

HEALTHY START IMPACT REPORT

I. Overview

The Maaajtaag Mnobmaadzid Healthy Start project seeks to address racial disparities in infant mortality and morbidity within the Native American population. Two additional grants from HRSA MCHB (Addressing Perinatal Depression and Interconceptional Care) expanded the project's ability to implement a more comprehensive approach than during the first funding period of 1997 to 2001. The project targets a 27 county area concentrated in Northern Michigan. Priorities were set for the project using baseline data gathered from State of Michigan live birth and matched infant death files obtained from vital records. Analysis of this data revealed that infant mortality is more than two times higher among Native American infants than among White infants. For the period of 1994 to 1998, the five year average IMR within the project area was 15.1 deaths per 1,000 live births, while the rate for White infants in Michigan was only 7.46 per 1,000 ('94-'98 five year average). Significant progress began in reducing the mortality rate and closing the gap between Natives and Whites when the project began in late 1997. This progress continued during the 2001-2005 funding period.

Nationally, within the general population, excess infant mortality is attributed to prematurity and low birth weight. However in Michigan, as in many Northern Indian populations, the mortality disparity between American Indians and Whites is highest for post neo-natal deaths, with the leading reported cause for American Indians being SIDS. Because of relatively small numbers and small population size, stable SIDS rates are difficult to calculate for the project area. Recent analysis of multi-year averages indicate that the Native SIDS rate in the Michigan is about 2.7 per 1,000 live births (2000-2003 4 year average) which can be compared to the statewide White rate of about .42 per 1,000 (2001-2003). In fact, 60% of the total disparity between Native American and White infant death rates is accounted for by SIDS.

Disparities in underlying risk factors are likely contributors to the Native/White infant mortality gap. For example, maternal smoking prevalence among Native Americans statewide is approximately 35%, and as high as 50% in some communities within the project target area. Underlying maternal health conditions such as diabetes and depression are also more prevalent, and are known to be associated with less favorable outcomes. A higher prevalence of social conditions such as domestic violence, poverty, unstable and overcrowded housing, and normalized tobacco and alcohol use within the communities are other examples of disparities which the project seeks to address.

When the project started, there was also marked disparity in receipt of first trimester prenatal care, and a general lack of access to maternal and child health services. For example, in many of the communities, there are no pediatricians, no perinatology or neonatology specialists or facilities within an hour's drive. Access to culturally sensitive services is equally sparse.

Given these factors, the following priorities were adopted by the project in 2001-2005, and are reflected in the project objectives for that period (full project objectives are presented in section II. below) :

1. Increasing access to and use of early prenatal care;
2. Increasing the cultural sensitivity of perinatal services;
3. Addressing maternal smoking;
4. Improving awareness, screening and referral for substance abuse;
5. Increasing the infant immunization rate;
6. Increasing access to perinatal specialty services;
7. Increasing the number of infants deaths reviewed by the project FIMR committee.

Two supplementary grants (Addressing Perinatal Depression and Interconceptional Care) allowed the project to place special focus on two other priority areas:

8. Improving awareness, screening and referral for perinatal depression;
9. Increasing access to medical homes and receipt of primary care for women and infants in the project.

II. Project Implementation

Outreach and Client Recruitment

- A.** The Inter-Tribal Council Healthy Start (HS) Project selected and implemented our approach to outreach and recruitment based on successful culturally appropriate strategies used in previous HS grant cycles. Because we have seven sites that serve Native American people throughout the State, each site developed unique approaches in their respective communities. Generally speaking, Native communities are small, rural, close-knit, interconnected societies. Word of mouth information spreads quickly. In focus groups, program participants stated that they heard about Healthy Start through the Tribal health system or through family members who are engaged in Tribal services. For these reasons, our outreach and recruitment efforts were designed to continually and heavily target Tribal centers using pamphlets, posters, videos, and in-person educational presentations. Outreach efforts involved Tribal health departments, Head Start, Early On, WIC, elder programs, social services, substance

abuse prevention and smoking cessations programs, childbirth and parenting programs, violence prevention programs, and so on. A culturally appropriate way to reach Native Americans is via community gatherings, which always involve extended family members, food, and cultural teachings, and therefore we took advantage of those events to promote Healthy Start. Outreach staff members coordinated these events.

At each of the seven Healthy Start sites, a Native American community member was hired to provide the core services of outreach and recruitment. Tribes have a long history of using trained community members in their health programs. The Indian Health Service has promoted this model calling the position “Community Health Representative” (CHR). The position title for the Healthy Start project has been “Outreach Worker.” As community members, Outreach Workers are trusted (as neighbors, friends or family members) and have a vested interest in recruiting and helping the people in their own communities. Outreach Workers worked under the supervision of the Healthy Start Nurses.

Because the Native American culture is typically organized by extended family relationships, outreach and recruitment efforts targeted the entire family structure—infants, youth, young women and men, middle-aged people, and elders. Older women (especially grandmothers) were particularly targeted for outreach as they often make decisions for younger members of the family. All women of reproductive age and infants were targeted for recruitment into Healthy Start, especially those at risk for poor perinatal outcomes, developmental delays or special needs.

- B.** The core service of outreach was conducted by Healthy Start Outreach Workers and Nurses who formed a team working side-by-side. The Healthy Start team provided the familiar and continuous loop between the client and project core services and access to networking and referral to the larger perinatal system. Outreach services have been directed at potential and current project participants, family members, health care providers, and community agencies. Some of the key outreach and recruitment strategies included: 1) Home visiting—program participants stated that visits to their homes by Healthy Start Nurses and Outreach Workers have been a key feature of the program, perhaps their best-loved feature, and that which kept them in the program; 2) Personal and regular visits were made to local healthcare providers, namely physicians, midwives, nurse-practitioners, and hospital nursing staffs to drop off project information and become familiar faces to ensure that providers understand the Healthy Start project and make referrals to the project; 3) Community

Events—the Healthy Start staff participated in events within their communities to make Healthy Start more visible, to recruit, to share information and to get referrals. For example, they have helped at local gatherings, such as Elder Meal Programs and Boy’s and Girl’s Clubs. Healthy Start staff have participated on local or regional health boards or attended meetings to talk to people and recruit at organizations such as Way to Grow, Parents Together, school programs, 0-5 Year Committees, and La Leche League.

Three specific examples of culture-based community events attended and/or organized by Healthy Start staff for outreach, recruitment and retention were:

Baby Celebrations: At most Tribal sites, annually the entire community (program participants, community participants and Tribal health staff) is invited to celebrate the birth of all “Healthy Start Babies” born that year. Also celebrated are the women who are “Healthy Start Mothers” and those who are currently pregnant with “Healthy Start Babies.” The “Healthy Start Babies” are highly honored as being the future of the Tribes. The event features a traditional feast, gifts for each baby and a certificate stating that s/he is a “Healthy Start Baby,” cultural presentations or performances (drumming, dancing, spiritual leaders). Prominently featured has been a Healthy Start booth staffed by the Outreach Worker and Healthy Start Nurse with educational materials and “give away” items. Healthy Start has been highly visible. At these gatherings, the Healthy Start program has been publicly praised and endorsed by current participants to other community attendees who then spread the word to family and friends.

Talking Circles: These regularly held meetings are safe, enjoyable, culturally designed forums for women to come together to share ideas and stories. The Talking Circles provide support, education and healing and they offer an ideal context in which to introduce and promote Healthy Start. They also provide an opportunity to recruit both program participants and community participants for the Consortium. These forums have also functioned as focus groups in which to elicit women’s (and men’s) stories about their experiences within the perinatal health system. Often, Talking Circles have been collaborative activities bringing Tribal Healthy Start, Tribal health and social services, and Tribal cultural teaching programs together while increasing the knowledge and understanding of the Healthy Start program with the people who are most likely to promote it to Native American families.

Powwows: Native American people travel around the State many times throughout the year to attend Powwows hosted by different Tribes, which last for a day or an entire weekend and draw large crowds. Healthy Start staff has attended many Powwows, they have set up booths, and many program participants have been recruited on the spot. In this festive atmosphere of dancing, drumming, food, family, and fun, potential participants are more easily engaged because Powwows provide “teachable reachable moments.”

- C. Successful initiation and implementation of project goals was able to occur due to the fact that, having received all three Healthy Start Grants (Disparities, Depression, and Interconceptional), we had the funds available to address project priorities. We were able to hire a full-time Outreach Worker at each of the seven sites.

Considering that six of our seven Inter-Tribal Healthy Start sites are reservation-based and located in rural areas of Michigan, often in areas considered wilderness territory, our outreach efforts have been very successful. Since our HS project is somewhat unique because we are “population-based” rather than “geographically-based” and we have seven service sites around the State—outreaching successfully to each separate site has been a challenge but we addressed this challenge vigorously.

We did not have any additional sources of funding to provide core services. Some Tribes were able to contribute to outreach services, for example Tribes were able to coordinate maternal and child outreach with elder outreach. The good news is that Tribes did make regular in-kind contributions that have assisted our Healthy Start outreach effort, for example by providing transportation to health and human service appointments; by co-sponsoring community events where outreach and recruitment for Healthy Start takes place, such as at Early Head Start meetings, new parent events, or community-wide Baby Celebrations; and by “sharing” health professional with the Healthy Start programs, such as dieticians and social workers.

Case Management

- A. Our approach to case management has been a work in progress. In the most recent Healthy Start grant cycle (2001-2005) our case management process evolved and strengthened. In the previous grant cycle (1997-2000) we were officially funded as a “Risk Reduction and Education Model.” During 2001-2005 we have been able to fully blossom into a “Case Management Model” by increasing partnerships, collaboration and linkages to the broad array of providers and services in each of the seven Healthy Start sites that served Native American clients. Because of their

locations within the State, each site has a different pool of services and providers from which program participants can choose and to which they can be referred—some choices are limited and some are extensive.

Although the Tribes comprise small numbers of people, the social and health challenges are often unparallel among larger ethnic groups. Therefore, our project staff has seen how the Case Management Teams have become lifelines for disenfranchised, isolated people, who are often historically disengaged from “the system,” many of whom suffer inter-generational grief and depression. The efficacy of the Healthy Start Case Management Model in our Native American population is that case management team members, in many ways, became activists for social justice and models for culturally competent professional healthcare encounters. In addition, they modeled and mentored a kind a behavior that led to greater self-determination in the target population.

For example, Outreach Workers who were from the Native communities, modeled engagement in a successful profession and increased self-esteem, while doing wholesome helpful work. We have seen how our chosen approach to case management has positively impacted birth outcomes, infant safety, maternal health, and family well-being by ensuring that there was a care plan for every mother and child, and by assisting families in getting the care they needed when they needed it most.

Because MCH disparities within the Native American population are well documented and discrimination in the delivery of health care services is evidence-based (as documented in the Institute of Medicine’s recent book called “Unequal Treatment”), our Case Management Teams have had the challenge of not only providing avenues to network clients into needed prenatal, postpartum, interconceptional, newborn, and specialty services, but also to promote empowerment and self-advocacy strategies so that program participants and their families can go after what they desire and deserve from the healthcare system. This holistic, multi-dimensional approach to case management has proven to be successful in serving our Healthy Start clients.

For the reasons stated above, one of the approaches that have worked well in case management is that Healthy Start clients were involved in developing their own service plans at the Initial Visit with the Healthy Start Nurse. They gave significant input regarding what their priority needs were, what services they wanted to address those needs, how services were coordinated, and where and by whom services were provided. At all seven HS sites, program participants reviewed their completed service plan and had continual input when reassessment of their care plan occurred.

B. The core service of case management for our Healthy Start project has been well established at all seven sites—six are rural locations and one is urban. Each component of case management was provided during a home, office or community visit. Case management was provided to infants and toddlers alongside the case management that is provided to their mothers or other primary caretakers. The key components of case management services were:

a. Enrollment and Assessment: The Healthy Start Nurse enrolled program participants, preferably in the woman’s home. Once enrolled (at the same visit) a comprehensive assessment tool (interview format) was used to identify risk factors and individual needs of each new program participant. The tool assessed medical, nutritional, psychosocial, and environmental factors. There was a specific version of the assessment tool for each type of new participants enrolled in Healthy Start including pregnant woman, postpartum or interconceptional women, infants, fathers, and other primary caregivers for an infant.

b. Risk Screening, Care Planning, Initiating Health Education, and Referral: Upon completing the assessment interview, the Healthy Start Nurse talked with the program participant to identify goals and priority issues. At the same visit, the nurse provided individual health education and referrals to address any immediate priority needs. Referrals may have been to fellow members of the case management team (Tribal WIC, social services, immunizations programs, etc.) or to community agencies with linkage agreements with Healthy Start (health department blood lead testing, prenatal care providers, shelters, etc.) Issues considered to be immediate priority needs included: non-initiation of care, current clinical symptoms (high blood pressure, symptoms of infection, etc.), current domestic violence or unsafe relationship issues, nutritional deficiency or eating disorders, maternal smoking, mental health issues, lack of transportation to healthcare appointments, unsafe housing or homelessness, and/or anything else that the program participant herself identified as a priority.

c. Monitoring, Continued Education, and Referral: After the initial assessment, all monitoring visits provided were considered “encounters” and were coded on a Patient Care Contact (P.C.C.) form. The standard case management protocol specified monthly visits with each pregnant program participant. For a pregnant woman, her status was monitored and health education and referrals were provided as needed. During the postpartum period

most participants were considered “lower risk” unless obvious problems occurred. After the initial early postpartum visit, participants were monitored quarterly during the interconceptional two-year period. For every visit the following was monitored: smoking status, concerns regarding domestic violence and safety issues, symptoms of depression, substance use/abuse, and vital signs. For program participants who have been identified as “higher risk,” that is, having multiple issues or who are in crisis, weekly or daily monitoring was provided as needed. Appropriate referrals were provided and collaboration and communication with healthcare professionals providing services was maintained. The Healthy Start staff acted as advocates to ensure that program participants were receiving the services they needed. Infants were monitored in the early postpartum period and then via monthly visits until one year, after which they received quarterly visits until two years of age. At each visit Healthy Start staff monitored infants for: weight gain, appropriate attachment, breastfeeding/ bottle feedings issues, safety issues, immunization status, signs and symptom of infections, or any concerns expressed by the care giver.

- d. Follow Up/ Reassessment, Continued Education, Referral, and Program Exit: The standard case management protocol specified that participants were to be followed through two years postpartum. During this time, periodic reassessments were done to update the initial assessment data collected at enrollment, identify any new needs, and to document progress. Newly identified needs were followed up via collaboration with case management team, health education, and referral when appropriate. For women, these reassessments were conducted at “First Postpartum Visit” and “Two Year Postpartum Assessment/ Program Exit.” For infants reassessments were at “One Year Old Assessment” and “Two Year Old Assessment.” For both adults and infants, an “exit plan” was designed including appropriate referrals such as to Early Head Start, Head Start, Early On, and so on.
- e. Home visiting: This is a key project feature and was provided by Healthy Start Nurses and Outreach Workers. In the last Healthy Start Grant cycle, program participants have identified home visits as highly educational and supportive, health-promoting, an intervention strategy, and culturally sensitive. For families who live in rural and outlying areas of the state, who lack choices regarding care providers, and who lack transportation, home visiting by Healthy Start staff was what has kept them enrolled in the program and what has facilitated them becoming connected with the larger perinatal system and networked into the care they need.

- f. Counseling and Guidance: These were ongoing and ever-present aspects to the Healthy Start Case Management plan. Healthy Start nurses provided counseling and guidance on a variety of health topics and lifestyle issues, and made referrals to other healthcare providers when appropriate.
- g. Coordination and Facilitation of Services: Because perinatal care is rarely “one stop shopping,” Healthy Start staff assisted program participants through the confusing and time consuming maze of coordinating healthcare services. The Healthy Start staff also acted as advocates for their clients and was able to facilitate accessing care more efficiently and quickly than families may be able to accomplish on their own. The case managers focused on interdisciplinary teamwork to meet their clients’ needs.

At each site the case management team consisted of the following care staff: Healthy Start maternal and child health (MCH) nurse, Healthy Start Outreach Worker, Tribal WIC staff and or Dietician, and Tribal Social Worker and/or Substance Abuse Counselor. Primary care clinical staff or supervisory staff, such as Directors of Community Health or Nursing Directors on site at the Tribes, may have been considered a part of the case management team, depending on the infrastructure of health services at each site.

Through linkages with family practice and the few pediatric practices in the implementation areas, the program nurses and outreach workers ensured that infants and toddlers were receiving the services that they needed. All tribes have linkages with early intervention programs and most have local Early Head Start programs. For infants with special health care needs, Healthy Start nurses and outreach workers spent a lot of time providing advocacy for families and helping them negotiate and access the services that are needed. Transportation to specialists is a considerable burden for families, which Healthy Start staff assisted in arranging.

From our “Perinatal Systems Assessment Project” conducted in the previous grant cycle, we learned that the primary barriers to our Healthy Start clients receiving necessary services that were: a) lack of healthcare providers in rural and outlying areas—obstetricians, midwives, nurse-practitioners, pediatricians, neonatologists, perinatologists, mental health specialists; b) lack of perinatal services—prenatal care, substance abuse treatment programs, shelters for victims of violence, infant special needs programs; c) lack of specialty care facilities—neonatal intensive care units (NICU), high-risk pregnancy centers, regional perinatal centers, Level III hospitals; d) client’s attitude of disengagement from the healthcare

systems; and e) perception of discrimination in the delivery of health care services.

In consultation with the team of care providers and keeping mindful of the woman's input regarding her own care, we tailored the care plan so that it was flexible and changed as needs surfaced. Based on the first assessment we devised an initial care plan, defining time, duration and frequency of visits, and altered the plan based on need and/or the program participant's request for changes.

- C. Successful initiation and implementation of project goals was able to occur due to the fact that, having received all three Healthy Start Grants (Disparities, Depression, and Interconceptional grants), we had the funds and personnel available to address project priorities.

Health Education and Training

- A. Health education is a cornerstone of our Healthy Start project. To conduct health education for program participants we decided to use a variety of standard, cultural and innovative approaches. In the past grant cycle, we had focused on how to produce and implement a successful health education program. We have conducted needs assessment via focus groups to understand the perceptions of the intended audiences (pregnant women, moms, dads, infant caregivers, grandmothers, elders). We have been involved in developing and testing concepts, messages and materials. We had produced culturally-appropriate educational materials (pamphlets, videos, posters, teaching modules.) Naturally, we have made refinements along the way. In addition, we have supported and collaborated with other programs and agencies doing similar work. Here are two examples of education approaches using innovative, culturally-focused education strategies that work well in Native communities.

Sema Project: This project is a culture-based collaborative of several individual tribes throughout the State. "Sema" is an Ojibwe word that means "tobacco." The purpose of the project is to test key messages about smoking and secondhand smoke in Native communities, to create culturally sensitive and motivational materials, and to disseminate these educational materials to the Tribes. This project also educates about the difference between what Native people call the "sacred uses of tobacco" (such as in spiritual ceremonies) from the "secular uses of tobacco" (i.e., smoking cigarettes). Smoking emerges in our Needs Assessment as a serious issue for Tribal women and their infants (and is one of our Project Performance Indicators). Therefore, we have collaborated with the Sema Project (sponsored by the Inter-Tribal Council of Michigan, Emory University and the Tobacco Technical Assistance Consortium) to do a needs assessment and test concepts, messages and materials (with

Healthy Start clients), and to utilize and disseminate culturally-targeted education about smoking and secondhand smoke. Forty-one percent of Native American women in the Healthy Start project area reported smoking during pregnancy (a 2002-2003 average.) Smoking is rarely an individual “habit,” but rather, is often a family and community “habit” for Native Americans. This culturally-focused model works well in educating at all levels and reinforces collaboration and linkages with existing programs. Healthy Start program participants will also be involved with follow-up evaluation of new *Sema* Project materials.

“Traditional Cradleboard Teaching” Regarding Safe Sleep: Native Americans may have originated the concept of “Back to Sleep” with their long-standing historical use of the cradleboard. A cradleboard differs from Tribe to Tribe, but essentially is a handmade-framed flat basket in which a baby spends its first year. The baby is placed on its back and swaddled into place. It is a safe and secure environment. Native teachings about cradleboards say that they help with the child’s skeletal development, strengthen neck muscles, and provide an opportunity for the infant to be visually and emotionally stimulated by its environment and family while being kept safely in a distinct location. The baby is carried on the mother’s (or father’s) back and the cradleboard can also be secured in place (on the floor or hung) when the baby is sleeping—on its back—so that it can always be in visual sight of the caregiver. Because post-neonatal infant death and SIDS are areas of critical disparities between Native American and White infants, teachings about how to keep infants safe that are also culturally-based are very valuable. Our Healthy Start brochure about the use of cradleboard and safe sleep practices, which is in the shape of a cradleboard for visual and cultural appeal, is called “Back to Sleep, Back to Tradition.” It has been successfully used to educate program participants and their families as well as MCH care providers and Consortium members.

- B.** The chief components of our health education plan include messages that are culturally appropriate and culturally competent while being instructive. We focus on educational messages and materials that are simple, clear, culturally sensitive, geared towards our intended audiences, and which support the existing healthy traditions within Native American communities. It has been our experience in the past grant cycle that the better our knowledge is of the communities and clients that we are serving and our awareness of their preferred educational styles, the more likely the messages will be heard and received. In turn, when educational messages met with greater receptivity, the more they affected behavioral change and improved outcomes for Native Americans.

Because of the prevalence of multiple risk factors (medical, psychosocial, environmental) among Native Americans we targeted certain topics to be

discussed more frequently and with more emphasis. The following topics were the primary components of health education for both program participants and community participants.

- a. Promotion and awareness of Healthy Start
- b. Importance of early and regular prenatal care
- c. Importance of interconceptional care
- d. Healthy pregnancy, nutrition, supplements, exercise, good health practices
- e. Pregnancy warning signs, preterm labor
- f. Substance use/abuse prevention; FAS/ FAE, prevention, treatment
- g. Smoking hazards, cessation, and dangers of second-hand smoke
- h. Sexually transmitted disease (STD)/ infection (STI); HIV/AIDS
- i. Depression awareness, prevalence, treatment
- j. Safe sleep practices; SIDS awareness, prevalence, prevention
- k. Breastfeeding, how to get started, benefits to mom and baby; human lactation
- l. Other priority topics identified by each community

When referring to another provider, we tracked our clients' receipt of health education via an "education checklist" located in the client chart. Program participants also kept this information in a Health Diary. The Healthy Start Nurse, who is also the Case Manager, was responsible for soliciting this information from program participants. Evaluation of effectiveness of individual level of education was built into the forms used in the periodic reassessment phases of the case management protocol.

Client health education is provided in a variety of ways.

- a. One-on-one instruction has been provided by Case Management Team members, but Healthy Start Nurses and Outreach Workers, via an education curriculum that we have developed. A Healthy Diary containing a standard set of topics is given to all program participants; it is reviewed at each visit; it is used as a consistent record of mutually-identified goals; and it is a place for participants to record services received, questions for providers, concerns, and goals achieved or which need more attention. The case management team will tailor educational messages and efforts based on cues from the client, the results of the mother and/or baby's assessment (and reassessments), the mother's stated needs, and items contained in the Health Diary.
- b. Group instruction via women's groups is a very common way that we have provided health education. Generally speaking, Native American people operate within a well-established extended family and/or clan system, and providing group events is not only

culturally-based, but works well for “spreading the word.” Typically, group settings will include such things as “Talking Circles,” a traditional way to receive and give information, community health fairs, and local and regional PowWows. Native American people consider children to be their greatest wealth, and so public education forums about keeping moms and babies healthy and safe are usually well-attended by a cross-section of the community.

- c. Brochures, videos and other educational materials have been provided for each of the standard topics of education. For example, when discussing Gestational Diabetes the client is given written nutritional information, pamphlets such as, “Patient Guide to Gestational Diabetes” and “Caring for You and Your Baby,” and shown a video on managing a “diabetic diet” and making healthy food choices.
- d. Referral to cultural/spiritual teachers and elders is common in Native American communities. There is a wealth of health practices and traditions designed to keep mothers and babies safe and healthy, and cultural teachers, elders and spiritual advisors provide education via the oral tradition of Native people. As part of a culturally competent health care model these teaching/training strategies are frequently incorporated into client care.
- e. Referral to maternal and child health (MCH) providers in the seven individual communities where our Healthy Start sites are located is part of the interdisciplinary approach to client education and care. Most of the sites, for example, have staff on the case management team who are certified in lactation support, childbirth education, infant and adult CPR and offer those services on site. Where certified staff is not always available at each of the Tribal centers, collaboration and linkages to programs sponsored by local hospital, health departments or private caregivers is provided.

C. An event that facilitated successful implementation of health education was the standardization of information provided to clients at all seven Healthy Start sites. Within the past year (and very near to the end of this grant cycle), the Healthy Start staff—led by the Healthy Start Nurses and in conjunction with the statewide Consortium—has been developing an educational curriculum for program participants. After reviewing several perinatal educational curricula we have chosen to use the Indian Health Service educational protocols. It has provided the Nurses and Outreach Workers with a standard format and materials. Because we have seven distinct sites, distinct communities, and distinct tribal governments and health systems, standardizing the education core service at all seven sites has been a work in process that has required good communication and multi-level collaboration—and we did it successfully, for which we are very proud.

Once again, successful initiation and implementation of project goals was able to occur due to the fact that, having received all three Healthy Start Grants (Disparities, Depression, and Interconceptional grants), we had the funds and personnel available to address project priorities

Interconceptional Care

- A.** A key lesson that we have learned from carefully reviewing Native American infant death cases through our population-based Fetal Infant Mortality Review (FIMR) was about the particular danger that families are in when they are disconnected from consistent and effective systems of care. Most FIMR cases have two things in common: the families involved have multiple stressors and very challenging life situations, and typically, those families have “fallen through the cracks” of the system despite documented involvement with a variety of agencies. We have found that two aspects of interconceptional care work well: first of all, personal, compassionate and consistent contact provided over time by Healthy Start staff to clients and their families’ builds trust and confidence. And secondly, the flexibility of the program to address concerns and problems in an individualized way that is uniquely tailored to a particular client and family provides security that healthcare and psychosocial needs can be satisfactorily met. These two approaches helped families stay engaged in Healthy Start services throughout the interconceptional period.

There is a common perception and experience in Native communities, especially among families who have had court involvement that social and human service staff members hold negative judgments toward the families they serve. Like all health and human services providers, Healthy Start staff have Child Protective Services reporting responsibilities when warranted, but do not engender the same air of suspicion that is found in many other programs. Because the seven local Healthy Start staffs are members of the communities they serve, and remain committed to their families over a long time period, and because there are no income or any other eligibility verification procedures that participants must contend with, the Healthy Start program is free from the stigma of being a program for poor or marginalized people. Many families who refuse county or other governmental services were willing to participate in Healthy Start, thus ensuring the connection necessary for early intervention when needed.

- B.** The goal of the interconceptional care component of the program is to ensure and promote the health of women and infants through networking them into a continuum of care. The key strategies are to keep women and their families connected to a broad array of services and support, and also to keep them actively engaged in caring for their own health. Between 2001 and 2004, 41% of pregnant women and 24% of postnatal women were assessed as high medical risk. The most common medical risk

factors were history of poor obstetrical outcome, diabetes, hypertension and poor nutrition. Depression and mental health issues, substance abuse, homelessness and/or housing problems, and domestic violence were the leading issues for psychosocial risk; 28% of pregnant and 26% of postnatal women were assessed as high psycho-social risk. Among infants, 27% were assessed as high medical risk. It is clear that the Inter-Tribal Healthy Start program is effective at engaging the families who are most in need of support.

The ITC Healthy Start program Nurses and Outreach Workers provide interconceptional care for up to two years postpartum as part of the seamless case management they provided during each woman's enrollment in Healthy Start. The interconceptional care provided by the program began with an assessment that took place during the first postpartum visit for women who enrolled in Healthy Start prenatally. For women who enrolled in the program postnatally, the assessment took place at the time of enrollment. The assessment comprehensively screened women for education and referral needs related to immediate medical conditions, medical home/primary and specialty care, family planning, nutrition, breastfeeding, health behaviors and psycho-social issues including emotional support, transportation, housing, domestic violence, and substance abuse. Based on assessment results, a care plan was developed with involvement of the program participant. Infants were assessed at enrollment and followed through two years of age. For women who enroll while pregnant, their infants were enrolled at the first postpartum visit. For women who enroll in the postnatal period, their infants were enrolled at the time of enrollment of the mother. The infant assessment was comprehensive as well, screening for education and referral needs related to medical conditions, need for specialty care or early intervention, medical home, feeding issues, growth, immunizations, potentially hazardous environmental exposures, and other potential risk factors. A care plan based on assessment results was developed with involvement from the mother (or other primary caretaker).

Once the assessment and care plans were completed, both women and infants were then followed and provided services such as referral, individualized education, transportation, and clinical nurse services according to the needs identified. Clinical nurse services that can be provided vary somewhat by site, but generally included checking vital signs, blood sugar checks, administering immunizations, incision and cord care, managing medications, lactation counseling and support, and assessment of physical symptoms to ascertain if further medical care should be sought. For women or infants who return from the hospital with monitors and or conditions that need close follow up, the Healthy Start nurses were of great assistance, providing hands on assistance, and advocacy for families negotiating the health care system. Outreach workers had an important part alongside or in a supporting role to the nurse by providing communication, transport, emotional

support and appointment scheduling as needed for families. Families in crisis, and/or with more critical or acute concerns were visited as often as needed. For many cases, Healthy Start staff was in regular communication and consultation with outside medical providers in order to facilitate coordinated care, and to help families make the most of the services available to them. Both women and infants were formally reassessed at one and two years postpartum. In between formal assessments, nurses provided health promotion education, any needed referrals and check to be sure that participants were up to date with recommended preventive care (ACOG guidelines for women and AAP well-child visit schedule for infants). The program visit protocol called for women in the interconceptional period who are considered to be “low risk” were visited at least twice during the first 8 weeks postpartum, and then at least quarterly. For participants identified as “higher risk” – having multiple issues or who are in crisis—were provided monthly, weekly or sometimes even daily contacts, as needed. Infants were visited as soon as possible after birth (usually within the first few days home), and then monthly through the first year.

- C. An event that detracted from successful implementation of full-spectrum interconceptional care was that the State of Michigan eliminated low-income dental care in the last project year.

Once again, successful initiation and implementation of project goals was able to occur due to the fact that, having received all three Healthy Start Grants (Disparities, Depression, and Interconceptional grants), we had the funds and personnel available to address project priorities

Depression

- A. The screening tool used by our Healthy Start program was the Edinburgh Postpartum Depression Screen (EPDS). Participants who enrolled in Healthy Start while pregnant received a minimum of four screens over the course of their participation in the program. Women who enrolled during the postnatal period received a minimum of three. Screens were performed at the initial assessment upon enrollment; again at the first postpartum visit, at 1 year postpartum and 2 years postpartum. In addition, screens were performed any time in between these intervals if there was a concern or the nurse senses the woman is at risk. The project performed universal screening; everyone enrolled in Healthy Start received screening unless they refuse.

The EPDS screening tool has been in use for four years in our HS project. Before using it, it was pre-tested with community members. The pretest revealed that the wording of one question “Things have been getting on top of

me” was not in common usage in the community and people were confused about its meaning. After discussion with other Healthy Start projects around the country, it was discovered that other communities have had trouble with this phrase as well. After consultation with MCHB, the wording of the questions was changed to “I’ve had a hard time coping”.

B. Perinatal depression screening was conducted by the program-employed Healthy Start nurses at each implementation site and was fully integrated into the overall risk assessment and case management services that they provide. The nurses, as the lead case managers, performed the screening and made referrals for further assessment if warranted. If services were located on site, as they are at some tribal facilities, the nurse will usually accompany the participant for an initial introduction to a mental health provider the same day as the screening.

Individualized education on the signs and symptoms of perinatal depression was included in the project’s education protocol. Education was provided before and after conducting the EPDS screen, as well as during the general education provided in helping women prepare for birth, and again at the first postpartum visit. Several brochures were distributed, and plans are underway to develop a Native American specific brochure on emotional wellness during the perinatal period, which included warning signs of depression. Community education was provided through media such as posters and brochures displayed and distributed at powwows, health fairs and special gatherings. Community awareness of perinatal depression was also targeted by another small Inter-Tribal Council program, which focuses more generally on women’s health.

Participants with a positive screen were referred to mental health providers who provided full assessment and treatment as necessary. These mental health providers included tribal social service/behavioral health programs, county and community mental health agencies, and other community agencies such as Women’s Resource Centers, Catholic Family Services, and other agencies.

C. Participants with a positive screen were referred to mental health providers who provide full assessment and treatment as necessary. These mental health providers include tribal social service/behavioral health programs, county and community mental health agencies, and other community agencies such as Women’s Resource Centers, Catholic Family Services, and other agencies. Full assessment and treatment

were not provided by Healthy Start funded staff and thus are not covered by the Healthy Start program. Assessment and treatment were covered by other resources including tribal support, Medicaid and insurance reimbursement. The following chart presents the variety of mental health providers in each implementation site area with whom the that Healthy Start nurses collaborate.

Tribal Site	Providers of Assessment & Treatment	Services available at Tribal Site?
Bay Mills Indian Community	1) Tribal Mental Health Services (Phd & B.S.W.) If schedules are full, referral is made to 2)County Health Department Social Worker	Yes
Hannahville Indian Community	1) Tribal Behavioral Health (M.A./L.P.C. R.S.W.) 2) Referral through primary care physician to contracted psychologist available 2 days per month, or 3) Employee Assistance Program Counselor (if tribal employee or relative)	Yes
Keweenaw Bay Indian Community	1) Tribal Youth, Elder & Family Services Dept. (R.S.W./M.S.W.) and (PhD Psychologist) or 2) Referral to Copper Country Community Mental Health, or 3)Private Practitioner in area	Yes
Little Traverse Bay Band	1) Referral to Women’s Resource Center of N. MI (M.S.W.), or 2) Referral to private provider	No
Lac Vieux Desert Band	1) Tribal Behavioral Health (M.S.W.), tribal general practice M.D. can order meds, or 2) Referral to Gogebic county Community Mental Health if need Psychiatrist	Yes
Saginaw Chippewa Tribe	1) Tribal Behavioral Health Program (M.S.W.) 2) Referral to Central Michigan Community Mental health 3) Private Practices in the area	Yes
Native American Community Services (urban- Grand Rapids)	1) Referral to Community Mental Health 2) Private Practices in the area	No

D. Successful initiation and implementation of project goals was able to occur due to the fact that, having received all three Healthy Start Grants (Disparities, Depression, and Interconceptional), we had the funds and personnel available to address project priorities

Local Health Systems Action Plan

- A.** We faced challenges in developing our Local Health System Action Plan (LHSAP) primarily due to the fact that our Healthy Start Project is a statewide, population-based project as opposed to a project that is geographically-based with a central discreet location within the State. While there has been significant stakeholder investment in the LHSAP, the disparate geographical sites (six rural tribal sites in the Upper and Lower Peninsulas of Michigan and one urban Indian site), are scattered throughout the State and each community has its own maternal and child healthcare needs, priorities, and perinatal systems. To overcome our challenges we have identified key strategies that will benefit all Native American families and communities throughout the State and these strategies have been the foundation of the LHSAP. These strategies have been developed after reviewing prior project activities, conducting needs assessment with the Healthy Start staff and program participants, and by gaining input and guidance from Consortium members and project supporters. The development and implementation of the LHSAP was primarily under the guidance of the Healthy Start staff and Consortium members, who represent key public and private partners, community leaders, Tribal health systems, local, state and Tribal governments, Title V staff, program and community participants, and consumers.
- B.** The LHSAP has been used to: set priorities for the statewide Consortium; focus political attention on specific perinatal system deficiencies as they relate to Native American consumers; provide a framework for developing collaborative relationships for seeking solutions to racial disparities in maternal and child health status and outcomes; and design multi-faceted service delivery systems. Based on data from many different sources including needs assessment, lessons learned during the first four years, and Healthy Start participant feedback, two overarching systems change issues have been prioritized. They were: 1) the need to improve access to quality maternal and child healthcare for Native Americans, ensuring linkages to an integrated delivery system that is culturally competent, holistic, and community-centered, and 2) the need for improvement in Native American representation in designing, structuring, and administering maternal and child healthcare programs and policies, both statewide and locally.

The following individuals or groups were responsible for working towards the goals of the LHSAP: Healthy Start Management Team (Project Director, Evaluator, Administrative Assistant, and project Nurse-Consultant; Healthy Start staff (nurses and outreach workers); representatives from the six sovereign Tribal Nations served by the project; Tribal community members (women of reproductive age, men and

a member of one or more of the four Consortium Standing Committees
(Access to Care, FIMR, Cultural Competency, and MCH Policy/Title V.)

Local Health System Action Plan

Collaborate with existing services to improve access to quality maternal and child healthcare (MCH) for Native Americans, ensuring linkages to an integrated delivery system that is culturally competent, holistic, and community-centered.			
Strategy	Priority Activity →	Timetable	Collaborators
I. Promote integrative & Complementary models of care that are proven to be effective, safe and satisfying for Native Americans to improve perinatal outcomes	<ol style="list-style-type: none"> 1. Assemble evidence of client MCH care preferences (providers & services) 2. Assess opportunities at each HS site for using a variety of MCH models of care 3. Recommend expanded integration of complementary models of care into healthcare system (Native American cultural healing practices; midwifery model of care; community-based public health models; medical model of care) 4. Develop promotion plan for expanded integrative MCH services for Tribes 	<p>Begin June 2005</p> <p>Begin June 2005</p> <p>By June 2006 & On-going</p> <p>June 2006 & On-going</p>	ITC Healthy Start (HS) Consortium; Tribal communities; MCH providers and service organizations; Michigan Department of Community Health (MDCH); Indian Health Service (IHS)
II. Promote improvement in client-provider communication and relationships	<ol style="list-style-type: none"> 1. Evaluate existing cultural competency training programs 2. Develop a provider training plan for those serving Native communities to address misunderstandings and/or discrimination based on differences in race, ethnicity, values, beliefs, behaviors, and language 3. Collaborate with other agencies statewide re: cultural competency training 	<p>Begin June 2005</p> <p>By June 2006</p> <p>June 2006 & On-going</p>	Office of Minority Health (OMH); Michigan Council for Maternal & Child Health (MCMCH); Healthy Mothers, Healthy Babies (HMHB); March of Dimes (MOD); ITC HS Consortium; Tribal communities; MDCH; MCH agencies
III. Increase the number of Native American MCH providers providing services in Native communities	<ol style="list-style-type: none"> 1. Explore ways to recruit & train Native American nurses, physicians, midwives, social workers, nutritionists & other health professionals 2. Explore training options through institutional partnerships 	<p>Begin June 2005</p> <p>By June 2006</p>	MCH providers; Universities; Tribal community members; Tribal Health agencies; Consortium; (IHS); private foundations & philanthropic agencies
IV. Strategize ways of ensuring availability of MCH care providers, primary services, and extended services in outlying & rural areas of	<ol style="list-style-type: none"> 1. Assess the need for increased MCH clinical hours & referral sites 2. Negotiate logistics for expanded services in rural areas; increase use of current services & referrals systems 3. Advocate for increased utilization of 	<p>Begin June 2005</p> <p>Begin June 2006</p> <p>By June</p>	HS Consortium; HS Project Director & staff; local and regional hospital and MCH providers; Tribal communities

the State	advanced nurse-practitioners & certified nurse-midwives	2006	
	4. Advocate for increased Medicaid reimbursement of mid-level providers	By June 2006	
V. Strategize ways to build and maintain partnerships for sustainability of existing MCH services for Native families	<p>1. Assess feasibility of receiving State approval for ITC Healthy Start sites to become MSS/ISS providers—State reimbursement for services for Medicaid-enrolled mothers and infants</p> <p>2. Assist sites in completing applications to become MSS/ISS providers</p> <p>3. Provide technical support to get MSS/ISS programs up and running, including proposed marketing plans</p>	<p>Begin June 2005</p> <p>Begin 2005</p> <p>Begin 2005</p>	Local & statewide stakeholders; Tribal governments & communities; governmental agencies; foundations; MCH providers, hospitals and service agencies; IHS

Advocate for improvement in Native American representation in design, structure, and administration of maternal and child healthcare programs and policies, both statewide and locally.

Strategy	Priority Activity →	Timetable	Collaborators
I. Advocate for the development of racially and culturally competent primary health care policies and structures that address population-based disparities	<p>1. Ensure Native American representation on MSS/ISS MCH program redesign workgroup</p> <p>2. Initiate a workgroup to research & design a blueprint for culturally, racially, and linguistically competent MCH care for Native Americans</p>	<p>Begin 2005</p> <p>Begin 2006</p>	Tribal Health Directors, Health Boards, community members and Governing Councils; MDCH; FIMR; Title V; social workers; MCH providers; MCH & women's health programs & agencies; MCMCH
II. Advocate for gathering population-specific data that will provide program planners with information necessary for policy development	<p>1. Collaborate with the State to draft training protocols for providers & staff who enter information on Vital Records regarding race & ethnicity</p> <p>2. Work with Tribes regarding accurate reporting on Vital Records</p> <p>3. Insure that the State's only Native American population-based FIMR has the support it needs to continue</p> <p>4. Explore preventable causes of fetal/ infant death in Native American population and design ways to get this information to MCH program designers and policy makers</p>	<p>Begin 2005</p> <p>Begin 2005</p> <p>Begin 2005</p> <p>Begin 2005 On-going</p>	Tribal Health Directors, Health Boards, community members; Tribal Governing Councils; MDCH; FIMR; Title V; social workers; MCH providers; MCH & women's health programs; Consortium
III. Advocate for inclusion of Michigan Tribes in Title V	1. Review project area target vital statistics and program participant data to identify health disparities & priority	Begin 2005	Tribal communities Consortium; HS nurses & outreach workers; HS

planning and priority setting	MCH issues 2. Insure inclusion of at least one indicator in the State’s Title V plan that specifically addresses Native American racial health disparities	Begin 2005	Project Director, Evaluator, Consultant staff; Title V staff; policy makers; MDCH
-------------------------------	---	------------	---

C. Successful initiation and implementation of project goals were able to occur on many levels due to the fact that, having received all three Healthy Start Grants (Disparities, Depression, and Interconceptional), we had the funds and personnel available to address project priorities

But there have been challenges in achieving the goals of the LHSAP in the larger health system arenas. State, local and Tribal health systems have not had the resources necessary to fully address the LHSAP priority issues such as, strategizing ways to ensure the availability of MCH providers and referral sites for Native people who are “falling through the cracks” of the systems, who are isolated in rural, outlying or underserved areas, who are without a continuum of care, or who lack follow-up services

Consortium

A. Our statewide Healthy Start Consortium was designed to address maternal and child (MCH) health disparities and priority issues facing Native American people in seven distinct and unique project sites located throughout the State of Michigan. Our approach to running our consortium evolved through our experiences in previous grant cycles. At that time we learned that efforts to eliminate race-based disparities and supplant imbalances with equity in health status must not only be informed and guided by the particular racial group experiencing the disparities, but must also be articulated through program designers, integrated by policy makers, and assigned priority by funding agencies. In order to have this kind of holistic impact, we engaged a multi-level, dedicated, talented group of stakeholders to be a part of our statewide Healthy Start Consortium.

B. The Inter-Tribal Healthy Start (HS) Consortium consisted of a diverse statewide group of professionals, consumers, maternal and child health (MCH) agency representatives, and Tribal entities and community members. It functioned as an advisory body and offered guidance to the HS Project. It was structured with a general membership body and four standing committees. Consortium members meet face-to-face twice annually with teleconference access at other times. All members participated in Consortium general meeting sessions; each member was active on at least one standing committee with clearly identified projects and tasks. Healthy Start Management Team, HS nurses, and key Consortium members provided facilitation and oversight of Consortium activities.

Our ambitious challenge was to influence systems changes on three levels: 1) individual, 2) community and 3) within policy and service delivery systems. Our Consortium members met several times per year for a full day, and at each meeting we had large-group time and small-group time. In order to define our strategies and focus our activities we created four Consortium Action Committees. The Committees were: 1) Access to Care and Barriers to Care; 2) Fetal & Infant Mortality Review (FIMR); 3) Cultural Competency; and 4) Maternal and Child Health (MCH) Policy & Title V.

The goals of the Access to Care Committee were to: 1) improve access for Native American families to perinatal services, especially early prenatal care and specialty care, such as perinatology, neonatology, pediatrics, NICU, etc; and 2) decrease barriers to utilization of inter-conceptual care services, lack of coverage for services, and access to providers who are acceptable to Native Americans.

The goals of the FIMR Committee were to: 1) review Native American fetal and infant deaths and try to gain an understanding of causes; and 2) use information gained in our FIMR Committee to ensure inclusion of accurate Native American perinatal health data in State planning and policy efforts.

The goals of the Cultural Competency & Holistic Care Committee were to: 1) increase the level of cultural competency and holistic healthcare approach in serving Native Americans; and 2) increase screening for perinatal depression and emotional well-being issues by perinatal providers with attention to a wide range of providers and practices that include Native cultural and Western medical modalities.

The goals of the MCH Policy and Title V Committee were to: 1) include Michigan tribes in Title V planning and priority setting that can help address Native American racial and health disparities; and 2) improve the accuracy of reporting Native American race on State Vital Records.

In addition to committee work other components of the consortium included: 1) creating a mission and vision for the Consortium; 2) working with the consensus decision-making model; 3) gaining a better understanding of people different from one's own race and culture; 4) and working collaboratively for a common goal with a variety of stakeholders, including: tribal community members and leaders; Tribal councils; Tribal health directors & Tribally-based MCH programs; urban Indians & organizations; health care professionals; MCH agencies; governmental agencies; policy makers; and funding agencies.

- C.** There have been challenges in achieving the goals of the Consortium. First of all, we believe the Healthy Start model was designed for urban populations that are located within a reasonably discreet section of a city or county. The

Inter-Tribal Healthy Start Project is spread out over a whole State, encompassing 27 service-area counties (as well as other counties in which program participants receive care) and including vast areas of wilderness and two peninsulas connected by the western hemisphere's longest bridge. When we switched from each of our seven sites having its own community-based consortium to our one statewide consortium we encountered some difficulties that detracted from our ability to fully implement the goals of the consortium.

Challenges to the effectiveness of the Consortium can be anticipated to be to fall into four general areas: insufficient staff time and/or programmatic resources to assist the Consortium efforts; irregular attendance by members; insufficient resources in the state and local communities to support goals of the Consortium; and lack of knowledge of the Consortium goals by stakeholders statewide. The concerns related to attendance of meetings are not only those involved with coordination of many peoples' schedules, but also involve vast geographical distances that some members must travel to attend Consortium meeting. Even with rotating meetings sites to equalize travel time for all, distance was still an issue. In order to include our Consortium members from each participating Tribal area statewide, certain people must travel up to eight hours to attend a single meeting—unlike most Healthy Start projects where travel to meetings is within the same metropolitan area in which the person lives or works.

A positive event that helped us to implement the goals of our Consortium was that we instituted Yahoo! Internet Groups for each consortium committee. This allowed people to be in contact with one another between meetings. Although not all committee members are computer-savvy, we are slowly but surely trying to bring people on board.

D. For consortium, please address the following additional elements:

1) Establishment of Consortium and addressing any barriers:
In our 1997 through 2001 grant cycle, each of seven tribal sites coordinated its own local consortia to accomplish community education and promotion of the Inter-Tribal council Healthy Start Project in a local, decentralized fashion.

However, with seven different consortia, activities were difficult to coordinate, evaluating and reporting became challenging, and it was difficult to join forces around the State. The decentralized local consortia structure—while very effective on the local level— was not successful in advocating for sweeping systems change on the statewide level.

In 2001, we began our single, centralized statewide consortium, which continued through 2005, with representatives from all seven HS sites and from other agencies involved with maternal and child healthcare within the State.

While we still maintain seven “local consortia/community committees” to implement educational and advocacy activities at our HS sites, our statewide consortium looks at systems change from an over-arching perspective.

2) Working structure, size, percentage of active participants, and composition of consortium by race, gender and types of representation (consumer, provider, government, or other):

Currently, we have fifty (50) members on our Consortium representing the following categories: state or local government (4); program participants (4); tribal elders (1); community-based organizations (2); private agencies or organizations (3); providers contracting with Healthy Start program (nurses and outreach workers) (15); other providers (2); community representatives from Tribal health and human services (5); Tribal Health Directors (6); universities (1); Inter-Tribal Council of Michigan representatives, including Healthy Start management team (7). (Note: several Healthy Start Nurses, Outreach Workers and Tribal health employees have previously been program participants (over 50%), but are listed here under categories other than “project participant”.) Of the total Consortium membership of 50 people, 32 are Native American (64%) and 18 are non-Natives (36%). Judging from member participation in 2000-2004, we anticipate that between 75-80% of the Consortium membership will remain active in the next four-year cycle. This estimate depends on where the meetings will be located throughout the state and how participants travel and per diem will be underwritten (i.e., private pay, Healthy Start, in-kind from Tribes and other agencies.)

While Tribal Health Directors at our Healthy Start sites were a part of the Consortium and invited to each statewide meeting, all Health Directors were not able to attend all Consortium meetings. They were, however, kept in the communication via the Healthy Start Project Director who attends the Tribal Health Directors’ quarterly meetings, reports on Healthy Start, and received input and feedback from them. Thus the communication loop remained intact. Because all Tribes are Sovereign Nations and operate their health systems independently, consistent communication and collaboration are very important for effective implementation of Consortium goals.

3) Activities this collaborative has utilized to assess ongoing needs, identify resources, establish priorities for allocation of resources, and monitor implementation:

On-going needs have been assessed via consortium member evaluations, focus groups that include program participants and potential participants from tribal and urban sites, and regular project management team meetings. Consumers contributed significantly to needs assessment, data collection, project evaluation, and the development of Healthy Start services. For example, each of our sites has conducted “Talking Circles” (a culturally designed paradigm for discussion and data-gathering) where consumers

provided feedback regarding key areas, such as perceptions of MCH services, providers, and educational programs available to Native families. The Consortium then took the data provided in Talking Circles and used it to inform Consortium activities, and implemented consumer suggestions into Healthy Start services. Consortium member established priorities via their involvement in the four standing committees. The Healthy Management Team monitored implementation of goals and activities and reviewed the meeting minutes carefully for activity plans.

A wonderful collaborative that the Inter-Tribal Council was instrumental in establishing was the “Healthy Start Native Peoples Council” (HSNPC)—a consortium of the HS projects that target Native populations. This Council emerged from a very powerful gathering of six HS projects in 2003. Among the accomplishments of the HSNPC is a booklet entitled “Speaking with One Voice.” It contains four position papers on maternal and child health issues that American Indian and Native Hawaiians face. This document has been used as an educational tool locally, regionally and nationally venues and at Consortium meetings to increase awareness of the disparities and unique issues that indigenous people face in matters of maternal and child health. It will be featured in a scientific session at the 2005 American Public Health Association Annual Meeting in Philadelphia, and Inter-Tribal Council of Michigan staff will be the presenters.

4) Community’s major strengths that have enhanced consortium development:

As mentioned before, our project has seven sites, thus seven communities. Each of these sites is different, with differing needs. Six of the seven are reservation-based, primarily rural, and under the governance of the Tribal Sovereign Nations. One site is urban and falls under the umbrella of Native American Community Services.

In general, the strengths of these communities are imbedded in native traditions and the ways in which cultural beliefs and practices contribute to health and well-being of the people. For example, historically Native cultures define an obligation that society has to support, honor and respond to women’s health needs, especially pregnant and nursing moms, because women are recognized as sacred givers and sustainers of life. This perspective meshes nicely with the goals of the consortium. There are many Native customs that surround pregnancy, birth and infancy that are historically designed to keep moms and babies safe and bring blessings upon. An example is the use of the cradleboard—the original “Back to Sleep” intervention and risk-reduction practice. Weaving these cultural practices into our work, which highlight the strengths of this population, enhanced consortium development and project implementation.

5) Weaknesses and/or barriers that had to be addressed in order for the

consortium to be moved forward:

It is an ambitious undertaking to address the comprehensive needs that exist for Native families while coordinating activities for seven discreet healthcare systems that include six Sovereign Nations, health boards, Tribal Councils, Tribal leadership, and so on.

We believe that the HS model was designed to serve one large urban population and in that context, consortium members probably have much more contact with one another on a regular basis than we do. HS funding is allocated based on the “population served” without attention to the logistics involved.

For us, we are geographically separated and the clients we serve that live mostly in rural locations, are at quite a distance from MCH providers, specialty care facilities, and HS staff. These realities often create significant barriers in moving our agenda forward at a pace that we would prefer.

6) Activities/strategies employed to increase resident and consumer participation:

The role of the consumer in our Consortium was three-fold: participation in annual strategic planning, active involvement in consortium projects, and evaluation of consortium activities. Consumers were involved with identifying and implementing strategic directions for the Consortium. For example consumers in the “Cultural Competency and Holistic Care Committee” have been instrumental in advocating for practical ways to address the Consortium goal of integration and delivery of high quality, culturally competent, holistic care for Native Americans.

These types of activities—such as soliciting consumers input regarding educational materials, involving them in media efforts, applauding their participation as project spokespeople, and hiring consumers into the project—are all strategies to not only keep consumers involved, but to increase their participation on many levels. Consumers are so proud when their baby becomes a “poster child” for Healthy Start, and this type of direct involvement with the people we are serving gets the attention of other community members, thus increasing their participation.

7) Consumer input in the decision-making process:

Consumers are a valued part of the Consortium decision-making process. A major way in which they provide input is via the focus groups, called Talking Circles that are conducted regularly at each site to assess the needs of program participants, potential participants, spouses, and family members.

For example, Consumers are involved in decisions regarding what type of materials will be produced and disseminated. They have an influence in media efforts by participating in designing, creating and disseminating Healthy Start educational materials, such as brochures, posters and calendars. They also

appear in media productions (videos) about Healthy Start, and they act as spokespeople for the project in local, regional and national venues (i.e., Tribal communities, health departments, Healthy Start Native Peoples' Council, and national Healthy Start grantee meetings, etc.) Consumers inadvertently are involved with decisions regarding recruitment and hiring of personnel because several former project participants have become Healthy Start Nurses or Outreach Workers.

To ensure that consumers have input into consortium decision-making, we are careful that membership on the Consortium is culturally representative. We specifically invite people (young men and women, families, elders) from Native American communities and Tribal health and human services and make arrangements for their travel, lodging and meals. In addition, Consortium meetings are conducted in culturally appropriate ways (i.e., opening meeting with traditional/ spiritual teacher or elder who says a prayer, blesses the group and/or provided a cultural teaching before we begin our work, using Talking Circle method of group discussion, and providing cultural teaching on the topics at hand), and to show honor and respect for the Native American people who the project serves.

8) Utilizing suggestions made by the consumers:

While we do have some consumers on the Consortium, frankly, we would prefer to see more, but many are unable to dedicate the travel time and overnight time that is necessary to participate in meetings. Even with travel and lodging assistance, many consumers are single moms and/or have small children and for some of our sites traveling to meetings is a three-day venture (two travel days and a meeting day). In Healthy Start projects operating in urban centers Consortium meetings probably involve only half of a day. So the best way for us to utilize suggestions made by consumers is to engage them in activities within the seven communities (via Talking Circles, Women's Gatherings, Baby Fairs, Health Days, and other community events), use their suggestions to inform the work of the Consortium and implement their suggestions in each of their own communities. As mentioned earlier, our project covers a vast geographical territory and involves many different communities (see map in appendices) and so our greater involvement with consumers has been at each of the individual project sites. Our Healthy Start staff members were astute at listening to their constituents, carrying their suggestions to the Consortium, and implementing their suggestions into their community-specific programs. Our Healthy Start Management Team made site visits yearly for those same purposes.

Collaboration with State Title V and Other Agencies

- A.** In developing an approach to collaboration with the State and other agencies, the project team sought to address the lack of inclusion of tribal entities and Native American data in most State and county level MCH initiatives. The Native population is comparatively small in Michigan when considering the size and political power of other population groups. Further, State and county programs have faced unprecedented budget cuts in recent years. For these reasons, it would be unrealistic to expect new program support or funding in any significant amount. The project did seek to increase collaboration with State level staff, as well as increase representation and participation in State programs such as the State FIMR network, Title V planning and perinatal data surveillance. Because the project covers such a wide area across the State (27 counties), for policy and systems issues, collaboration with State and regional level entities was deemed more appropriate than seeking to work with the very large number of local county level programs and agencies in the entire target area. Individual service delivery sites worked with their local county health departments on case management and referrals. Over the project period, the project management team also found collaboration on a regional and national level to be very worthwhile, particularly with other agencies serving Native populations, including other HRSA divisions and the Indian Health Service. The project worked with the other Healthy Start sites serving indigenous populations and helped form the Healthy Start Native People's Council.
- B.** The main mechanism through which collaboration was sought was by recruiting agency representatives for participation on the project consortium, and by our project management team members becoming involved in various State committees. Because collaboration was on a statewide level, it involved a lot of travel. When possible, participation in meetings was sought by phone conference. Most statewide agencies are in the southern part of Michigan while the project headquarters is in the north. A lot of collaborative work was also conducted by email and letter correspondence. Position papers, reports, sharing of project data, powerpoint presentations, and meeting attendance were the main avenues of collaboration. See the consortium section for more details and examples of collaborative work that was accomplished.
- C.** The project consortium formed a special committee dedicated to addressing Title V and MCH policy issues. (please see more detail about committee initiatives in the consortium section). One challenge to working with this structure was that the committee members are located throughout the State and meetings are only held quarterly because of the travel time and cost involved. In addition, budget shortfalls, and more specifically, downsizing of staff at the Michigan Department of Community Health,

seriously impacted the amount of collaboration possible. The time and expense involved with travel to participate in State committees prevented project staff from participating more fully. The need to spend time on project management issues related to direct service provision also hampered the projects ability to participate more fully in statewide collaborative efforts. One component of the evaluation plan involved a comparative analysis of Healthy Start participant data with several comparison groups. This analysis was dependent on a collaborative partner within the State Vital Records division constructing and making the comparative data available. Over the four years, the data was provided once (in 2001), but not again, as was originally planned due to lack of staff time within the division.

Sustainability

- A.** In determining an approach to sustainability, the project management team considered funding mechanisms that tribal health programs are eligible for and have access to. For example, at one point, much emphasis was placed at the national level by HRSA on negotiating with HMO and managed care providers as a sustainability strategy. This was not an avenue that was pursued because tribes and tribal members are, for the most part, exempt from Medicaid Managed Care. The project decided to explore alternative and additional funding for project activities which the tribes could realistically seek, given their infrastructure and long term needs.

- B.** The major areas explored to build sustainability included third party reimbursement, additional grants, advocacy for permanent funding to institutionalize Healthy Start as a core public health service, and partnering with other programs to share costs, particularly tribally supported programs. The resources needed to implement these approaches were staff time, contacts and travel.

Third party reimbursement through the Michigan Maternal Support Services (MSS) program was explored. The MSS program provides reimbursement for non-clinical support services provided by certified providers to high risk Medicaid enrolled pregnant women and their infants. In order to access this reimbursement, tribes had to undergo an application process to become certified, which included a large amount of documentation and assembly of protocols and procedures. The process of exploring MSS with tribes was lengthy and involved evaluating the cost benefit of proceeding. By the end of the project period, one tribe out of the 7 sites had become a certified provider and was receiving some State reimbursement. Another site was in the process of preparing an application, and two more were committed to going forward.

A variety of other grant opportunity were explored, and several small grants were secured, including support for five FIMR case medical

abstractions, and general support for women's health obtained from the Indian Health Service, which a few tribes used to enhance MCH programming. The project also supported a national effort through Indian Health Service to found regional tribal MCH epidemiology centers across the country. The center funded in Wisconsin has Michigan within its service area. The Healthy Start Evaluator serves on the advisory board for the center. For advocacy, project management staff attended national Healthy start association meetings, made educational visits to legislators, spoke at a variety of State, regional and national conferences, and issued several policy papers.

C. Communication with other Healthy Start projects and other MCH programs within the State deepened during this project period, and contributed to progress with sustainability activities. With staff time being the major resource needed, it was a limiting factor in that project management issues related to direct service provision tended to take priority. Another barrier to further progress with sustainability was the perception among some at the State and county levels that Indian Health Service fully funds all health needs within tribal communities. This misperception results in weak support for including tribal programs in major public MCH initiatives (Title V, Medicaid, etc.) The eventual certification of one of the tribes as an MSS (Medicaid reimbursement) site required extensive advocacy, meeting with and educating State representatives about tribal needs and capabilities.

E.

a. Efforts with Managed care and Third Party billing: Please see section A. and C. above.

b. Factors in Identification and Development of Resources: A major factor affecting identification and development of new resources was the deepening budget crises within the State and federal governments. As budgets have been cut, programs and funding have generally contracted, not expanded. In addition, program operating costs has risen steadily. In particular the cost of health insurance for program staff has increased substantially, making it challenging to cover comprehensive program costs. Internal tribal support for Healthy Start was explored at several tribal sites. Each of the tribes is different in their ability to provide in-kind support and/or funding for Healthy Start. At one site which has comparatively more tribal resources available for health programs, two FTEs on Healthy Start are paid for with tribal funds. Other tribal sites provide in-kind supervision and clerical support. Long term sustainability using these local resources will continue to vary according to the economic success and political climate at each tribe. Please see section C. above for more discussion on resource development.

An additional factor that affected tribes ability to participate in the State reimbursement program was the obligation to comply with the State documentation requirements to become a certified provider. The State documentation essentially parallels the data collection forms in use to meet the Healthy Start reporting requirements. Even though the content of the forms is essentially the same, the State rejected the possibility of using the Healthy Start forms because they follow a different format.

- c. Overcoming barriers: The project had some success in advocating at the State level for consideration of tribes for the State MSS program (Medicaid reimbursement for maternal support services). In addition, the project was able to decrease the negative effects somewhat of the sharp rise in program costs by obtaining a few small grants for supplementary activities which helped increase the visibility and importance of Healthy Start in the communities.

III. Project Management and Governance

- A. The Healthy Start project is managed by the Health Services Division of the Inter-tribal Council of Michigan. The overall management of the Health Services Office is the responsibility of the ITC Health Services Director who provides guidance and direction to a number of preventive health care personnel in their efforts to deliver effective and efficient programming. For the first 7 years of the project the ITC employed a Healthy Start Program Manager who was responsible for daily activities grant management, communication with Tribal Healthy Start Nurses, and organizing Healthy Start meetings and special events. In addition, the ITC had as contractual Evaluator who became an ITC staff member during year five of the project. The ITC also employs an administrative assistant who takes care of data entry, processing financial requests from the Tribal sites, and organizing quarterly staff and consortia meetings. This site has also maintained a contractual agreement with a Nurse Consultant who has worked on many special projects.
- B. The most valuable resources available to the project which proved essential for fiscal and program management are the staff and project consultants – both at the Inter-Tribal Council and the tribal level. Secondly, the guidance and leadership of the HRSA/MCHB Healthy Start Office, including Janice Berger, our Project Officer, and Maribeth Badura, Director of Healthy Start.
- C. One major change in management came in the spring of 2005 when our Healthy Start Program Manager resigned to seek employment elsewhere. Other major changes came when the agency was able to offer full time employment to our contractual Project Evaluator.

- D. The process for distribution of funds was difficult, but ultimately deemed fair by all parties. In the first four years of the project all tribal sub-contracted agencies received the same amount of funds, regardless of tribal enrollment, case load or disease burden. During the application process for the second cycle of funding, it was determined that sub-contracts should be formulated based on tribal service area population, number of Healthy Start cases, and Native American birth rate in the tribal service area. This allowed for more equitable funding for each site.
- E. As the project moved forward, individual tribal health and human service programs were able to allocate some limited funds for MCH programming. In addition, the Inter-Tribal Council's Healthy Start staff and contractors were able to secure grant funds from agencies such as the Indian Health Service to implement other women's health initiatives.
- F. Cultural competency of project staff and contractors is of utmost importance. All staff and contractors are exposed to ongoing cultural training. New and existing staff and contractors are encouraged to attend traditional ceremonies, read literature, talk openly with Native and non-Native co-workers and traditional healers/teachers. The agency and its constituents have been very fortunate in that a very high majority of staff and contractors came to us with a high cultural I.Q.

IV. Project Accomplishments

A. Table of Project Accomplishments by Objective 2001-2005

Project Period Objectives	Strategy and Activities	Accomplishments
<p>Project Period Objective 1: By 5/31/05, increase to at least 80% the percentage of Native American women in the Project Area who receive 1st trimester prenatal care, and to at least 75% the percentage who receive adequate levels of prenatal care based on the Kessner Index</p> <p>Baseline: Among the 1,186 Native American births that took place in the project area from 1996-1998, 857, or 72% received prenatal care</p>	<ol style="list-style-type: none"> 1. Individual Service Level: Assessment of prenatal care status of every pregnant Outreach contact; Assessment of prenatal care status of every pregnant enrolled Participant Referral and follow up of all referrals to prenatal care. 2. Community Education: Brochures and posters in community locations promoting the importance of early prenatal care; inclusion of messages about pre-conceptual health and early prenatal care in presentations given to teens and general community 3. Provider Education: Dissemination of the Perinatal Systems Assessment Project (PSAP) findings and disparity data to raise awareness; and training in cultural sensitivity/cultural competency is expected to result in higher patient satisfaction, and therefore better compliance. 	<p>Accomplished. In CY 2004 81% (157/195) of pregnant participants received 1st trimester prenatal care</p>

<p>in the first trimester. 779 out of 1,186, or 66% received adequate prenatal care based on the Kessner Index.</p>	<p>4. Consortium Activities: Investigation of access barriers (i.e. provider practices not accepting patients until the 13th week). Practices will be verified, and providers will be contacted, etc. Full details are in section on Local Health System Action Plan.</p>	
<p>Project Period Objective 2: By 5/31/05, increase to at least 80% the percentage of medically high risk Native American mothers and infants in the Project Area who access specialty care providers and services (OB/GYN, Pediatricians, Perinatologists, Neonatologists, NICU, etc.)</p> <p>Baseline: Based on the vital record data, only 70% of births with at least one identified medical risk had received adequate prenatal care based on the Kessner Index. It is therefore estimated that only approximately 65% of women and infants who meet the project defined criteria of high risk access medical care from appropriate specialists).</p>	<p>1. Individual Service Level: Referrals transport and follow up provided as part of case management.</p> <p>2. Provider Education: Provider training covering diabetes and other medical issues prevalent within the target population. Dissemination of the P.S.A.P. findings to providers and decision makers to raise awareness of unmet needs and disparities in access to high level of care</p> <p>3. Consortium Activities: Pursuit by the Consortium and Project administrative team of federal and rural telemedicine funds to expand access to distantly located specialist (see Local Health Action Plan).</p> <p>4. Advocacy for additional providers and/or expanded days/hours for Perinatologist services in the northern part of the state (see Local Health Action Plan).</p>	<p>Partially Accomplished. In CY 2004, 84% (36/43) prenatal participants with medical high risk had specialty care providers, most commonly, OB/Gyns. Among infants with medical high risk, 52% (17/33) had specialty care providers, most commonly pediatricians.</p>
<p>Project Period Objective 3: By 5/31/05, reduce the percentage of Native American women in the Project Area who smoke during their pregnancy to less than 30%, and the percentage of Native American infants who are exposed to in-</p>	<p>1. Individual Service Level: All participants are assessed at every visit about their smoking status and household exposure. Appropriate education is provided, using the Smoke Free baby and me curriculum. Referrals are made to additional services for cessation support</p> <p>2. Community Education: Presentation to groups, Health Fairs, and public information activities will promote knowledge of the harmful effects of smoke and will present smoke free</p>	<p>Partially accomplished. In CY 2004, 43%, or 59/135 prenatal participants smoked during their pregnancies. 23% of infants were exposed to in-home ETS upon exit from the</p>

<p>home environmental tobacco smoke (ETS) to less than 45%.</p> <p>Baseline: From 1996-1998, 38%, or 446 out of 1,186 births among Native American women in the Project Area had maternal smoking as a risk factor. Based on 1998-2000 Healthy Start participant data, 66% of infants are exposed to ETS in their homes</p>	<p>environments as the expected norm for children.</p> <p>3. Provider Education: in-service for providers to raise awareness of the awareness of the prevalence of smoking and 2nd hand smoke and how powerful and effective primary providers can be in motivating patients to change their smoking behavior.</p> <p>4. Consortium Activities: Involved in provider training mentioned above</p>	<p>program. Maternal and family smoking continue to be one of the most challenging risk factors to impact</p>
<p>Project Period Objective 4: By 5/31/05, increase the percentage of Native American women in the Project Area who are screened for substance abuse (alcohol and other drugs) to 100%, and among those with a positive screen, increase the percentage who receive assessment, education, and referral; and as appropriate, based on assessment results, treatment, support, and follow up to at least 60%.</p> <p>Baseline: Based on 1998-2000 Healthy Start participant data, only 75% of pregnant women were <u>fully</u> screened for substance abuse issues. Data on the percentage who received full assessment, referral, and treatment will be further refined and developed during Year Two</p>	<p>1. Individual Service Level: All participants are screened at every visit about their substance abuse states. Appropriate education is provided and referrals for full assessments are made, followed by referral and facilitation to attend treatment. Those completing treatment will receive intensive ongoing support and follow up.</p> <p>2. Community Education: Presentations to groups, Health Fairs, public information activities will promote knowledge of the harmful effects of alcohol during pregnancy, FAS/FAE, and will present total abstinence during pregnancy norm.</p> <p>3. Provider Education: In-service for providers to increase screening skills and knowledge of places to refer clients for assessment and treatment services. Promote the knowledge of no safe limit known for alcohol intake during pregnancy.</p>	<p>Partially accomplished. In CY 2004 98% (135/138) of pregnant women were screened for substance abuse. Overall, for all referrals, 70% (219/311) were completed.</p>

<p>Project Period Objective 5: By 5/31/05, increase the percentage of Native American 2 yr olds in the Project Area who are fully immunized to at least 86%.</p> <p>Baseline: Among the '98-'00 Healthy Start infant participants for whom complete immunization records were available, 68 out of 82, or 82.9% were fully immunized. The 1996 rate for the project area was approximately 78%</p>	<p>1. Individual Level Service: Immunization status is assessed at 1 yr visit and 2 yr old visit. Parents are encouraged to track infant's immunization record in their Health Diary. Reminder phone calls and postcards will be used to prompt parents. Healthy Start nurses can give immunizations at the tribal clinics. Where not available, referral can be made to county health departments or family practice providers.</p> <p>2. Community Education: Articles in tribal newsletters and displays at Health Fairs</p>	<p>Accomplished. In CY 2004, 91% (72/79) of infants being exited from the program (normally at 2 years old) were on schedule for immunizations.</p>
<p>Project Period Objective 6: By 5/31/05, increase the percentage of Native American infant deaths in the Project Area that are reviewed by the consortium's FIMR committee to 100%.</p> <p>Baseline: At present, there is no FIMR process in place within the project area, baseline is 0%).</p>	<p>1. Consortium Activities: a sub-committee will be formed that will be trained and will become the FIMR Review team. See full details under Consortium section.</p>	<p>Accomplished: An active FIMR committee has been established. All infant death cases for which information was obtainable in the project area have been reviewed. Post neo-natal and SIDS deaths received in-depth reviews as priority issues</p>
<p>Project Period Objective 7: By 5/31/05, increase the cultural competency of at least 75% of all identified providers within the Project Area's perinatal systems as measured through pre and post tests</p> <p>Baseline: Improvement to be based on pretest and post-test results</p>	<p>1. Provider Education: Dissemination of the Perinatal Systems Assessment Project (PSAP) findings and disparity data to raise awareness; training in cultural sensitivity/cultural competency.</p> <p>2. Consortium Activities: Contribution of Consortium members to organization and presentation of provider training focused on cultural competency.</p>	<p>Partially accomplished: PSAP was widely disseminated; Providers working within the project received cultural sensitivity education during special sessions of the consortium meetings. Ideas for reaching providers outside of project staff were</p>

		discussed, but did not come to fruition. Pre and post testing was not completed.
<p>ICC Project Period Objective 1: By 5/31/05, increase the percentage of Native American women to 90% who have a medical home/reliable source of primary care where they receive standard periodic well-women care during the inter-conceptual period.</p> <p>Baseline: To be refined based on assessment data gathered during Year I of the ICC project. At present, it is estimated that less than 70% of women meeting the ICC high-risk criteria have an identified, stable medical home).</p>	<ol style="list-style-type: none"> 1. Individual Service Level: provision of intensive monitoring, referral, facilitation and follow up services. 2. Community Education: community educational events and public information materials (newsletter articles, brochures, etc.) which promote the importance of inter-conceptual care, and Medicaid enrollment. 3. Provider Education: provider trainings to increase cultural competency, and increase awareness of the importance of inter-conceptual care. 4. Consortium Activities: formation of sub-committee to further assess and plan for addressing inter-conceptual care issues, will issue annual recommendations to the project. 	Accomplished. In CY 2004, 88% of mothers (322/364) had a medical home.
<p>ICC Project Period Objective 2: By 5/31/05, increase the percentage of Native American infants to 100%, who have a medical home/reliable source of primary care where they receive standard well-baby health checks during the first two years of life.</p> <p>Baseline: To be refined based on assessment data gathered during Year I of the ICC project. At present, it is estimated that approximately 80% of infants meeting the ICC</p>	<ol style="list-style-type: none"> 1. Individual Service Level: provision of intensive monitoring, referral, facilitation and follow up services. 2. Community Education: community educational events and public information materials (newsletter articles, brochures, etc.) which promote the importance of regular well-baby care, and Medicaid and MI-Child (CHIP) enrollment. 3. Provider Education: provider trainings to increase cultural competency, and advocate for increased availability. 4. Consortium Activities: formation of sub-committee to further assess and plan for addressing inter-conceptual care issues, will issue annual recommendations to the project. 	Accomplished. In CY 2004, 95% of infants (288/304) had a medical home.

<p>high-risk criteria have an identified, stable medical home for the duration of the first two years of life</p>		
<p>Addressing Perinatal Depression Project Period Objective 1: By 5/31/05, increase the understanding and awareness of maternal depression, and knowledge of where to refer clients for further assessment and/or treatment of at least 75% of all identified providers within the Project Area's perinatal systems as measured through pre and post tests.</p> <p>Baseline: Improvement to be based on pretest and post-test results.</p>	<ol style="list-style-type: none"> 1. Provider Education: provider trainings to increase cultural competency, and advocate for increased availability. 2. Consortium Activities: Contribution of Consortium members to organization and presentation of provider training focused on cultural competency. 	<p>Partially accomplished: Providers working within the project received education during special sessions of the consortium meetings. Ideas for reaching providers outside of project staff were discussed, but did not come to fruition. Pre and post testing was not completed.</p>
<p>Addressing Perinatal Depression Project Period Objective 2: By 5/31/05, increase the percentage of Native American pregnant and postpartum women in the Project Area who are screened for depression and mental health issues, as well as for social and environmental factors which contribute to depression and mental health issues, including domestic violence, social isolation (lack of family support), and housing problems to 100%; and among those with a positive screen, increase the percentage who receive</p>	<ol style="list-style-type: none"> 1. Individual Service Level: All participants are screened periodically for depression using the EPDS tool. Appropriate education is provided and referrals for full assessment are made, followed by referral and facilitation to attend treatment when needed. Those completing treatment will receive intensive on-going support and follow up 2. Community Education: Presentations to groups, Health Fairs, public information activities will promote knowledge of perinatal depression 3. Provider Education: In-service for providers to increase screening skills, use of the EPDS tool, and knowledge of places to refer clients for assessment and treatment services. 	<p>Partially accomplished: In CY 2004, 87% (150/172) pre and post natal women were screened upon enrollment in the program. Overall, for all referrals, 70% (219/311) were completed.</p>

<p>assessment, education, and referral; and as appropriate, treatment, support and follow up to at least 60%.</p> <p>Baseline: From 1998 - 2000, 175/487, (36%) of pregnant and postpartum Healthy Start participants received emotional health screening</p>		
---	--	--

Additional accomplishments: The ITC Healthy Start staff was active in the development and support of two new significant national initiatives to address Native American infant mortality. First, staff shared information and added its voice to others to draw attention to the serious data and epidemiology shortfalls with State and national tracking of Native American infant mortality, due to misreporting of race, lack of priority at the national and State levels, and lack of infrastructure at the regional and local level. A new effort was funded by the Indian Health Service to start regional tribal MCH epidemiology centers to serve tribes. Project staff contributed ideas to the start up of this initiative and continues to serve in an advisory capacity on the regional MCH epidemiology center serving Michigan, which is located in Wisconsin.

The second national initiative focused on the need for improved SIDS prevention education in Indian country. A national group was convened by NICHD in partnership with the Indian Health Service and the national SIDS Alliance. ITC's project Evaluator, Special Projects Consultant, and a nurse from one of the tribal sites gave presentations and shared information on community experiences with SIDS and infant mortality prevention efforts. The Project Consultant also coordinated local focus groups to assess the appropriateness and effectiveness of proposed new educational messages. The work of this national group is continuing, and ITC Healthy Start staff will stay involved.

B. Mentoring

While the project staff had a lot of collaboration with other project sites serving Native populations, formal mentoring was not a significant activity during the project period. Staff shared ideas and information on educational initiatives, strategies for meeting data reporting requirements with other Native-serving projects through discussion, reports, and presentations given at national Healthy Start conferences. The most significant coming together of the projects serving Native communities occurred at the Healthy Start Native People's Summit held in Hawaii in February of 2003. The Summit resulted in the formation of the Healthy

Start Native People's Council, which published a summary of the meeting and a series of five position papers based on the discussions and conclusions reached at the Summit.

V. Project Impact

A. Systems of care

The target population for the ITC Healthy Start Project consists of Native American families in six federally recognized tribal communities and one urban Indian area in Michigan. Each of the seven implementation sites serves between one and ten counties within their service area. The total project area includes 27 counties, a total of 19,840 square miles, concentrated in Northern Michigan. In 11 of the 27 counties, Native Americans represent the largest minority group.

Our Healthy Start program participants utilize two general systems of care: first, six of our seven sites have Tribal health and social service systems, and secondly, all seven sites have access to the larger community systems to which the general population has access in their respective areas of the State.

It must be noted that assessing and measuring "project impact"—while important to funders, planners and evaluators—is often an exercise in best-guessing. While we can and must ask the question, "How are we doing?" the deeper levels of impact of a project on individuals, communities and agencies may occur in subtle ways that cannot be measured, the benefits of which may not appear for several years. Keeping that in mind, we must say that we believe the impact of Healthy Start is that it is an excellent model in promoting personal and community empowerment, which may not be able to be adequately described but can certainly be felt by our HS women, families and communities.

1. *Impact of enhanced collaboration:* The Healthy Start project has enhanced collaborative interaction first and foremost by bringing stakeholders together with a shared vision to progressively work towards pursuing the vision. Our primary approach has been to network with all of the agencies at which our clients seek services. First, we worked at the Tribal health system level to establish a system of referral and follow-up; secondly we developed a working relationship with maternity care providers by visiting them, providing lunch, and introducing them to our program and making follow-up visits; next, we created working relationships with agencies in the larger community such as school systems, behavioral health, social services and domestic violence prevention programs and shelters; and finally we established collaboration with other Healthy Start programs both

locally and nationally. Additionally, the ITC Healthy Start Statewide Consortium has provided an excellent and impressive forum for interaction among MCH organizations and has been a springboard for a variety of strategic interventions to address joint planning, team approaches, service overlap and shared resources.

Examples of enhanced collaborative interactions are:

The Healthy Start Native Peoples Council—is a consortium of the six HS projects that target Native populations. This Council emerged from a very powerful gathering of six HS projects in 2003. Among the accomplishments of the HSNPC is a booklet entitled “Speaking with One Voice.” It contains four position papers on maternal and child health issues that American Indian and Native Hawaiians face. This document has been used as an educational tool locally, regionally and nationally to increase awareness of the disparities and unique issues that indigenous people face in matters of maternal and child health. It will be featured in a scientific session at the 2005 American Public Health Association Annual Meeting in Philadelphia, and Inter-Tribal Council of Michigan staff will be the presenters.

Infant Health Implementation Team—is a consortium of agencies that provides MCH services within a particular region of southeast Michigan. This group includes Healthy Start staff, medical providers, MCH agencies, and has been working for systems change to reduce infant mortality, to reduce racial disparities and to improve access to care. Because of our consistent and effective participation in this consortium, and because we have become a “known quantity,” we have been able to work more collaboratively with local and regional agencies of all kinds, such as social services, pregnancy support groups, Family Independences Agency (FIA), mental health services, Medicaid, and with health care providers.

The Chippewa County Multi-Purpose Collaborative Body—is an inter-agency initiative with a multitude of working committees to address issues of pre-birth through five years. Located in southeastern Michigan, this group has developed numerous strategies for meeting community needs related to maternal and child health, and HS staff have been active members and leaders of this collaborative for many years.

2. *Impact related to structured changes for system integration:* We have been successful in advocating for procedure and policy changes—such as promoting the implementation of comprehensive health data collection for minority populations—at the State level in order to better assess and monitor health status. We were instrumental in advocating for the State to add a field to Vital Records that included “Tribal Affiliation.” This will assist the State in tracking data specific to American Indian individuals and Tribal communities.

Access to services such as Maternal Support Services/ Infant Support Services (MSS/ISS) through the Michigan Department of Community Health has been difficult for many rural Tribal members due to inaccessibility, fragmentation of services, discontinuity of care, and long distances to be traveled to obtain services. Because the provision of MSS/ISS services at Tribal clinics would remove one barrier to accessing these services, we have applied for, been granted, and have initiated MSS/ISS services at one tribal site and are applying for programs at other tribal sites.

Through our participation in the Kent County Collaborative in southwestern Michigan where our urban Indian site is located, we have been a part of developing a Pregnancy Resource Guide including screening and assessment tools and a “Core Concepts” document for caring for women and infants in the perinatal period. This guide has been widely circulated and embraced by a number of agencies and has proven very useful to consumers.

At many of the Tribes we have been very successful in collaborating on the creation of an inter-agency, inter-departmental referral system that allows our Healthy Start staff to work back and forth with social services, behavioral health, public health, prevention programs, early childhood programs, hospitals, county health departments.

We have structured changes for system integration within our own project by developing a standard health education patient referral and education checklist to be utilized by staff at each of the seven Healthy Start sites. We also elected to use the Indian Health Service maternity care protocols as our teaching guidelines for client education. Each of the seven sites has a hefty binder containing all of the appropriate protocols and standard educational materials and handouts.

3. *Development of key relationships:* Many relationships have been established to enhance provision of educational, health and social services. For example, Healthy Start Nurses and Outreach Workers have taken the initiative to establish and maintain professional-to-professional and agency-to-agency relationships, as well as relationships with consumers and community leaders. Our staffs have developed key relationships with: Early On, WIC, Head Start, Early Head Start, and other MCH agency coordinators to ensure infant care; directors of social services and behavioral services to define and coordinate roles; parenting programs and day care centers to ensure education, safety training and role modeling for teen parents; public health nurses to ensure that all providers are “on the same page” with client care; childbirth educators and lactation consultants to ensure that client’s educational and practical

support needs are met before and after their births; hospital staff to ensure that client's birth plans are followed and that cultural aspects are understood by hospital staff; Department of Human Services Indian Outreach Workers for collaboration, coordination and referral purposes; community members and relatives of program participants to spread the word about Healthy Start; and State Congress people to explain the ITC Healthy Start Project, seek their continued support, to keep them updated on the project and to invite them to community events.

Additional examples of important relationships that Healthy Start staff has built and nurtured over time are these: At one of our sites there are two distinct local groups to address cultural issues. First, Ziibiwing is a formal cultural society and museum that houses artifacts and provides community presentations. And second, Seventh Generation is a place for putting cultural teaching into practice such as traditional farming, sweat lodges for health and healing, Native crafts like stone cutting and basket-weaving and Native language lessons. The Healthy Start staff at this site have developed and nurtured relationships with staff at these two centers and have encourage them to include and promote Healthy Start as a culturally appropriate healthcare model. The cultural centers and Healthy Start have co-sponsored events such as making cradleboards. A cradleboard differs from Tribe- to-Tribe, but essentially is a handmade-framed flat basket in which a baby spends its first year. The baby is placed on its back and swaddled into place. It is a safe and secure environment. Native teachings about cradleboards say that they help with the child's skeletal development, strengthen neck muscles, and provide an opportunity for the infant to be visually and emotionally stimulated by its environment and family while being kept safely in a distinct location. The baby is carried on the mother's (or father's) back and the cradleboard can also be secured in place (on the floor or hung) when the baby is sleeping—on its back—so that it can always be in visual sight of the caregiver. Because post-neonatal infant death and SIDS are areas of critical disparities between Native American and White infants, teachings about how to keep infants safe that are also culturally-based are very valuable, and co-sponsorship of these educational teachings is important.

4. *Impact on provision of comprehensive services:* The ITC Healthy Start Project has impacted the comprehensiveness of services in several ways. In terms of eligibility and intake requirements, one of the major impacts has been the advocacy provided to program participants that assists them in removing barriers to participating in MCH programs. As advocates, HS nurse have been able to affect changes when a client has been told that they were not eligible for a particular services when, in fact, they were.

Other barriers have been addressed and removed through education—by simply informing client's of the existence and availability of services;

through helping clients complete tedious and cumbersome paperwork; through helping them deal with difficult case managers in agencies such as Medicaid and Family Independence Agency (FIA); by encouraging reluctant clients to seek services they might not otherwise choose to seek or those to which they felt they were not eligible such as SCHIP, housing subsidies, WIC, or services for special needs infants. In addition, each of our HS sites has sponsored information sessions and presentations on cultural sensitivity and cultural competency in healthcare. These presentations have resulted in increased provider knowledge and awareness and decreased barriers to care, perceived and/or actual, for Native American consumers.

The Healthy Start Project has had an important positive impact on care coordination and continuity of care. Our project staff and Case Management Teams have become lifelines for disenfranchised, isolated people, who have often historically been mistrustful of and disengaged from “the system.” HS staffs have provided the support that was needed to assist in care coordination. Healthy Start nurses have created a system of referral and follow up to ensure that clients are getting the array of comprehensive services they need and have also encouraged client compliance in attending referral appointments. For example, at several of the hospitals, good relationships have been established so that, with the clients’ permission, hospital labor nurses will contact HS nurses to act as doulas when their clients are admitted to labor, or lactation consultants will call HS staff upon discharge of clients to facilitate scheduling home visits for breastfeeding support.

The efficiency of agency records systems and sharing data across providers varies from site to site and provider to provider. HIPAA laws have made things exceedingly difficult, especially in sharing information between health service and behavioral service agencies. For example, even within tribal health systems, behavioral health staff members are not allowed to mention the name of a person/client over the phone that they and Healthy Start may have in common, much less share data without the client consenting in writing each time a new issue/problem arises. This makes case management very challenging for the providers and cumbersome for the clients. One nurse stated, “With HIPAA nothing is easy anymore.” Our nurses also state that working with social service agencies has been much easier than working with behavioral health agencies, and working with physician offices varies from being satisfactory to unsatisfactory, “If you can get them to return calls.” Timeliness is a critical factor in how well data sharing across providers actually works. Nonetheless, HS nurses have made impressive inroads in providing client data to many referral sources (with the client’s permission) to prevent duplication of services and to ensure continuity of care.

5. *Impact of enhancing client participation in evaluation:* The most important impact that involving Healthy Start clients in program evaluation has had is that citizens were able to articulate a vision for culturally, racially, and linguistically competent primary health care for Native Americans. Clients were routinely asked to assess the perinatal care and services that were provided to them throughout their tenure with Healthy Start. Client assessments were documented on the first postpartum visit, on the first year postpartum record, and on the exit record. Mothers were asked to rate their primary care providers, their medical home, the staff, and any additional or complimentary services that they received. In the case of negative or unsatisfactory experiences, the Healthy Start nurses assisted the client in contacting the appropriate people to express their concern, such as the Nurse Manager of the hospital OB Department. Clients were also advised to contact providers who provided excellent care and to let them know that they would recommend others to seek their services. In this way the HS program participants learned to become better and more responsible consumers of healthcare and providers received appropriate feedback on the care they provided.

At some Healthy Start sites the nurses administered additional surveys to solicit client's input on availability of services, satisfaction with services, providers and educational materials, and suggestions for improvement. As a result program participants made specific recommendations regarding utilization of complementary models of care that are effective, safe and satisfying for Native Americans, such as traditional American Indian healing practices, the midwifery model of care, and community-based public health models.

As a result of project evaluation by program participants, Healthy Start clients have been instrumental in designing culturally appropriate educational materials such as posters, brochures, and videos and intervention strategies for such things as childbirth education, parenting skills, safe sleep practices, and smoking reduction mechanisms. Project participants have also provided information, reflection, or identification of areas to be considered for refinement and improvement related to services, systems and policies.

B. Impact on community

Community empowerment is difficult to measure and implement as part of a health promotion program such as Healthy Start. The important issue is making community empowerment operational. To do this people must be mobilized—individuals, families, groups, communities—to address the social, political, economic and life circumstances that keep them

powerless, such as racial disparities in health status, chronic disease, drug and alcohol addiction, racism, and inequality in accessing goods and services.

In addressing the impact of the Inter-Tribal Healthy Start Project on the seven communities we serve, it is important to look at community empowerment as both a process and an outcome (it is commonly viewed as both in the literature.) Individuals are empowered as a result of gaining control over their decisions and inter-personal relationships. Communities gain power when a diverse group of stakeholders identifies problems, finds solutions, and implements actions to make changes. Communities are also empowered when they feel that they have a *shared life* with other community members. While rural, reservation and urban communities are very different from one another, Native American communities in our seven sites have been empowered—to greater and lesser degrees depending on many variables including community readiness—as a result of the Healthy Start project. However given the differences, it is not really surprising that what works in one community may not work in another. And each community needs to use the culture, values, strengths and characteristics that are uniquely its own to build policies, programs and interventions that meet the community's needs and empowers its residents.

1. *Residents knowledge and ability to access resources:* It is fair to say that since the beginning of the Inter-Tribal Healthy Start project 8+ years ago, residents at most of our HS sites have moved from having very little knowledge of MCH disparities and the issues surrounding unequal access to maternity care services, to recognition of the problems, and finally to motivation for action. One nurse remarked, “If women want services they now know where services are provided, and they know where to find us.” Program participants have stated (in focus groups) that they also now know where to find advocates for themselves—the Healthy Start nurses and Outreach Workers—and they do not hesitate to utilize them and to share their knowledge with friends and family members. In Talking Circles one client stated, “Healthy Start is my lifeline,” and other women nodded agreement to this statement.
2. *Consumer participation in changing standards or policies:* At some Tribal sites concerns have been expressed that consumers are not impacting Tribal governments or policies very much because there are so many serious and significant problems on the table that all vie for attention that maternal and child health is only one area of concern. However, at other sites consumers are having an important impact by facilitating the development of racially and culturally competent primary health care policies and structures for Native American populations. For example, consumers with the support of HS staff have changed hospital standards and policies to allow Native American cultural practices during labor, birth and postpartum. They have been able to help hospital staff understand

culturally-based health-seeking behaviors historically practiced by Native families and communities. In certain communities Native consumers can now smudge the birth room with herbal smoke, have traditional medicine men/women perform ceremonies in the labor and/or delivery rooms, can take possession of the babies' placentas for traditional postpartum burial at the parents' home, and can conduct newborn blessing ceremonies immediately post-partum. The role of "expert" has been shifted to include traditional medicine people, and this is an empowering experience for Native people.

3. *Community experience in working with divergent opinions, resolving conflicts, and team building:* Making community empowerment operational over time involves the process of shifting from powerlessness to powerfulness. The measure of this movement is not so much in the ease or difficulty with which changes are made, but in the willingness or unwillingness of community members to be part of the movement, and thus, part of the change. Again, because we have seven distinct and unique sites, they differ in their willingness or unwillingness to deal with divergent opinions, resolve conflicts and utilize team building for activities. At each site, however, Healthy Start has sponsored or collaborated in providing venues for community empowerment; here are some examples.

Native communities—who have always organized themselves by extended family groups and clans— typically enjoy and engage in group activities. Healthy Start collaborated to create the CradleBoard Project. Other collaborators included Ziibiwing and Seventh Generation, which are both cultural and/or Tribal entities.

For almost a year members of the community met to make cradleboards for young parents and new babies. Team participants included elders, youth, young parents, tribal healthcare workers, HS nurses and outreach workers, grandmothers and grandfathers and spiritual teachers. It was definitely a team building activity—with the spiritual teachers telling the stories about how the cradle board originated and has been used historically by Natives; the HS nurse teaching about how the cradle board is an historical strategy for keeping babies safe during sleep; the men making the cradle board frames out of wood; the women purchasing the fabrics and leathers in which to wrap the cradle boards; the grandmothers and grandfathers doing beading and weaving to decorate them; and the children offering inspiration. The nurses stated that there were many divergent opinions in how to proceed with the cradleboard project as well as when discussing strategies for safe infant sleep, but that the group overcame the differences in favor of accomplishing the work. It was empowering for the group to be reminded and to remember that Native Americans have always had mechanisms for keeping babies safe during sleep and that a return to some traditional ways was an empowering choice. In fact, the brochure that was developed to reflect a culturally-

specific message on this topic featured a cradleboard on the cover and was called “Back to Sleep, Back to Tradition.”

Several of the sites have hosted breastfeeding support groups monthly or quarterly that have brought community members together; that are a collaboration of several health and social service agencies; and that promote a message about feeding Native infants that—while there may be divergent opinions about—has been able to unite the community under the banner of a traditional and healthy practice for moms, babies and communities and empower young mothers to begin and continue breastfeeding.

Similarly, each of the sites had regular (or irregular) Healthy Start community gatherings, which were sometimes held in conjunction with other women’s meetings. All Healthy Start program participants were invited to these events along with any guests that they choose to bring. Often these events were co-sponsored by Tribal youth groups, alternative schools, fitness programs, dieticians, behavioral health and Tribal social services. They were typically hotbeds of divergent opinions out of which sometimes developed community-based initiatives—like the Women’s Walking Club.

4. *Creation of jobs*: The Healthy Start Project has spawned two categories of jobs: the Healthy Start Nurses position, and perhaps more significantly, the Outreach Worker position all of whom come from the Tribal communities in which they serve at each of the seven sites, as do some of the nurses. Most of the outreach workers have been HS program participants prior to being employed by the project.

Each of the six Tribal Healthy Start sites has a position called “Community Health Representative” (CHR), and while Healthy Start has not created any of these positions, our project collaborated with CHR’s from other Tribal divisions to provide services for our HS client’s, such as transportation and child care.

C. Impact on the State

The ITC Healthy Start project was a member of the statewide Healthy Start network in Michigan, along with the other four project sites in the State. It was difficult to participate in all meetings, as they were held in the southern part of the State necessitating overnight travel to attend. Participation in this network and discussion at meetings allowed project staff to become more aware of new initiatives, policies and changes happening with the Title V and other State MCH programs. Project participation in the network also provided an opportunity to educate State representatives and staff from other projects about the unique issues and infrastructure challenges in addressing MCH needs within Michigan’s

Native communities. The participation of State representatives in the project's consortium also contributed to this increase in awareness. All the interaction with the State, presentations given at conferences sponsored or co-sponsored by the State, and submission of position papers and other advocacy materials served to increase the visibility of the project and the unmet MCH needs of the target population.

D. Local Government Role

Activities with local government included communications with tribal governments and local county health departments. The success of these activities varied by site. Some local county health departments worked closely with Healthy Start sites, referring clients and providing needed services. Examples include counties coming on site to provide WIC and Medicaid and or SCHIP enrollment. The role of tribal governments was important, and in many cases critical to the feasibility of the project. Tribal governments not only endorsed project activities, but in many cases provided additional support – both funding and in-kind to maintain or expand services. Tribes supported media coverage, production costs for educational materials, and use of tribal vehicles for transport among other contributions. At several sites tribal police departments collaborated with Healthy Start to sponsor car seat safety checks, infant CPR classes and babysitter training classes. Local project staff at some sites made regular presentations to tribal council to update them on the status and accomplishments of the project, and inform them of on-going unmet needs. Some sites began advocating for tribal work site policy change to be more supportive of breastfeeding, as well as raise awareness of the dangers of second hand smoke.

VI. Local Evaluation

The Local Evaluation Report is attached as a separate document

VII. FIMR

The project formed its FIMR committee in 2001 and has held quarterly or semi-annual meetings since its formation. FIMR was set up as a committee of the consortium; therefore its meetings coincide with the quarterly consortium meetings. Because the committee can only meet a few times a year, reviews are restricted to infant deaths. Because of this limited meeting time, the committee is able to review a total of between five and eight cases per year. Fetal death, child death and maternal deaths are not reviewed at this time. The review process involves obtaining death certificates for any infant identified as American Indian on their death certificate, or who has a parent reported as American Indian. The project evaluator, who also serves as the FIMR Coordinator, reviews the death certificates as they are sent to her by the State FIMR program. In consultation with other staff and committee members, she selects cases for full review which meet the committee's priority criteria. SIDS deaths, undetermined cause of

death, post neo-natal deaths and deaths within the project's target area are the priority criteria for review. Once cases have been identified, the coordinator arranges for abstraction of the medical records. In several cases, project site nurses have sought to conduct home interviews. The medical abstract is obtained either from a contracted abstractor, or in some cases, from local county FIMRs or Child Death Review teams who have already abstracted the case for their local review. A small grant to cover the contractual costs for medical abstraction of five cases was received from the State to help support the FIMR.

VIII. Products

Please see enclosed binder

IX. Project Data

The complete set of required data reports will be submitted electronically