

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## Attachment 2: Updated Project Work Plan

Grant Number: U7AMC33718

Montana Obstetrics and Maternal Support Program (MOMS)

Montana Department of Public Health & Human Services (DPHHS)

Primary Contact Name: Amanda Eby

Objective A: Catalyze multidisciplinary collaboration in maternal health		
Responsible: DPHHS		
Strategies	Activities	Timeframe: Milestones / Deliverables
Elevate maternal health as priority issue in Montana	Maintain the Maternal Health Leadership Council	<ul style="list-style-type: none"> <li>Facilitate conversations on planning cultural safety and trauma-informed care training for maternal health care providers and council and other related partners serving mothers.</li> <li>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</li> <li>Become advisors on program and policymaking regarding rural maternal health at the local, state and national level.</li> <li>Establish a distribution plan and protocol for the Montana Maternal Health Annual Report and other MOMS reports.</li> <li>Continue to publicize the Leadership Council meetings open to the public</li> </ul>
	Establish the Maternal Mortality Review Committee (MMRC)	<ul style="list-style-type: none"> <li>Establish consistent communication between ERASE MM program and MOMS program staff.</li> <li>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.</li> </ul>
	Develop maternal health strategic plan through public input process	<ul style="list-style-type: none"> <li>Hold grant team strategic planning meetings June through August to prepare final strategic plan.</li> </ul>

Conduct community education to have annual well-woman visit, initiate 1 <sup>st</sup> trimester prenatal care, maintain prenatal care, seek insurance coverage, receive postpartum screening and care	<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>
Maintain Montana membership in AIM	<ul style="list-style-type: none"> <li>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.</li> </ul>
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.	<ul style="list-style-type: none"> <li>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.</li> </ul>

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

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

Strategies	Activities	Timeframe: Milestones / Deliverables
Collect and analyze maternal health data	Study Montana severe maternal morbidity (SMM) based on hospital discharge data	<ul style="list-style-type: none"> <li>Create two reports based on: <ul style="list-style-type: none"> <li>Montana preparing for AIM using the SMM findings and</li> <li>Focus on rural and racial disparities based on data match between birth records and hospital discharge data (to be done in PQC grant program)</li> </ul> </li> </ul>
	Provider postpartum survey based on ACOG clinical guidance	<ul style="list-style-type: none"> <li>Implement winter/spring of 2022 and share results in the summer 2022</li> </ul>
	Patient survey on general pregnant and postpartum experience	<ul style="list-style-type: none"> <li>Implement summer of 2022 and share results in year 4</li> </ul>
	Maternal Health Annual Report	<ul style="list-style-type: none"> <li>Annually publish report based on HRSA requirements through Y5</li> </ul>
	Levels of Care Assessment Tool (LOCATe)	<ul style="list-style-type: none"> <li>Disseminate and apply results through participation in the ASTHO Risk Appropriate Care state team.</li> </ul>

	AIM enrollment	<ul style="list-style-type: none"> <li>Continue management and administration of AIM data platform for hospitals to submit data through UMRI to AIM quarterly.</li> <li>Serve as data manager role to help PQC hospitals submit data required for the AIM Severe Hypertension bundle to the AIM data center.</li> </ul>
	NORC data tracking tool	<ul style="list-style-type: none"> <li>Manage annual updating and tracking of data for submission to HRSA</li> </ul>
	Needs Assessment	<ul style="list-style-type: none"> <li>Ongoing activity that regularly reports to inform all program activities and related maternal health initiatives</li> <li>Submit reports to MOMS grant team biannually according to the WHO systems of care building blocks</li> </ul>

Objective C: Promote and execute innovation in maternal health service delivery		
Responsible: Billings Clinic Demonstration Project		
Strategies	Activities	Timeframe: Milestones / Deliverables
Provide technical assistance and education to medical and public health providers to improve maternal health interventions	Conduct professional development and maternal health grand rounds through Project ECHO.	<ul style="list-style-type: none"> <li>Continue Project ECHO clinics twice per month through Y4</li> <li>Continue recruitment efforts to increase physician and other health care provider attendance</li> <li>Host twice yearly curriculum planning meetings with ECHO hub panel and consider evaluation feedback to advise curriculum</li> <li>UM-Evaluation and Research Team continue to provide bi-annual reports for Billings Clinic to review</li> </ul>
	Conduct listening sessions and research resources in local communities to inform the LIFTS platform.	<ul style="list-style-type: none"> <li>Community Resource Guides – LIFTS - ongoing               <ul style="list-style-type: none"> <li>Partnership with Healthy Mothers, Healthy Babies nonprofit and tribal liaisons</li> <li>Eastern Montana and Tribal Communities</li> </ul> </li> <li>Annual study reports on Empaths and Cuddling Cubs</li> </ul>
	Provide opportunities for healthcare professionals to participate in education, certification and licensing	<ul style="list-style-type: none"> <li>Simulation Leadership Academy               <ul style="list-style-type: none"> <li>Train 12-18 facilities in simulation design and facilitation (3 cohorts)</li> </ul> </li> </ul>

	opportunities to improve maternal health care delivery knowledge and competency across the state.	<ul style="list-style-type: none"> <li>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.</li> <li>Indigenous and Recovery Doula Training <ul style="list-style-type: none"> <li>Sponsor annual doula training</li> </ul> </li> </ul>
	Provide simulation training opportunities for non-birthing and birthing facilities of all levels in teamwork/communication and a variety of birthing scenarios	<ul style="list-style-type: none"> <li>SIM-MT <ul style="list-style-type: none"> <li>Sponsor on-site, mobile obstetric simulations on an as needed basis</li> <li>Topics include trauma in pregnancy and shoulder dystocia</li> </ul> </li> <li>Simulation Leadership Academy <ul style="list-style-type: none"> <li>Continue offering courses that align with the quality improvement interventions of the MPQC</li> </ul> </li> </ul>
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.	<ul style="list-style-type: none"> <li>Empaths <ul style="list-style-type: none"> <li>Offer training and support to sites to implement screening for PMADs and suicide severity risk</li> <li>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</li> <li>Onboard additional states as capacity allows and dependent on outcome of the RMOMS grant application intended on supporting the Empaths program</li> </ul> </li> </ul>
	Establish access to visiting specialists, via live or telemedicine program in rural communities.	<ul style="list-style-type: none"> <li>Develop and promote self-paced, online prenatal education program to be available to all mothers and families across Montana and include the following topics: mental health, physiological birth, physical therapy, standard childbirth education, family dynamics.</li> </ul>
	Enable front-line health care providers to provide or receive real-time psychiatric and substance use disorder (SUD) consultation and care	<ul style="list-style-type: none"> <li>Empaths <ul style="list-style-type: none"> <li>Partnership with Rimrock and the Mental Health Center</li> </ul> </li> <li>Partner with and promote the PRISM psychiatric consultation line</li> <li>Project ECHO</li> </ul>

Implement team-based approaches to perinatal care through the University of Montana	coordination support in treating pregnant and postpartum women.	
	Support multidisciplinary networks of providers to expand service access in rural communities.	<ul style="list-style-type: none"> <li>• Project ECHO</li> <li>• Empaths</li> </ul>
	Establish linkages with and among community-based resources, including mental health resources, primary care resources and support groups	<ul style="list-style-type: none"> <li>• 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: <ul style="list-style-type: none"> <li>○ Home visitors</li> <li>○ Lactation consultants</li> <li>○ Doulas – recovery and indigenous</li> <li>○ Peer Support Specialists</li> <li>○ Community Health Workers</li> </ul> </li> </ul>



# 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.**

# Land Acknowledgement

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.



## Tribal Territories in Montana

Boundaries as defined by the Fort Laramie Treaty of 1851, and the Flathead and Blackfeet Treaties of 1855.\*



Reservations today shown in red.



Star indicates location of tribal capital.

### Names Tribes Call Themselves: A Key

**Salish** / Sélish

**Pend d'Oreille** / Qlispé

**Kootenai** / Ksanka

**Blackfeet** / Nlitsitapi (Pikuni)

**Chippewa** (Ojibwe) / Annishinabe

**Plains Cree** / Ne-i-yah-wahk

**Gros Ventre** / A'aninin

**Assiniboine** / Nakoda, Nakona

**Sioux** / Lakota, Dakota

**Northern Cheyenne** / Tssetsêhesêstâhase and So'taa'eo'o

**Crow** / Apsáalooke

**Little Shell Chippewa** / Annishinabe and Métis

### Reservation Lands in Montana, and American Indian Tribes based on those lands

**Blackfeet Reservation:** Blackfeet

**Fort Belknap Reservation:** Gros Ventre and Assiniboine

**Rocky Boy's Reservations:** Chippewa Cree

**Crow Reservation:** Crow

**Fort Peck Reservation:** Assiniboine and Sioux

**Landless, but headquartered in Cascade County:** Little Shell Band of Chippewa

**Flathead Reservation:** Salish, Pend d'Oreille, Kootenai

**Northern Cheyenne Reservation:** Northern Cheyenne

\* Boundaries shown on this map reflect the demarcation of territories by non-Indian officials at treaty time, and do not necessarily accurately represent tribal territories occupied in the 1850s.

© 2014 Regional Learning Project, the University of Montana, Missoula

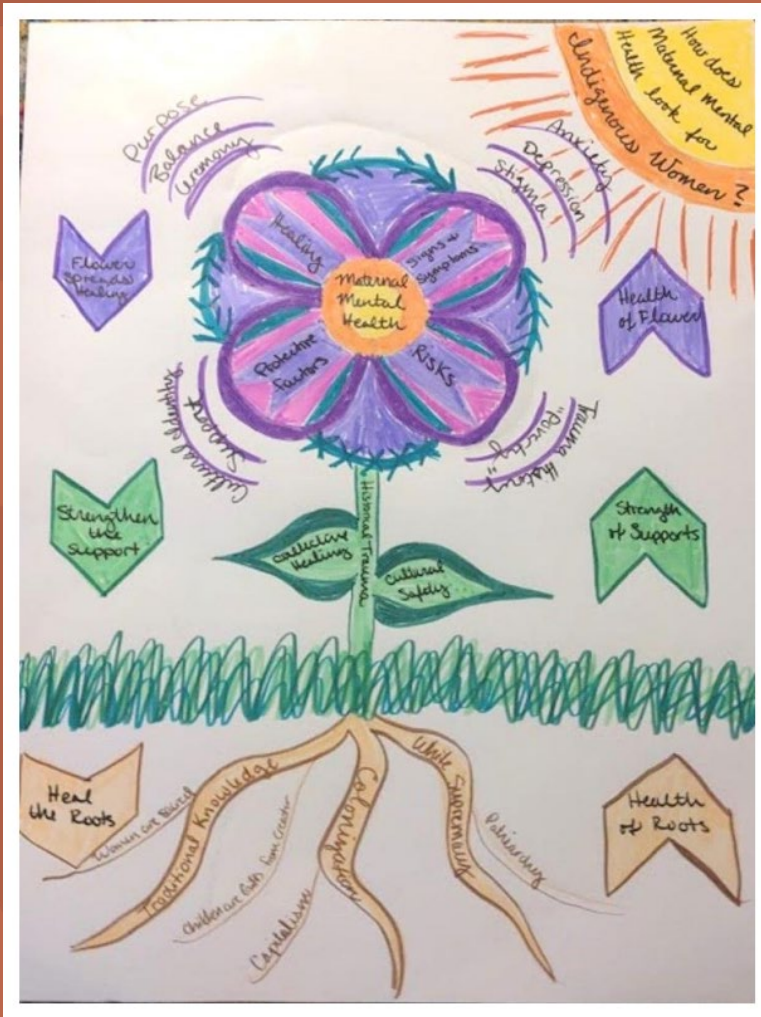
MT Women's Policy  
Leadership Institute,  
2020

# Overview

**Why Cultural Safety & MOMS?**  
**Terminology & Definitions**  
**Social Determinants of Indigenous Health**  
**Recommendations/Considerations**  
**Resources**  
**References**  
**Q&A**



# Review



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)

# Curtis's Literature Review on Cultural Safety

Curtis et al. *International Journal for Equity in Health* (2019) 18:174  
<https://doi.org/10.1186/s12939-019-1082-3>


International Journal for  
Equity in Health

RESEARCH

Open Access

## Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition

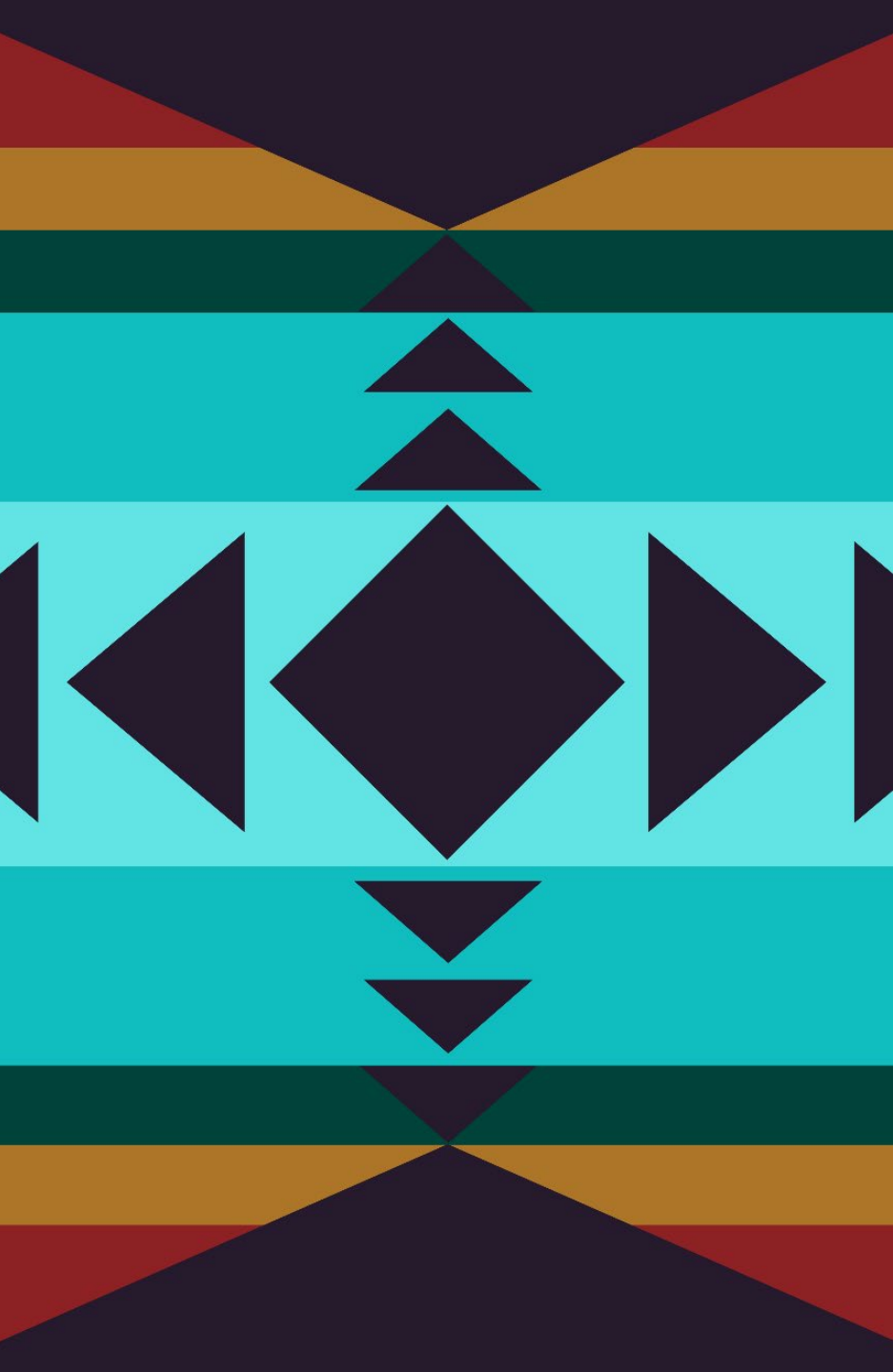


Elana Curtis<sup>1\*</sup> , Rhys Jones<sup>1</sup>, David Tipene-Leach<sup>2</sup>, Curtis Walker<sup>3</sup>, Belinda Loring<sup>1</sup>, Sarah-Jane Paine<sup>1</sup> and Papaarangi Reid<sup>1</sup>

# 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)



A decorative vertical panel on the left side of the slide. It features a series of horizontal bands in dark purple, red, gold, and teal. Overlaid on these bands are various geometric shapes, including triangles, diamonds, and chevrons, in dark purple and teal colors, creating a complex, symmetrical pattern.

*"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)*

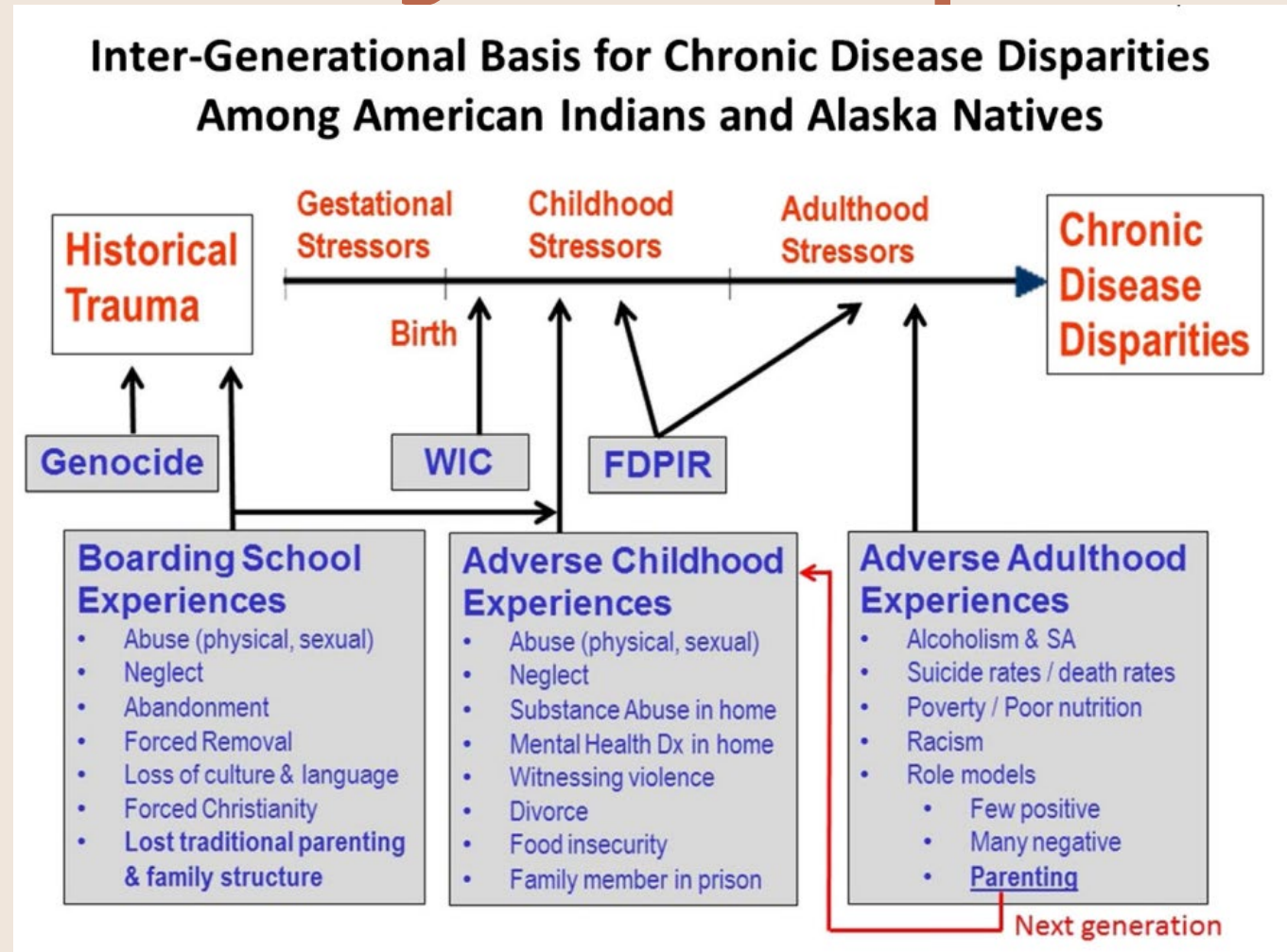
***"There is nothing wrong with Native Women. We are perfect just as we are and just like other moms, we all want the best for our children."***

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 measureable 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](#)



# References

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S. J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International journal for equity in health*, 18(1), 1-17.

Darroch, F., Giles, A., Sanderson, P., Brooks-Cleator, L., Schwartz, A., Joseph, D., & Nosker, R.. (2017). The United States Does CAIR About Cultural Safety: Examining Cultural Safety Within Indigenous Health Contexts in Canada and the United States. *Journal of Transcultural Nursing*, 28(3), 269–277. <https://doi.org/10.1177/1043659616634170>

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World Health Organization. 2022. Social Determinants of Health. [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_1](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1)

# Questions & answers

# 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).

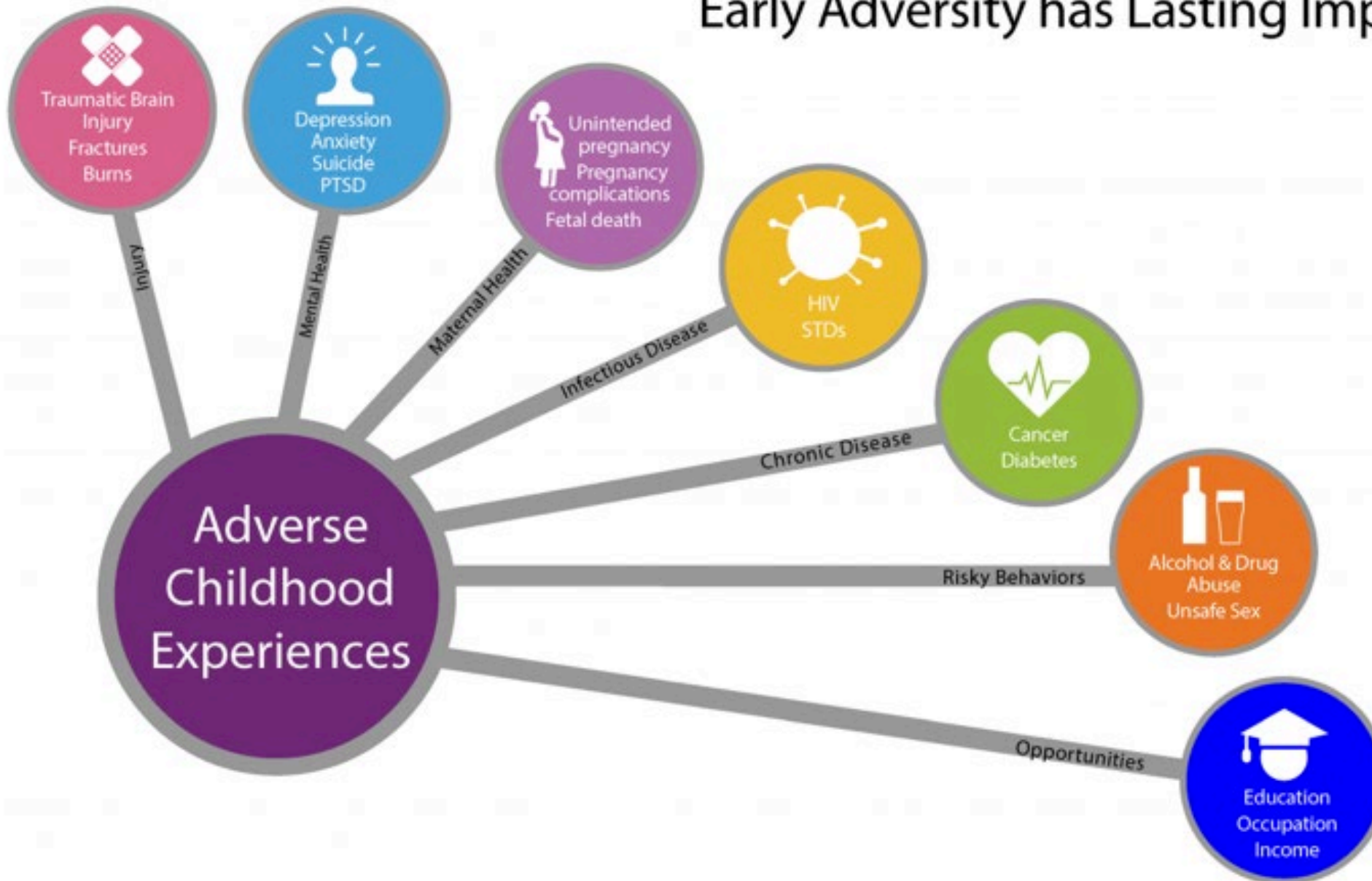
# Examples of trauma (Menschner & Maul, 2016, p.2)

- 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.

# Early Adversity has Lasting Impacts



Content source: [National Center for Injury Prevention and Control, Division of Violence Prevention](#)



*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 policies 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

# Key Ingredients for Implementation

(Menschner & Maul, 2016)

## *Exhibit 1. Key Ingredients for Creating a Trauma-Informed Approach to Care*

Organizational	Clinical
<ul style="list-style-type: none"><li>■ Leading and communicating about the transformation process</li><li>■ Engaging patients in organizational planning</li><li>■ Training clinical as well as non-clinical staff members</li><li>■ Creating a safe environment</li><li>■ Preventing secondary traumatic stress in staff</li><li>■ Hiring a trauma-informed workforce</li></ul>	<ul style="list-style-type: none"><li>■ Involving patients in the treatment process</li><li>■ Screening for trauma</li><li>■ Training staff in trauma-specific treatment approaches</li><li>■ Engaging referral sources and partnering organizations</li></ul>

# 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



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# MOMS Rapid Response Mini-Grant Program Update

July 18, 2022

Annie Glover, PhD, MPH, MPA

Molly Molloy, MSW



Montana  
Obstetrics &  
Maternal  
Support

Rural Institute



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

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- 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

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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

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

# 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.