

Healthy Communities:  
A Tribal Maternal – Infant Health  
Strategic Plan



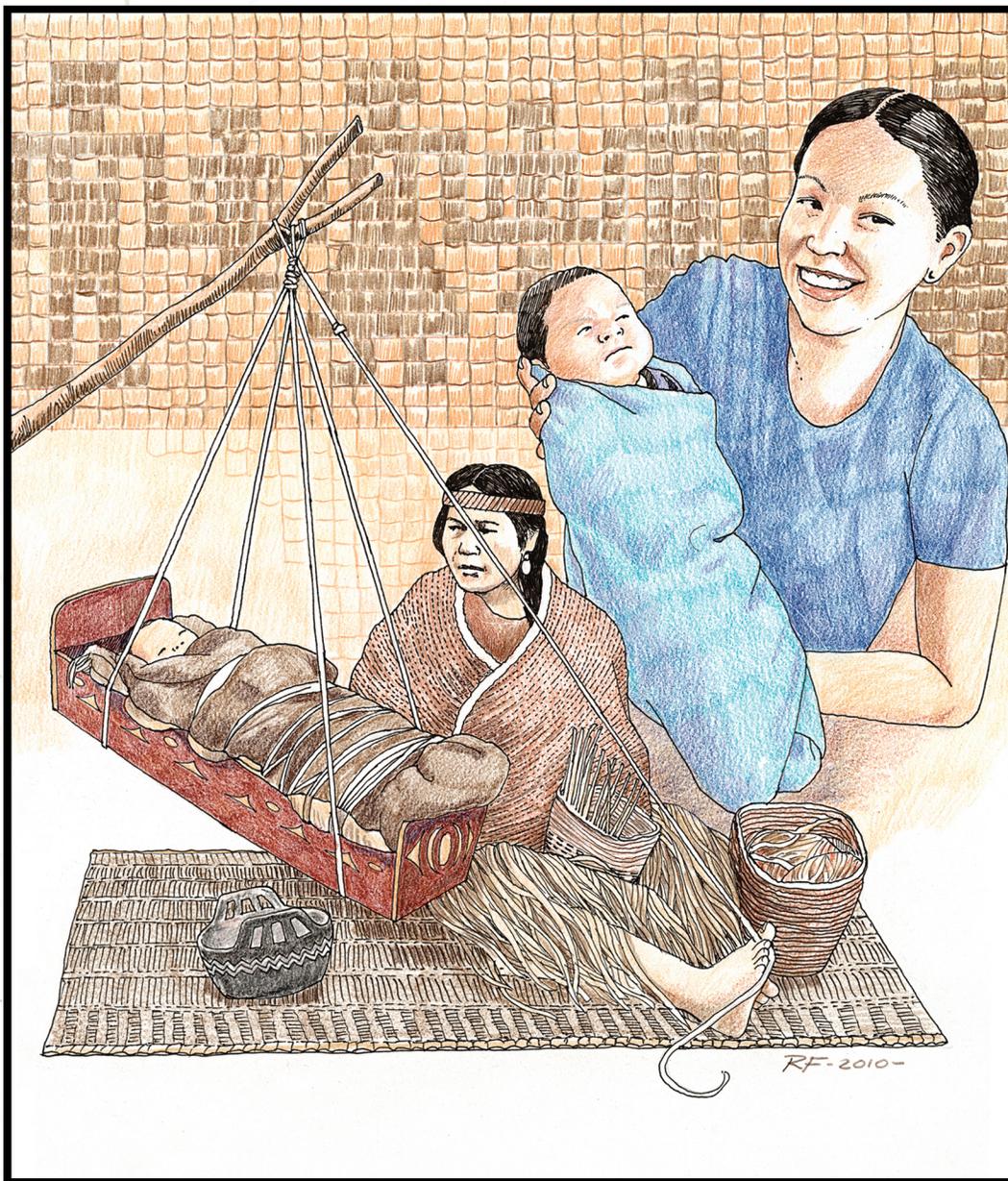
Executive Summary • 2010

American Indian Health Commission for Washington State



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# Healthy Communities: A Tribal Maternal – Infant Health Strategic Plan



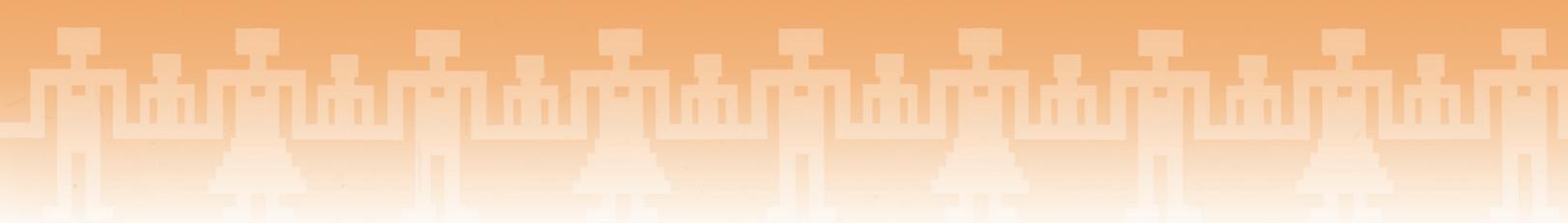
## Executive Summary • 2010

American Indian Health Commission for Washington State



### **The American Indian Health Commission (AIHC) for Washington-State**

is a Tribally-driven non-profit organization with a mission of improving health outcomes for American Indians (AI) through a health policy focus at the Washington State level. AIHC works on behalf of the 29 federally-recognized Indian Tribes and 2 Urban Indian Health Organizations (Urbans) in the state. The AI population continues to experience the poorest health outcomes and highest overall mortality rates than any other population in Washington. AIHC serves as a forum where a collective Tribal government voice is shaped on shared health disparity priorities and Tribes then work collaboratively with Washington State health leaders, the Governor's Office and legislators to address these priorities. The Commission's policy-work improves individual Indian access to state-funded health services, enhances reimbursement mechanisms for Tribal health programs to deliver their own, culturally-appropriate care and creates an avenue for Tribes and Urbans to receive timely and relevant information for planning purposes on state health regulations, policies, funding opportunities, and health-specific topics. By bringing state and tribal partners together, specific health disparity priorities can be addressed across multiple systems - pooling resources and expertise for greater health outcomes. The Tribal Maternal-Infant Health Strategic Plan is a product of that unique partnership.



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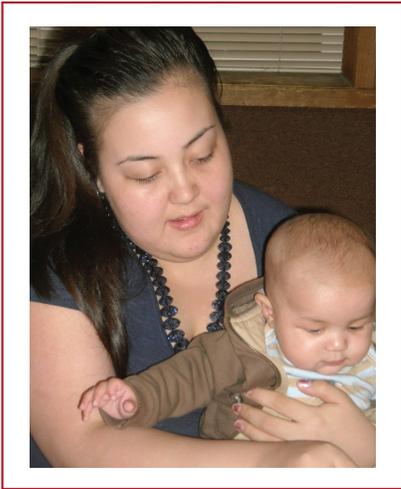
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# FOUNDATION

## Principles

### Principles Guiding MIH Strategic Plan

- Identify the most significant problems where interventions can make the greatest difference in outcomes in the next 5 years.
- Create measurable goals to eliminate disparities between American Indians and the population as a whole.
- Adopt strategies using approaches proven to be effective.
- Tribes and urban Indian programs can deliver the most culturally appropriate and most geographically accessible programs to American Indians.



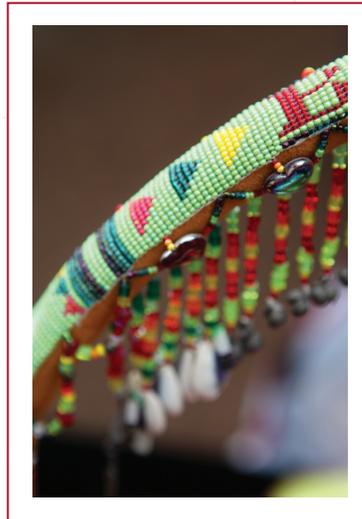
- While problems are prioritized at a statewide level, each tribe and urban Indian clinic must prioritize the actions that they will take to implement strategies that have been identified.
- Look for solutions that are cost effective, even if it means challenging existing rules and regulations for established programs.
- State investment in maternal and infant health services for American Indians should help the State of Washington reduce their Medicaid expenditures in the short term and the long term.
- Integrate state-funded and federally-funded programs with existing tribal, urban Indian clinic, and Indian Health Service programs.

# APPROACH

## Methods

### Methods Used to Develop MIH Strategic Plan

- Review literature
- Analyze data
- Interview knowledgeable people in state and tribal governments
- Review MCH Block Grant reports to identify potential model programs in other states and investigate further
- Survey tribal and urban Indian health programs
- Visit WIC tribal programs that won awards for breastfeeding
- Hold focus groups and meetings with two tribes and one urban Indian program in Washington State
- Review and discussion by MIH Workgroup and AIHC



# DISPARITIES

## American Indian Infant Mortality

**T**he infant mortality rate is more than twice as high for American Indians (AI) compared to the population as a whole in Washington State. In Washington State there have been improvements in infant mortality for the total population in the past 12 years, but the situation for American Indians has gotten worse and the disparity has grown over time.

Over 85 percent of American Indian infant mortality can be attributed to the following 8 causes of death that are listed in order of frequency. The causes in red are higher for American Indians at rates that are statistically significant.

“ I’m scared we might get in a car wreck with baby in the car. ”

— *Focus Group Participant*



## Causes of American Indian Infant Mortality in Washington State

1. **Sudden Infant Death Syndrome (SIDS).** The SIDS rate is 3 times higher among American Indians than the population as a whole in Washington State.
2. **Birth Defects.** The rate is 30 percent higher among American Indians.
3. **Injuries.** Causes of death that are related to behavior occur at a rate that is 5 times higher among AI compared to the total population of infants in Washington State. These include hanging, strangulation and suffocation (nearly 4 times higher among AI), homicide (7 times higher among AI), poisoning (7 times higher among AI), transportation accidents (6.5 times higher among AI), and other accidental injuries (4 times higher among AI).
4. **Complications of Pregnancy and Delivery.** The infant mortality rate from complications of pregnancy and delivery is 50 percent greater among AI babies compared to all babies in Washington State.
5. **Prematurity and Low Birth Weight.** American Indian babies die from being born prematurely and at a low birth weight at a rate that is 60 percent higher than the rate for all babies born in Washington State.
6. **Infectious Disease.** Infectious diseases account for nearly 10 percent of the AI infant mortality and these occur at rates more than 3 times that of the population as a whole. The rates are especially high for infant deaths due to influenza and pneumonia (7 times higher) and perinatal infection (nearly 3 times higher).
7. **Digestive System Problems.** Among AI babies, deaths from digestive system problems occur at 3 times the rate of the total for Washington State babies.
8. **Unknown causes.** About 5 percent of AI infant deaths are from unknown or ill-defined causes. On average, one AI infant death per year is from an unknown cause. This is 4.5 times the rate of unknown causes for all infants who die in Washington State.

# PREGNANCY

## Risk Factors



**T**he risk factors for poor pregnancy outcomes were prioritized using indicators of frequency, severity and disparity. The result is a list of the top six risk factors for poor pregnancy outcomes among American Indians in Washington State.

“I hope that I can handle parenthood.”

— *Focus Group Participant*

## Top Risk Factors for Poor Pregnancy Outcomes Among American Indians with Medicaid in Washington State

1. **Mental Health.** A mental health diagnosis during pregnancy or up to 1 year postpartum affects over a third AI pregnant women. This is 2.7 times the rate for all pregnant women. This is the risk factor for low birth weight that affects more AI pregnant women than any other risk factor.
2. **Alcohol and/or Substance Abuse** for alcohol and/or substance abuse during pregnancy or 1 year postpartum. AI births had 3.3 times the rate compared to all Medicaid births.
3. **Smoking.** Nearly 28 percent of AI pregnant women reported that they smoked during their pregnancy, compared to 17 percent of all pregnant women on Medicaid, a rate that is 70 percent higher.
4. **Threatened Pre-Term Labor.** The rate for symptoms of preterm labor was 2 times higher for AI births than for all births on Medicaid. Among AI women 15 percent had this condition which requires medical intervention during pregnancy.
5. **History of Prior Low Birth Weight Baby, Preterm Delivery, or Fetal Death.** The rate of this risk factor for low birth weight is 50 percent greater for AI than for the total Medicaid population.
6. **Nutrition and Weight.** If a person meets the criteria for obesity prior to pregnancy (defined as greater than or equal to a body mass index of 30) and their weight gain during pregnancy is outside of the guidelines established by the Institute of Medicine, then there is a higher risk of complications in pregnancy and childbirth from a high birth weight baby, as well as preterm birth. About a quarter of AI births have this risk factor, a rate 30 percent higher than the Medicaid population as a whole.

# DIRECTION

## Goals and Objectives

**T**he goal of this strategic plan is to eliminate the disparities in maternal and infant health for American Indians in Washington State. Specific measurable objectives were developed after identifying disparities in causes of infant mortality and disparities in risk factors for poor pregnancy outcomes using state databases, as well as a survey of tribes and urban Indian clinics.



“ I feel like I have to check on her when she’s sleeping to see if she’s still breathing. ”

—— *Focus Group Participant*

## Goals and Objectives for MIH Strategic Plan

- ▶ Reduce overall AI infant mortality by 38 percent.
  - Reduce AI SIDS deaths by 54 percent.
  - Reduce AI infant deaths due to injuries by 69 percent.
  - Reduce AI infant deaths due to infectious disease by 68 percent.
  - Reduce AI infant deaths from unknown causes by 74 percent.
- ▶ Reduce low birth weight births for AI by 22 percent.
  - Reduce the number of AI pregnant women with an untreated mental health diagnosis by 63 percent.
  - Reduce the number of AI pregnant women who are consuming alcohol and other nonprescription drugs by 70 percent.
  - Reduce smoking among AI pregnant women by 40 percent.
  - Reduce the number of AI women who threaten pre-term labor by 50 percent.
  - Reduce the incidence of low birth weight, preterm labor and fetal death in first pregnancies of AI women by 35 percent.
- ▶ Reduce number of AI pregnant women with BMI >30 who gain weight outside IOM guidelines by 25 percent.
- ▶ Reduce the number of births to AI women between 15 and 19 years old by 43 percent.
- ▶ Increase breastfeeding among AI mothers and infants.
  - Increase the initiation of breast feeding by AI women by 7 percent.
  - Increase the percentage of AI women breastfeeding at 6 months by 34 percent.
- ▶ Increase AI enrollment in First Steps/Maternity Support Services by 17 percent.
- ▶ Increase chemical dependency treatment for AI pregnant women with substance abuse problems by 50 percent.

# Strategies were identified

using the best available research, to achieve each of the objectives. Some strategies can be employed to achieve more than one objective. Some objectives can be achieved using more than one strategy.

## STRATEGIES

Smoking Prevention & Cessation

Parent / Patient Education

Breastfeeding – Hospital Policies

Breastfeeding – Community Support

Breastfeeding – Workplace Policies

## GOALS & OBJECTIVES

		Smoking Prevention & Cessation	Parent / Patient Education	Breastfeeding – Hospital Policies	Breastfeeding – Community Support	Breastfeeding – Workplace Policies
<b>Reduce Infant Mortality</b>						
SIDS	↓54%					
Injury	↓69%					
Infectious Disease	↓68%					
Unknown Causes	↓74%					
Total Infant Mortality	↓38%					
<b>Reduce LBW</b>						
MH Diagnoses	↓63%					
Alcohol, Drugs Use	↓70%					
Smoking	↓40%					
Threaten PT Labor	↓50%					
LBW First Pregnancies	↓35%					
Total LBW	↓22%					
<b>Reduce HBW</b>						
>30 BMI, Weight Gain	↓25%					
<b>Reduce Teen Births</b>	↓43%					
<b>Increase Breastfeeding</b>						
Initiation	↑ 7%					
BF at 6 mos	↑34%					



# CULTURAL

## Programs for Strategic Intervention

**M**ore than 39 programs have been identified to implement the strategies. Four established programs are described: the Federal Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Medicaid First Steps Maternity Support Services (MSS), Maternal and Child Health Block Grants, and Healthy Start grants. In addition, there are summaries of 15 model programs that have been evaluated and demonstrated their effectiveness, 10 promising programs that have not been evaluated, and 10 best practices that could be used in the design of new programs and/or the improvement of existing programs.

### Summary of Programs and Practices to Implement Strategies

STRATEGIES	MODEL PROGRAMS/PROMISING PROGRAMS	BEST PRACTICES
Smoking Prevention & Cessation	<ul style="list-style-type: none"> <li>• First Steps</li> <li>• California Smokers Helpline</li> <li>• Home Visiting</li> </ul>	<ul style="list-style-type: none"> <li>• Telehealth</li> <li>• WA State Guidelines for Providers</li> </ul>
Parent/Patient Education	<ul style="list-style-type: none"> <li>• WIC</li> <li>• First Steps</li> <li>• Breastfeeding education by providers, childbirth educators (to include fathers)</li> <li>• Young Women’s Group at Port Gamble S’Klallam Tribe</li> <li>• Seattle Indian Health Board Prenatal Care Model</li> <li>• Washington State Bedtime Basics for Babies (SIDS reduction)</li> <li>• Intergenerational risk reduction workshop for sexually active teens (NIWHRC)</li> <li>• Home Visiting</li> <li>• Honoring Our Children (Wisconsin)</li> <li>• Intergenerational Indian Women’s Health Education Program (Ponca Tribe of Nebraska)</li> <li>• Coming of the Blessing (March of Dimes)</li> </ul>	<ul style="list-style-type: none"> <li>• Grants to tribes</li> <li>• Preconception counseling</li> <li>• Group services</li> <li>• Cradleboard Project (SIDS education)</li> <li>• Formula marketing guidelines in clinics</li> <li>• Childbirth educator training for AI</li> <li>• Telehealth</li> </ul>
Breastfeeding: Hospitals	<ul style="list-style-type: none"> <li>• Baby Friendly Hospitals Initiative</li> <li>• Can Do 5</li> </ul>	<ul style="list-style-type: none"> <li>• Formula marketing guidelines in hospitals</li> <li>• Cultural Training (Lower Elwha)</li> <li>• Hospital Infant Feeding Plan (Kewa Pueblo)</li> </ul>

STRATEGIES	MODEL PROGRAMS/PROMISING PROGRAMS	BEST PRACTICES
Breastfeeding: Community Support	<ul style="list-style-type: none"> <li>• Pueblo of Zuni Breastfeeding Program</li> <li>• Navajo Nation Breastfeeding Coalition</li> <li>• WIC</li> <li>• Peer Counselors <ul style="list-style-type: none"> <li>• Loving Support Peer Counseling (WIC)</li> </ul> </li> <li>• Honoring Our Children (Wisconsin)</li> </ul>	<ul style="list-style-type: none"> <li>• Group services</li> <li>• Social marketing</li> <li>• “An Easy Guide to Breastfeeding for AI and AN Families”</li> <li>• Formula marketing guidelines in clinics</li> </ul>
Breastfeeding: Workplace	<ul style="list-style-type: none"> <li>• Business Case for Breastfeeding</li> <li>• Navajo Nation Healthy Start Act of 2008</li> </ul>	
Equipment	<ul style="list-style-type: none"> <li>• WIC (breast pumps)</li> <li>• Washington State Bedtime Basics for Babies (cribs, SIDS risk reduction)</li> <li>• Shoalwater Bay CHS program for pregnant women</li> <li>• Honoring Our Children (Wisconsin)</li> </ul>	<ul style="list-style-type: none"> <li>• Grants to tribes</li> </ul>
Chemical Dependency Prevention & Treatment	<ul style="list-style-type: none"> <li>• Safe Babies, Safe Moms</li> </ul>	<ul style="list-style-type: none"> <li>• WA State Guidelines for Providers</li> <li>• Group services</li> </ul>
Mental Health Screening and Treatment	<ul style="list-style-type: none"> <li>• First Steps</li> <li>• Honoring Our Children (Wisconsin)</li> <li>• Home visiting (screening for prenatal, postpartum depression)</li> </ul>	
Domestic Violence Prevention	<ul style="list-style-type: none"> <li>• Domestic Violence Health Care Response</li> <li>• Alaska Justice Center</li> </ul>	<ul style="list-style-type: none"> <li>• WA State Guidelines for Providers</li> <li>• DOJ Principles for Tribal Domestic Violence Programs</li> </ul>
Access to Care	<ul style="list-style-type: none"> <li>• First Steps</li> <li>• CenteringPregnancy</li> <li>• Honoring Our Children (Wisconsin)</li> </ul>	<ul style="list-style-type: none"> <li>• Group services</li> <li>• Grants to tribes</li> <li>• Telehealth</li> </ul>
Statewide AI Infant Death Review	<ul style="list-style-type: none"> <li>• Intertribal Council of MI Statewide Review of AI Infant Deaths</li> </ul>	
Immunizations		
Involve Youth in Leadership, Planning, Messaging	<ul style="list-style-type: none"> <li>• Akimel O’odham/Pee-Posh Council (Gila River)</li> <li>• UNITY</li> </ul>	<ul style="list-style-type: none"> <li>• Preconception counseling</li> </ul>
Nutrition Education & Physical Activity	<ul style="list-style-type: none"> <li>• WIC</li> <li>• Four Winds Model for Healthy Eating</li> <li>• Home Visiting</li> </ul>	<ul style="list-style-type: none"> <li>• Preconception counseling</li> <li>• Telehealth</li> <li>• Group Services</li> </ul>

# COLLABORATION

## Implementation

### Recommendations

Recommendations have been offered to increase American Indian enrollment in the WIC and First Steps programs and make it more likely that tribes will become providers of services through those programs. Recommendations have also been offered to ensure access for all AI women to high quality obstetrical care and develop methods to successfully engage them in healthy lifestyles. The complete list of 81 recommendations is provided at the end of this Executive Summary, along with cost estimates for implementing the recommendations.

### Implementation

With resources and focus, the goal of this MIH Strategic Plan is completely achievable. To implement the MIH Strategic Plan, there are roles for the American Indian Health Commission (AIHC), the State of Washington, and tribes.

### Role of AIHC

Because the American Indian Health Commission for Washington State (AIHC) represents all 29 tribes and 2 urban Indian programs, and has engaged with the State of Washington in this MIH planning effort, it is ideally positioned to help coordinate the implementation of many of the recommendations. This could be done by funding and staffing 5 initiatives. To carry out these activities, the AIHC would need funding from the State of Washington and/or philanthropic foundations.



## AIHC Role in Program Coordination and Advocacy

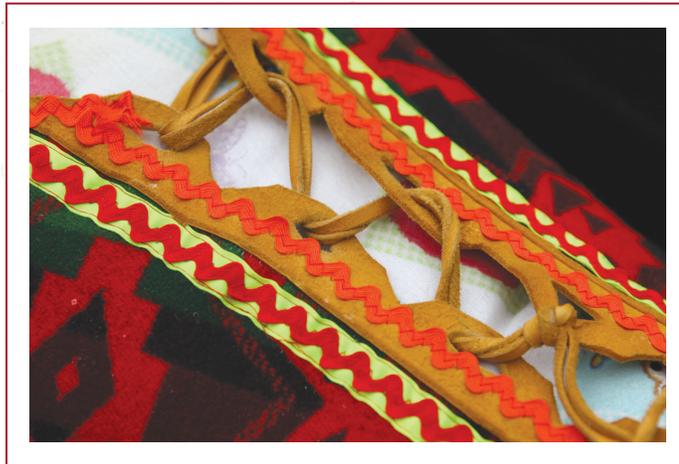
1. **MIH Improvement Grants to Tribes and Urban Indian Clinics** – To implement programs that would carry out the strategies to achieve the objectives in this MIH Strategic Plan requires funding for tribes. Two types of grants are needed, one for community organizing and planning, and another for implementation. AIHC would provide technical assistance and coordinate the grants program. A full-time MIH Small Grants Program Coordinator should be hired by AIHC to work with tribes to understand this MIH Strategic Plan, to assist them in developing tribal-specific implementation plans, and provide technical assistance as they are carrying out their plans to improve maternal and infant health.
2. **Health Care Reform Implementation** – New resources are becoming available through the federal Patient Protection and Affordable Care Act of 2010, which includes the Reauthorization of the Indian Health Care Improvement Act. Notification is sent to the State of Washington about new funding sources with very fast turnaround times. AIHC needs to hire policy analysts to be engaged on behalf of tribes in Washington State.
3. **Youth Involvement in Improving MIH** – AIHC should hire a Youth Services Coordinator to develop and implement strategies to involve tribal and urban Indian youth in reducing risk factors and improving outcomes for maternal and infant health.
4. **Breastfeeding Promotion and Policy Development within Tribes** – The AIHC can promote breastfeeding programs and policy development within tribes. An AIHC Breastfeeding Coordinator (.5 FTE) can serve as a resource person and assist in the implementation of recommendations. A small grant program to provide incentives could be managed by the AIHC Breastfeeding Coordinator.
5. **Tribal Liaison for WIC Program and Policy Development** – At the AIHC there needs to be a Tribal WIC Liaison (.5 FTE) who can represent tribes in discussions with the WIC State Agency and the U.S. Department of Agriculture (USDA). The Tribal WIC Liaison could assist the state WIC agency in developing culturally-appropriate materials, and convening a workgroup to improve WIC data. The Tribal WIC Liaison can work with Tribal Colleges and other institutions to increase the number of American Indians who are trained as Registered Dietitians and midlevel nutritionists.

# RESPONSIBILITY

## Washington State Implementation of Recommendations

**T**he previous page outlines ways that the American Indian Health Commission (AIHC) can assist with implementation of recommendations in this MIH Strategic Plan. The State of Washington is asked to fund the 5 positions and programs that would become activities of the AIHC for an estimated cost of \$916,500 in Year 1, \$1,261,500 in Year 2, and \$1,326,500 ongoing. These activities can and should be implemented quickly so that AIHC has the capacity to work with the State of Washington to carry out the goals, objectives and recommendations in this MIH Strategic Plan.

In addition, there are 8 areas of recommendations that require action on the part of the state Department of Social and Health Services and/or the Department of Health. To implement these recommendations, the State needs to assign responsibility to a leader of the effort and provide adequate resources.



## Washington State Implementation of Policy and Program Recommendations

1. **New Resources to Improve Health Services** – The state and tribes should work together to acquire more resources for tribes in Washington State through the Patient Protection and Care Act of 2010. These recommendations need to be implemented immediately in order to leverage federal funding.
2. **Low Cost Programs that can be Implemented Quickly** – Four low cost programs have been identified that could be implemented quickly: 1) funding for NAWDIM for the Cradleboard Project to be extended to tribes statewide; 2) develop and distribute provider guidelines for preconception counseling; 3) initiate an American Indian Youth Advisory Panel for the DOH, DSHS, and the Office of Superintendent of Public Education; and 4) fund a youth speaker's bureau on MIH issues through an existing youth organization.
3. **Implementing WIC Recommendations at State Level** – There are recommendations in this MIH Strategic Plan regarding training of WIC employees, the use of telehealth by Registered Dietitians for counseling and management, and breastfeeding promotion.
4. **Change State Policies and Programs to Encourage Breastfeeding** – Three recommendations have been made to change state policies and programs to encourage breastfeeding, including: 1) reward hospitals for Baby Friendly Hospital Initiative accreditation; 2) require hospitals to implement “Can Do 5” measures; and 3) ensure lactation support is reimbursable by insurance and Medicaid.
5. **Increase Tribal Participation as First Steps Providers** – Six recommendations have been made to increase tribal participation as First Steps Providers. Greater tribal participation would result in greater enrollment of AI pregnant women and lower costs to the State, because of the 100 percent FMAP for services delivered through tribal facilities.
6. **Research and Data Analysis** – There are three major recommendations for research and data analysis: 1) creation of an AI/AN MIH Data Coordinating Council; 2) statewide AI infant death review; and 3) reporting AI immunization rates for infants for pneumococcal and influenza vaccines. Other recommendations involve research on disparities in birth defects, improvement of WIC and SIDS data.
7. **Review Policies and Practices for the WA State Tobacco Quit Line** – Smoking cessation is a strategy that can impact 6 of the 15 objectives in this plan to bring American Indians to parity with the rest of the population of Washington State. The WA State Tobacco Quit Line policies and practices should be reviewed to assure that the services are culturally appropriate and to maximize their utilization.
8. **Long Range System Changes** – Four recommendations have been offered to provide long range system changes: 1) demonstration projects for tribes to serve as medical homes for obstetric care; 2) expand the Seattle Indian Health Board residency training model to rural tribal areas and MIH disciplines; 3) leverage the Federal Tort Claims Act to increase the number of obstetric providers in rural areas, and 4) consider changing MSS reimbursement from fee for services to the federally-approved encounter rate.

# COMMUNITY

## Actions Tribes Can Take

**W**hile many of the recommendations in this plan require funding and policy changes, as well as tribal participation, some things have been identified that tribes can do immediately to improve the health of pregnant women and infants who are tribal members.

“ I hope my baby will go to school and get good grades, have a great childhood, go to college, be active, and not exposed to drugs, alcohol and smoke. ”

— *Focus Group Participant*



## Actions Tribes Can Take to Improve Maternal and Infant Health

1. **Support Breastfeeding** – There are many steps that tribes can take as employers, educators, and health service providers to encourage breastfeeding by tribal members. Tribal governments can adopt codes to promote breastfeeding in the workplace, and tribal offices and businesses can review their policies to assure that women who return to work after giving birth can continue to breastfeed their babies. Tribal clinics can eliminate advertising for infant formula and train some providers to become lactation specialists and peer counselors to provide support to breastfeeding women. Childbirth education programs offered by tribes can include information about breastfeeding. Tribally-operated high schools and youth programs that provide life skills education can include breastfeeding and other topics related to maternal and infant health.
2. **Focus Existing Tribal Services to Improve Maternal and Infant Health** – Tribes can modify their existing services to create greater focus on improving maternal and infant health. For example, preconception counseling can become a regular part of annual exams for young women. Tribes can develop systems to screen women who are pregnant or postpartum for depression, and refer them for treatment. Tribal smoking cessation programs should prioritize pregnant women. Tribes can take action to participate in Bedtime Basics for Babies, a free program that provides cribs and SIDS prevention information. To reduce childhood injuries and deaths, tribes that have the resources could provide car seats and teach parents how to use them. If a tribe has a fire department, it could serve as a place where parents can drop by to make sure their car seats are installed properly. Tribes can pass and enforce seat belt laws.
3. **Advocate for Tribal Technical Advisory Group (TTAG) for WIC Nationally**– Many of the WIC recommendations in this MIH Strategic Plan may require policy changes at the national level and possibly changes in federal regulations. To make this happen requires involvement of tribal leaders with the U.S. Department of Agriculture, a federal agency that has not historically developed close working relationships with tribes. Tribal leaders individually and through the Northwest Portland Area Indian Health Board and national tribal organizations can advocate for the USDA to have a tribal consultation policy that includes a Tribal Technical Advisory Group (TTAG) for the WIC program at the national level. Through the TTAG and through other tribal consultation processes, tribal leaders can use the issues in this MIH Strategic Plan as agenda items and the basis for testimony and resolutions.
4. **Engage with Universities to Promote Training and Research to Improve MIH** – If tribes in Washington State are going to benefit from the federal investment in the National Children’s Study, there must be sufficient enrollment of American Indian infants. The University of Washington should be asked to consult with tribes about the study and to address any concerns that tribes may have. Tribes can support the Northwest Portland Indian Health Board to coordinate an effort to make internships more accessible to increase the number of Registered Dietitians available to work with tribes and urban Indian clinics.

# LEADERSHIP

## Investment

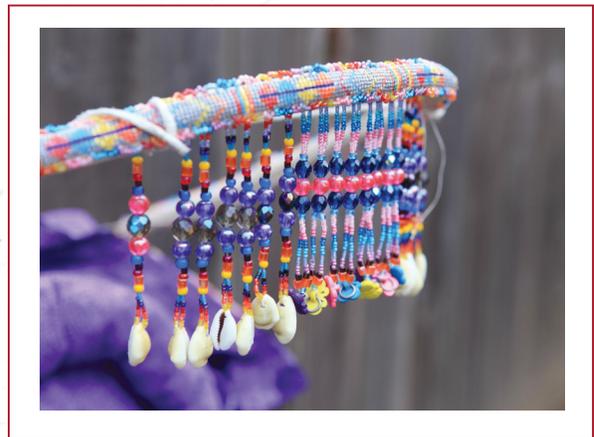
### Costs and Savings

Implementation of the 81 recommendations in the MIH Strategic Plan would cost about \$2 million in the first year, if all recommendations were implemented simultaneously. A direct investment of \$2-3 million dollars per year by the State of Washington to improve maternal and infant health among Native Americans is expected to increase funding from federal sources and save state Medicaid expenses in both the short term and the long term.

If just 41 American Indian pregnant women reduced their risk factors and delivered normal weight babies, it would pay for a \$2 million investment in maternal and child health. If just 62 women reduced their risk factors and delivered normal weight babies, it would pay for a \$3 million investment. Behavioral changes in just 2 to 3 percent of the population of current and future pregnant American Indian women would pay for all the recommendations in this report.

### Continued Role for MIH Workgroup

The AIHC MIH Workgroup should be continued to provide oversight for the implementation of the MIH Strategic Plan.



# ACHIEVABLE

## Summary

**T**he goals and objectives of this plan to eliminate disparities in maternal and infant health for American Indians in Washington State can be achieved if there is the commitment, the resources, the management, and the leadership to implement the recommendations in this plan.

“ I hope that he will continue to be healthy. ”

— *Focus Group Participant*



# ACTION

## MIH Strategic Plan Recommendations

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

#### Issue 1. Shortage of Registered Dietitians

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

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

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

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

#### Issue 2. Indirect Cost Rates

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

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

#### Issue 3. Direct Cost Rates

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

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

#### **Issue 4. Accounting**

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

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

#### **Issue 5. Training for WIC Program Coordinators for Tribes**

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

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

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

#### **Issue 6. Culturally Appropriate Outreach Materials for American Indians**

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

#### **Issue 7. WIC Data**

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

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

#### **Issue 8. USDA Tribal Consultation on WIC Programs**

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

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

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

### **Issue 9. Implementation of WIC Recommendations**

WIC.9.1. The State of Washington should provide funding to the AIHC to hire a project coordinator and for travel and support for two years to coordinate with tribes and urban Indian health programs, as well as regional and national tribal organizations, to implement the 19 recommendations for WIC in this strategic plan and participate in the tribal breastfeeding coalitions.

## **First Steps Maternity Support Services Program (FS)**

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

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

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

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

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

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

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

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

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

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

## **Resources for Tribes to Expand and Improve MIH Services (R)**

### **Issue 1. Resources to Implement the MIH Strategic Plan**

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

R.1.2. The State of Washington should provide implementation grants to tribes that have completed the planning and community organization phase of the project and identified programs to carry out the strategies that they have selected as their focus for MIH improvements.

R.1.3. With funding from the State of Washington, the AIHC should create a forum for tribes to share their experiences in developing and implementing programs to carry out the objectives and strategies in this MIH Strategic Plan.

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

R.2.1. Washington State should fund AIHC to assist State agencies responding to health care reform initiatives that involve new funding or new programs to include tribes and urban Indian health programs in planning and implementing the state response to the initiatives, particularly if the funding is intended to reduce health disparities and data about AI/AN are used to justify funding requests.

## Access to Care and Coordination of Services (AC)

### Issue 1. Medical Homes and Access to Obstetrical Care

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

### Issue 2. Services in Rural Areas

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

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

## Smoking Prevention and Cessation (SM)

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

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

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

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

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

## Sudden Infant Death Syndrome Risk Reduction (SIDS)

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

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

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

## Injury Prevention (IP)

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

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

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

## Preconception and Prenatal Counseling for Healthy Lifestyles (PPC)

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

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

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

## Support for Breastfeeding (BF)

### Issue 1. Building Coalitions to Support Breastfeeding in Tribal Communities

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

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

## **Issue 2. Parent Education for Breastfeeding**

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

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

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

## **Issue 3. Hospital practices to encourage breastfeeding**

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

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

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

## **Issue 4. Peer Counseling and Community Support for Breastfeeding**

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

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

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

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

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

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

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

BF.4.8. WIC Loving Support Breastfeeding funding should be used to integrate lactation support services with home visitation programs at tribes to ensure that lactation problems are identified early and that mothers are referred for appropriate help and services.

#### **Issue 5. Work Place Breastfeeding Support**

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

## **Involving Youth (Y)**

#### **Issue 1. Elevate the focus on American Indian youth in addressing MIH issues.**

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

#### **Issue 2. Involve AI youth statewide in designing interventions to reduce risk factors that lead to poor maternal and infant health.**

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

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

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

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



## Estimated Costs to Implement Recommendations in MIH Strategic Plan

Topic	Issue	Rec#	Recommendation	Funding from State of WA			Pg. #
				YR 1	YR 2	On-Going	
<b>A. AIHC PROGRAM COORDINATION AND ADVOCACY</b>							
<i>1. MIH Improvement Grants to Tribes (1FTE plus program costs)</i>							
R	1	1	Planning and community organizing grants to select objectives/strategies (8/yr @ \$30,000)	\$150,000	\$150,000	\$150,000	142
R	1	2	Implementation grants to carry out strategies for MIH improvements (8/yr @ \$50,000)	240,000	240,000	0	115
R	1	3	State funding to AIHC for forum for tribes to share experiences implementing.	0	400,000	1,550,000	115
			<b>Subtotal</b>	<b>\$390,000</b>	<b>\$795,000</b>	<b>\$1,705,000</b>	
<i>2. Health Care Reform Implementation- Advising and Coordinating Tribal Input (40% of HCR costs)</i>							
R	2	1	State response to health care reform initiatives should include tribes, urban AI clinics.	1	1	1	116
			<b>Subtotal</b>	<b>\$146,001</b>	<b>\$146,001</b>	<b>\$146,001</b>	
<i>3. Youth Involvement in Improving MIH (1 FTE plus program costs)</i>							
Y	2	1	State funding to AIHC to hire Youth Service Coordinator to develop, implement.	\$144,000	\$144,000	\$144,000	143
Y	3	1	Integrate MIH information into educational curriculum and school activities.	1	1	1	128
Y	3	2	Recruit sponsors for activities that engage youth in sharing MIH information.	1	1	1	128
Y	5	1	Assess opportunity/needs for MIH information on internet and social networking.	1	1	1	129
			<b>Subtotal</b>	<b>\$144,003</b>	<b>\$144,003</b>	<b>\$144,003</b>	
<i>4. Breastfeeding Promotion and Policy Development within Tribes (.5 FTE plus program costs)</i>							
BF	1	1	State to fund AIHC to initiate, coordinate tribal breastfeeding coalitions.	\$58,000	\$58,000	\$58,000	144
BF	3	3	Hospitals should coordinate with tribes for training, referrals, peer support.	1	1	1	122
BF	4	7	AIHC develop, disseminate tribal resource directory for lactation support services.	1	1	1	124
BF	4	3	Small grants to tribes/urban clinics for incentives for BF support programs (31 @ \$3,500)	\$108,500	\$108,500	\$108,500	124
BF	1	2	Community education messages and programs to include fathers and others.	\$40,000	\$20,000	\$10,000	122
			<b>Subtotal</b>	<b>\$206,503</b>	<b>\$186,503</b>	<b>\$176,503</b>	

AC = Access to Care, BH = Behavioral Health, BF = Breastfeeding, FS = First Steps, IP = Injury Prevention, PPC = Preconception Counseling R = Resources, RDA= Research & Data Analysis, SM = Smoking, Y=Youth

## Estimated Costs to Implement Recommendations in MIH Strategic Plan - continued

Topic	Issue	Rec#	Recommendation	Funding from State of WA				Pg. #
				YR 1	YR 2	On-Going		
<b>B. STATE OF WASHINGTON POLICY AND PROGRAM RECOMMENDATIONS - continued</b>								
<i>3. Implementing WIC Recommendations at State Level</i>								
WIC	5	2	State employees travel to tribes to deliver WIC training	\$114,000	\$114,000	\$114,000	147	106
WIC	5	3	Involve tribes in training and mentoring other tribes.	\$77,000	\$13,000	\$13,000	106	106
BF	4	1	WIC funds to train at least 3 tribal employees as peer bf counselors at each tribe.	0	0	0	124	124
BF	4	2	WIC should provide a variety of breast pumps.	0	0	0	124	124
BF	4	8	Integrate WIC funding with home visitation programs for lactation support services.	0	0	0	124	124
WIC	5	1	WIC training on-line	0	0	0	106	106
WIC	2	1	Federally-approved indirect costs for tribal WIC programs	500,000	500,000	500,000	104	104
WIC	3	1	Increase WIC payments to tribes for direct costs				104	104
WIC	1	1	Telehealth demonstration for RD counseling and monthly in-service	80,000			101	101
			<b>Subtotal</b>	<b>\$771,000</b>	<b>\$627,000</b>	<b>\$627,000</b>		
<i>4. Change State Policies and Programs to Encourage Breastfeeding</i>								
BF	3	1	State should reward hospitals for BFHI accreditation.	\$100,000	\$100,000	\$100,000	147	124
BF	3	2	State should require hospitals to implement "Can Do 5" measures.	\$10,000	\$10,000	\$10,000	124	124
BF	4	4	State should ensure lactation support is reimbursable by insurance, Medicaid.	0	0	0	124	124
			<b>Subtotal</b>	<b>\$110,000</b>	<b>\$110,000</b>	<b>\$110,000</b>		
<i>5. Increase Tribal Participation as First Steps Providers (reduce state funding for MSS)</i>								
FS	2	1	DSHS should recruit tribes as MSS Providers.	\$(591,073)	\$(591,073)	\$(591,073)	147	111
FS	2	2	Tribes should invite DSHS to their facilities to provide training on billing for MSS.	116,000	116,000	116,000	111	111
FS	2	3	State should create small grant program through AHC for incentives for First Steps.	100,000	94,000	94,000	111	111
FS	3	2	MSS staffing requirement should be reviewed to be more flexible.	50,000	50,000	50,000	111	111
FS	3	3	Demonstration project to explore telehealth in delivery of MSS services.	1	1	1	112	112
FS	3	1	Increase AI with CBE training and pay for their services through MSS.				112	112

**AC = Access to Care, BH= Behavioral Health, BF = Breastfeeding, FS = First Steps, IP = Injury Prevention, PPC = Preconception Counseling R = Resources, RDA= Research & Data Analysis, SM = Smoking, Y=Youth**

## Estimated Costs to Implement Recommendations in MIH Strategic Plan - continued

Topic	Issue	Rec#	Recommendation	Funding from State of WA				Pg. #
				YR 1	YR 2	On-Going		
<b>C. ACTIONS TRIBES CAN TAKE TO IMPROVE MATERNAL AND INFANT HEALTH</b>								
<i>1. Support Breastfeeding</i>								
BF	5	1	Tribal codes to create workplace support for breastfeeding.	1	1	1	1	149
BF	2	1	Childbirth education programs to include breastfeeding	0	0	0	0	126
BF	2	2	Clinic policies to eliminate logos and advertising for infant formula	0	0	0	0	123
BF	2	3	Prenatal care providers should discuss breastfeeding, including teen mothers.	0	0	0	0	123
BF	4	5	Walk-in breastfeeding clinics in tribal communities.	1	1	1	1	124
BF	4	6	IBCLC breastfeeding support to pregnant AI/AN teens with parenting ed in schools	1	1	1	1	124
<i>2. Focus Existing Tribal Services to Improve MIH</i>								
PPC	1	1	Annual exams for young women to include preconception counseling.	1	1	1	1	150
BH	1	4	Tribal protocols for screening and treatment of prenatal & postpartum depression.	1	1	1	1	121
PPC	1	3	Screen all pregnant women for gestational diabetes and provide counseling.					130
SM	1	5	Tribes should prioritize pregnant women for smoking cessation activities.	0	0	0	0	121
SIDS	1	1	Tribes, urban Indian clinics should enroll women in Bedtime Basics for Babies	1	1	1	1	119
IP	1	1	Car seats for all infants leaving hospital and parent training to use them.					120
IP	1	2	Tribal fire departments or others trained for car seat installation.					121
IP	1	3	Pass and enforce tribal codes to require seatbelt use on tribal lands.	0	0	0	0	121

AC = Access to Care, BH = Behavioral Health, BF = Breastfeeding, FS = First Steps, IP = Injury Prevention, PPC = Preconception Counseling R = Resources, RDA= Research & Data Analysis, SM = Smoking, Y=Youth

## Acknowledgements

The American Indian Health Commission for Washington State would like to thank the Maternal and Infant Health Workgroup which provided guidance and oversight for this MIH Strategic Plan, reviewing countless drafts and participating in frequent teleconferences and meetings. Funding and other support from the Washington State Department of Health was essential for the development of this MIH Strategic Plan.

Knowledgeable and wise people gave generously of their time for interviews. Directors of award winning WIC programs shared their experiences and the elements of their success, including Adele King (Navajo Nation), Ruby Wolf (Zuni Pueblo), Karen Greigo-Kite (Five Sandoval Tribes), Rita Pacheco and Carole M. Farina (Kewa Pueblo). All across the nation, people working to improve tribal health care shared information about their inspiring programs, including Pamela E. Iron (National Indian Women's Health Resource Center), Elizabeth Kushman (Inter-Tribal Council of Michigan), Cindy Weborg (Great Lakes Inter-Tribal Council) and Denise Morris (Alaska Native Justice Center), and Cindy Robison and Shane Garcia (N.A.T.I.V.E. Project).

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At the earliest stages of this project, Kris Locke and Anna Kidder offered their expertise to help guide the development of the plan. Kris interviewed key stakeholders in tribes and state government, who have remained anonymous, although the information they provided informed the recommendations in this MIH Strategic Plan. Lisa Rey Thomas (University of Washington) assisted with the survey of tribal health programs. Jim Roberts (Northwest Portland Area Indian Health Board) was an excellent sounding board for strategic and budget issues. Throughout the project, Sheryl Pickering (Washington State Department of Health) was a conduit for helpful information, a source of encouragement, and an extraordinary editor. Special thanks to Laurie Cawthon, MD, MPH, (Washington State Department of Social and Health Services), who provided expertise, data, calculations and valuable advice.

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There are so many other people who provided information, data, references, guidance and encouragement. We hope that this plan honors your contributions.



**American Indian Health Commission for Washington State**  
“Improving Indian Health through Tribal-State Collaboration”

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To a request a full report of the  
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*Strategic Plan,*  
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Seattle Indian Health Board  
NATIVE Project of Spokane

#### **Issue 4. Enlist youth to speak to their peers and younger children about MIH risk reduction issues.**

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

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

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

### **Access to Behavioral Health Services (BH)**

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

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

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

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

### **Research and Data Analysis (RDA)**

#### **Issue 1. Infant Death Reviews**

RDA.1.1. The AIHC and the State of Washington Department of Health should work together to develop legislation to create the necessary legal authority and protections for a statewide AI/AN Infant Death Review process.

RDA.1.2. The AI Infant Death Review process should also consider reviewing maternal deaths and near miss maternal mortality.

## **Issue 2. Research on Disparities in Birth Defects in Eastern Washington**

RDA.2.1. State of Washington should fund a research team that includes genetics, anthropology, medical and dental researchers working with an advisory group representing tribes in Eastern Washington to review existing data and research, and learn more about the disparity in birth defects and to suggest strategies to reduce those birth defects and improve infant mortality rates, including access to genetic testing for families with a history of cleft lip and cleft palate.

## **Issue 3. Data Coordination, Analysis, and Use for Monitoring Progress Toward Goals**

RDA.3.1. The State of Washington should establish an American Indian Maternal and Infant Health Data Coordinating Council that includes epidemiologists and others maintaining and analyzing MIH databases in various agencies of state government, as well as representation selected by the American Indian Health Commission of Washington State from tribes, the Seattle Indian Health Board and Urban Indian Health Institute, and the Northwest Portland Area Indian Health Board.

RDA.3.2. The State of Washington should institutionalize reporting of AI/AN immunization data, including pneumococcal and influenza vaccines for infants.

## **Issue 4. National Children's Study**

RDA.4.1. The Pacific Northwest Center for the National Children's Study at the University of Washington should consult with tribes in Washington State about the study and enlist their support in recruiting participants.

# RESOURCES

## Budget Estimates

### Estimated Cost for Implementing Recommendations

Costs in the following spreadsheet are estimates based on assumptions and incomplete information. Changes to the assumptions used in estimating costs, as well as unknowns, could significantly change these estimates.

The following guidelines were used in preparing the cost estimates:

- Dollar amounts in the budget spreadsheet are funds that would have to be provided or reallocated in order to implement the recommendation. In many cases, funds are already available for a staff position that could be assigned to carry out tasks needed to implement a recommendation, so those costs would not be included in the spreadsheet numbers. In other words, this is not the total cost to the state, but rather the additional funding needed.
- A one (1) in the budget means that the costs of implementing the recommendation are already included in another line in the spreadsheet. In other words, this recommendation could not be implemented without the funding that has been identified in a separate line.
- A zero (0) in the spreadsheet means that there are no additional costs for the recommendation and/or that existing staffing and programming can provide the support needed to carry out the recommendation.
- A blank in the spreadsheet means that it is not possible to provide a cost estimate at the present time. In some cases, a planning phase is needed before estimates can be prepared for implementation.
- The last column in the spreadsheet provides page numbers in the MIH Strategic Plan where the issues and recommendations are summarized. Additional information about the issues may be found in the section of the MIH Strategic Plan called, "Research Findings on Outcomes and Risk Factors," pages 15 through 41.

Topic	Issue	Rec#	Recommendation	Funding from State of WA				Pg. #
				YR 1	YR 2	On-Going		
<b>A. AIHC PROGRAM COORDINATION AND ADVOCACY -continued</b>								
<i>5. Tribal Liaison for WIC Program and Policy Development (.5 FTE plus program costs)</i>								
WIC	9	1	State funding for project coordinator for AIHC to implement WIC recommendations.	\$58,000	\$58,000	\$58,000		145
WIC	8	1	State should fund AIHC for tribal consultation with USDA	\$10,000	\$10,000	\$10,000		108
WIC	8	2	State, AIHC chair travel to Washington, DC, & meet with USDA to resolve problems.	\$10,000	\$10,000			108
WIC	1	3	Investigate potential tribal college training for RDs and/or midlevel nutritionists	1	1	1	1	101
WIC	6	1	State should fund AIHC to develop culturally appropriate WIC materials.	\$40,000				107
WIC	7	1	State should fund AIHC to convene workgroup on WIC data	1	1	1	1	107
			<b>Subtotal</b>	<b>\$118,002</b>	<b>\$78,002</b>	<b>\$68,002</b>		

<b>B. STATE OF WASHINGTON POLICY AND PROGRAM RECOMMENDATIONS</b>								
<i>1. New Resources to Improve Health Services</i>								
R	2	1	State response to fed health care reform initiatives to include tribes, urban clinics.	1	1	1	1	146
BH	1	1	State planning grants to tribes for proposals to IHS (\$10,000x31)	\$310,000				116
BH	1	2	State technical assistance to tribes for grant applications for behavioral health.	0	0	0	0	130
BH	1	3	State and AIHC sponsor forum for tribes on behavioral health planning, funding.	\$10,000	\$10,000	\$10,000	\$10,000	130
			<b>Subtotal</b>	<b>\$320,000</b>	<b>\$10,000</b>	<b>\$10,000</b>	<b>\$10,000</b>	
<i>2. Low Cost Programs that Can Be Implemented Quickly</i>								
SIDS	1	2	State should fund NAWDIM for Cradleboard Project for tribes, and evaluation	\$120,000	120,000	120,000	120,000	146
PPC	1	2	State to develop provider guidelines for preconception counseling	\$11,215	1,400	1,400	1,400	120
Y	1	1	American Indian Youth Advisory Panel on MIH	52,400	52,400	52,400	52,400	121
Y	4	1	State grant funding for youth speaker's bureau	150,000	25,000	25,000	25,000	126
			<b>Subtotal</b>	<b>\$333,615</b>	<b>\$198,800</b>	<b>\$198,800</b>	<b>\$198,800</b>	129

AC = Access to Care, BH = Behavioral Health, BF = Breastfeeding, FS = First Steps, IP = Injury Prevention, PPC = Preconception Counseling R = Resources, RDA= Research & Data Analysis, SM = Smoking, Y=Youth

Topic	Issue	Rec#	Recommendation	Funding from State of WA				Pg. #
				YR 1	YR 2	On-Going		
<b>B. STATE OF WASHINGTON POLICY AND PROGRAM RECOMMENDATIONS - continued</b>								
<i>6. Research and Data Analysis</i>								
RDA	1	1	Statewide AI Infant Death Review process.	8700			148	
RDA	1	2	Consider reviewing maternal deaths and near miss maternal mortality.	0	0	0	132	
RDA	2	1	State funding for birth defects disparity research among Eastern WA tribes.	\$50,000	\$50,000	0	135	
RDA	3	1	State should establish AI/AN MIH Data Coordinating Council	0	0	0	136	
WIC	7	2	State WIC data specialist should participate in interagency tribal health data team.	0	0	0	107	
RDA	3	2	State should report AI infant immunization, including pneumococcal and influenza.	0	0	0	136	
SIDS	1	3	Improve SIDS data collection	1	1	1	120	
			<b>Subtotal</b>	<b>\$58,701</b>	<b>\$50,001</b>			
<i>7. Review Policies and Practices for WA State Tobacco Quit Line.</i>								
SM	1	1	Culturally competent counselors, materials, messages for Tobacco Quit Line.				148	
SM	1	2	TV advertising for Tobacco Quit Line in tribal areas.				119	
SM	1	3	Monitor data for AI/AN use of Tobacco Quit Line, set goals and strategies.				119	
SM	1	4	Implement additional recommendations from AIHC Workinggroup re smoking				119	
			<b>Subtotal</b>					
<i>8. Long Range, System Changes to Improve MIH - Planning Process</i>								
A	1	1	Demonstration projects for tribes to serve as medical homes for OB care.	\$25,680	\$8,060		149	
A	2	1	Expand SIHB residency training model to rural tribal areas and MIH disciplines	1	1	1	117	
A	2	2	Leverage FTCA to increase number of OB practitioners in rural tribal areas	1	1	1	118	
FS	1	1	Consider changing MSS reimbursement from FFS to encounter rate for tribes.	1	1	1	110	
			<b>Subtotal</b>	<b>\$25,684</b>	<b>\$8,064</b>			

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Topic	Issue	Rec#	Recommendation	Funding from State of WA			Pg #
				YR 1	YR 2	On-Going	
<b>C. ACTIONS TRIBES CAN TAKE TO IMPROVE MATERNAL AND INFANT HEALTH-continued</b>							
<i>3. Advocate for a Tribal Technical Advisory Group (TTAG) for WIC Nationally</i>							151
WIC	8	3	Explore Tribal Technical Advisory Committee for WIC at USDA nationally.				108
WIC	1	2	Explore midlevels for nutrition counseling				101
WIC	2	1	Federally-approved indirect costs for tribal WIC programs				104
WIC	2	2	Explore self-governance compacting with USDA for WIC programs				104
WIC	3	2	Reduce requirements for WIC and/or re-design for tribal settings				104
WIC	4	1	Change financial accounting and reporting for tribes operating WIC programs				105
WIC	4	2	Combine funding sources to hire RDs and simplify payment processes.				105
WIC	5	1	WIC training on-line				106
WIC	3	1	Increase WIC payments to tribes for direct costs				104
WIC	1	1	Telehealth demonstration for RD counseling and monthly in-service				101
<i>4. Engage with Universities to Increase Training and Research to Improve MIH</i>							151
RDA	4	1	Tribal participation in National Children's Study				137
WIC	1	4	NPAIHB coordinate effort to make RD internships more responsive to tribal needs				101
<b>TOTAL ESTIMATED COST TO IMPLEMENT ALL RECOMMENDATIONS</b>				\$2,298,437	\$2,022,302	\$2,854,238	

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