Arizona Health Improvement Plan

Forum Suggestions

2021-2025

Stakeholder and community forums were held for each priority during which suggestions were captured. The suggestions were reviewed and included based on alignment with the priority strategies in AzHIP plans.

This document includes a compilation of suggestions which were not included for additional tactics and action steps. These ideas will be reviewed periodically throughout the life of this 2021-2025 AzHIP and incorporated into the action plans whenever possible.

Health Equity

Data

- Consider integrating information from NVDRS and/or WISQARS (helpful data sets in development of a strong data infrastructure).
- Leverage Electronic Health Record used by the entire state for use for both community base providers and health providers (both behavioral, physical, mental).
- Accessibility to data systems. Not many systems are willing to provide their data. How can we utilize data from Health Information Exchanges?
- Assess and understand the many different ways in which data is already collected and determine how all the systems can work together seamlessly and ultimately strengthen the system, get buy-in from additional partners, and actually make it function the way it should. Leverage available national and state level data on Arizona (UDS mapper and health center reporting requirements).
- Look at data systems that are already available and how they could fit in well with this (i.e. UDS mapper, health center data etc.).
- Leverage the MySidewalk data platforms of the 7 county health departments.
- Ensuring there is consistency in how data is collected is crucial to doing research on social determinants of health and health outcomes - for instance mortality rates by PCA is useful, but the COVID cases are now being reported by ZIP codes.
- Leverage the partner tool as a resource for measuring partnership impact and promote engagement. https://visiblenetworklabs.com/partner-platform.
- Include focus on not just accessibility to data, but data literacy to ensure people/organizations understand how to use the data that is available to them, or how they can utilize it for their specific programs. Building the infrastructure is much needed, but equipping people to use it is equally important.

Communication

- Cross sharing of information with key stakeholders (healthcare, education, criminal, etc.).
- Convene non-profits who provide services to those who experience health inequities so we can collaborate and not invent a data collection tool and impact evaluation.
- Synthesize information on what areas need collective investment.
- Convene AZ nonprofits who all have the same challenges on collecting data and evaluating impact so we can collaborate and not duplicate.
- Designate a data 'translator' to ensure data is effectively communicated to groups/agencies so data can be utilized to inform, etc.
- Ensure data is understandable and usable to end users.
- Coordinate with the communication team to brainstorm different ways to share and disseminate data.

Populations/Communities

- Possible development of a health equity index to measure health priority area.
- Include school health office data, to the extent possible.
- Include collection of school health and tobacco data.
- Link data with criminal justice/law enforcement databases.
- Develop and/or engage committees inclusive of foster youth or youth advocates that have lived experience a better description in regards to data framework meaning and unified electronic health record.
- Include foster youth community and those with lived experience.
- Identify special populations such as Farmworkers.
- Include workforce development entities and data
- Partner with AHCCCS to help align data indicators.
- De-segregate data based on race, ethnicity, income.
- Data should be by Zip Code area.

<u>Community Partnership and Engagement</u>

Assessment

- Perform evaluations of programs and resources will be utilized.
- Increase access to and understanding of clinical trials for families on Medicaid.
- Leverage a universal database that all providers can access for obtaining transcripts, immunizations, AHCCCS eligibility or enrollment verification to prevent barriers for families to have access to care.

Populations/Communities

- Convene the right partners to leverage impact.
- Direct engagement and involvement with direct care workers and not just executives.
- Identify existing coalitions/groups already working on some of these issues might be helpful - AZ Health Equity Conference, existing research groups (ASU/UofA are doing a lot of projects around equity and community engagement), regional coalitions, etc. These could be good ways to increase community partnership/engagement, as well as identify additional partners. I also think that there needs to be engagement at the law enforcement level to advance equity.
- Importance of truly investing in preventative care and not forgetting mental health is part of the wellbeing of folks.
- Establish MOUs and or other types of agreements to strengthen partnerships.
- Highlight the critical role of schools in helping all Arizonans achieve their full health potential.
- Include impacted communities as an essential component of policy recommendations & solutions.
- Include different ethnicities/races/genders in clinical trials and research.
- Include language services provided across providers from the state to be inclusive without funding being a barrier from the provider perspective.
- Build upon common language, ensuring the utilization of big numbers and county/district-specific maps when educating legislators, stakeholders and the public.
- Include mixed immigration status families and trained mental health navigators on the different barriers to accessibility for some family members depending on lack of immigration status and current local, state and federal policies/laws.
- Meet with communities on a regular basis to build community partnerships and expose all partners to the community they live in.

Policy

- Lobby for increased and expanded funding for telehealth which should include psychosocial support.
- Engage policymakers on a deeper level to prioritize initiatives based on cost savings and show the impact from an economic perspective to move PSE forward.
- Use common language that everyone understands - lay terms, easy-to-understand explanations, etc.
- Include systems change within our organizations that don't rise to the policy level, but can have a huge impact on service delivery and outcomes.
- Drive policy change to increase access to telehealth, tele-wellness, and tele-community engagement.
- Drive policy change to incentivize healthcare providers to focus on addressing SDOH. Cumulative SDOH improvements will result in substantial health improvements.

Policy Systems and Environmental Change

- Policies should be inclusive and promote overall the improvement of quality of life.
- Address inequities and access to clinical trials for those on Medicaid.
- AZDHS to include health equity in the actual strategic plan as an agency and on the forefront of all its marketing and media along with COVID-19 similar to that of Unity Care's COVID Black Campaign.
- Influence policy and systems change that lead to ensuring basic needs are met (i.e., food, shelter) to affect the availability of affordable housing is a major component here - and inequity.

Funding

- Secure funding that allows us to hire a team/focus group for this plan.
- Leverage media used most by specific communities.
- Make sure representation is at the table for major chronic diseases, impact of nutrition, and how NFPs can form collaborative networks to meet the needs that most face (i.e., their need is not singular, it's usually health, financial, housing, food, etc.).
- Strengthen integration with non-traditional community-based organizations and building collaborations within foster youth community organizations.
- Engagement and partnering with organizations.
- Prioritize health inequities and convening the right partners to address.
- Utilize funding (Prop 207) to support the partnerships and engagement.
- Dissemination via lay and scholarly media.

Health in All Policies/Social Determinants of Health

Coordination

- Evaluate/coordinate programs, specifically rental assistance/prevention programs, to lessen confusion. Evaluate/restructure State Homeless Coordinator Position within DES. Consider a single housing coordinator possibly reporting directly to the Governor to coordinate these programs and develop integrated strategies.
- Reconvene the Arizona Commission on Housing & Homelessness to enhance state coordination on housing issues.
- Coordinate with other governing bodies that oversee HUD contracts.

Financing

- Increase robust rental assistance to landlords and tenants (eviction and/or homeless prevention).
- Support policy to ensure vouchers available to everyone eligible.
- Develop protections for housing options for low-income people. Prepare, prevent, and respond to rental assistance due to COVID – Cares Act Funding.
- Engage banks and lenders on solutions to ease people into homeownership, including use of Community Reinvestment Act funds for low and moderate income families.

Connecting individuals to services.

- Secure sustainable funding source for training – existing sources or new
- Develop curriculum based on established housing related standards (mental health first aid, housing basics, employment, etc.) – and develop accreditation
    - Increase data sharing between AHCCCS, HMIS, Eviction Courts, the Juvenile justice system, jails/prison, foster care to transform the work in homelessness and housing.
- Facilitate sharing of documents (e.g. centralized repository) required by multiple agencies to place people in housing more efficiently and quickly Initiate a formal project to address process challenges/gaps (Arizona Management System - AMS) Consider contracting out to local organizations for administration, streamlining eligibility criteria and the application process, including ensuring the minimal amount of documentation is requested.Address challenges in filling available housing units due to outreach resource challenges, barriers in identifying the housing, and gaps in services chain.
- Develop a campaign to communicate to make individuals aware of available units and/or referrals (eligibility/directory)
- Ensure adequate housing based supportive services for all populations.

Equity

- Review widespread use of VI-SPDAT (Vulnerability Index - Service Prioritization Decision Assistance Tool) to determine if it is adding to systemic inequities.

Other Points to Consider

- Ensure these coordination efforts are clear & available to everyone who works with those experiencing housing concerns.
- Ensure housing funding has flexible parameters as long as the funding is removing barriers to housing.
- Increasing funding will be critical for success. Perhaps partnering with Amazon, Google, or other tech companies to help with integration would be helpful.
- Engage with partners to address how connectivity becomes "systemized", specifically around SDOHs - Create a system that matches services to families and with the data that helps make all that happen.
- Focus on issues that will move the needle but not require additional funding which may not be forthcoming.
- Train incarcerated people to build homes.
- Weave in workforce retraining and employment assistance for long-term sustainability.
- Need to have more policy-based solutions. Policies such as Opportunity Zones, Infill Incentive Districts and Community Benefit Agreements can play an integral role in housing affordability and the health impact of development projects.

Mental Well-being

Reduce opioid use and overdose fatalities

Communication, Resources, & Training.

- Create awareness that this is a medical problem so as to reduce stigma.
- Create and market a resource for families to seek help for getting their loved one into treatment.
- Add awareness that this is a medical problem.
- Understand some tribes utilize traditional healing practitioners and are not considered an alternative therapy but rather the primary intervention/ treatment.
- Train providers to expand competency of mental health/SUD providers in addressing chronic pain (many do not have needed training).

Partnerships

- Our community would benefit from greater collaboration/coordination of care between inpatient/residential treatment programs for substance use and outpatient treatment programs to help sustain recovery.
- Promote integrated primary care so BH providers are in the clinics patients are receiving pain treatment.
- Partnerships with peer led organizations and organizations led by people who formerly used drugs as connections and trust builders.
- Include all prescribers in education efforts (e.g. Nurse Practitioners as well as physicians)
- Partnerships with community services and local government agencies, education, and training.
- Increase waivered providers.
- Integrating folks from arthritis foundation, Lupus foundation, etc. where the rubber hits the road.
- Invest more heavily in integrated behavioral health providers to work in primary care settings. Given that most people go to their primary care provider for pain, they need to be able to access mental/behavioral health providers at that point of care, rather than simply coordinating with specialty mental health. Receiving care in your primary/medical environment additionally reduces stigma as it is part of routine health care. Invest in workforce development programming (offered by experts in integrated care and comorbid pain/opioid use, such as the DBH program faculty at ASU) to increase the number of available mental health providers who can bill for services in primary care. Enhance funding for telehealth services to increase access to rural communities
- Utilize peer support, nurses, and/or CHWs as community connectors for in home follow-up after an overdose.
- Crisis Response Network is equipped to operate a line in collaboration with the Opioid Assistance and Referral (OAR) Line Coordinate local-level access to care and partnerships for wrap-around services for people with substance use disorders. Provide technical assistance for local groups in gaining access to needed support services.
- Targeted naloxone distribution to the community, not just law enforcement, in areas where opioid overdoses are higher, or where more at-risk populations reside.

Systems

- Integrate trauma treatment awareness/resources into this plan (Chronic Pain, Substance Use Disorder and Trauma are intertwined).
- Like the telehealth strategy and will need to consider barriers with telehealth & technology; especially in rural areas.
- Easy connection to treatment services via web, phone, text services
- Targeted naloxone distribution.

- As adult substance dependence can have its roots in the person's adolescent years, inclusion of some emphasis toward teen/young adult population.

Social isolation and loneliness

Communication, Resources, & Training

- Public messaging needs to frame the need for social connection and physical distancing amidst COVID-19 reality. Above and beyond, increase awareness and knowledge, real time strategies will be critical.
- Leverage campaign to reduce anxiety and loneliness induced by social media "addiction."
- Offer connections opportunities where services are provided.
- Include lessons of mental health programs provided at the Cottonwood-Oak Creek School District including neuro-sequential modeling, focus zones for mindfulness, the RISE program for children with TBI and severe autism, etc.
- Include lessons from the UK campaign to address loneliness and isolation, specifically among older adults: https://www.campaigntoendloneliness.org/about-the-campaign/.
- Trauma-informed, and mental-health-based care is critical in SUD treatment. All of these topics beget each other and therefore absolutely need to be included in a well-rounded plan. The Overdose Response Strategy focuses on promoting evidence-based practices for preventing overdoses as well as data sharing. As much as we can find opportunities to partner on these important topics, the better. Review Vitalyst Trauma Sensitive Schools Survey and Report.

Partnerships

- Establish a Statewide Reassurance Hotline where individuals and families can register for outbound calls which will be made by qualified specialists to check in on and ensure individuals are safe and connected.
- Promote community engagement for relationship building that is virtual. Game nights, support groups, etc. that meet beyond COVID restrictions and enable another method for meeting and engagement that is not as big a commitment as meeting in person.
- Normalize the promotion of community-based activities and support groups (i.e., game nights, support groups, interest-based groups, etc.) via virtual settings even beyond COVID-19 impacts.
- Connect with Tribes/communities to identify social gatherings/events and how these can be enhanced.
- Include individuals who are isolated even before COVID because of chronic disease like cancer.
- Partner with Cancer Support Community AZ to assist families impacted by cancer. Utilize home-sharing to address social isolation and keep seniors in their homes longer (see www.silvernest.com).
- Home sharing programs (similar to www.silvernest.com) should be explored to address social isolationism and keep seniors in housing longer.

Systems

- Continue expansion of the availability of telehealth services.
- Prioritize ensuring all Arizonans have access to high speed broadband internet, especially in tribal and rural areas - will be necessary to ensure access to telehealth strategies.
- Crisis Response Network is currently positioned to implement a reassurance hotline within 120 days with adequate funding.
- Procure and preserve data so results can be measured and published.

Reduce suicide-related events

Communication, Resources, & Training

- Expand home sharing to address social isolationism and keep seniors in their homes longer.
- Sponsor tribal-specific suicide prevention virtual conference
- Cross-train prevention and intervention services of what each other is doing.
- Educate animal shelters and veterinarians as they often interact with people who surrender pets or euthanize pets which can be a profound source of loss.
- Focus on train the trainers being people who represent the population as much as possible (i.e., youth, BIPOC, transgender, etc.).
- Increased focus on social emotional development in early childhood settings.

Partnerships

- Coordinate state-wide crisis intervention services.
- Increase BH services and adopt trauma sensitive practices across all schools.
  - Not just for AHCCCS covered students.
  - Adopt and provide self-care services for school admin, staff and teachers
  - Partner with ASU, University of Arizona, NAU and K-12 school districts to target educators as front line/public facing staff to receive training.
- Integrate behavioral health providers into primary care to help people who are seeing their primary care provider before committing suicide.
- Support and encourage tribal traditional ceremonies for suicide prevention.
- Encourage Medicaid plan amendment to transform existing school-based Medicaid (expand number of kids receiving services eligible for plan reimbursement).
- Utilize non-profits currently conducting Youth Mental Health First Aid in AZ.
- Get parents involved with education and information regarding the stressors kids have especially with social media. Many parents are in denial of their kids needing help.
- Analyze discharge data for suicide attempts and follow up with them to ensure they are attending/performing their therapies.
- Engage ASU faculty to assist with claims and other data, as well as develop programming. ASU (especially the DBH program) has also a demonstrated track record of developing train the trainer programming related to integrated care.
- Engage Crisis Response Network to implement crisis text and/or chat within 90 days with adequate funding. Partner with SUD Coalitions to assist in this aspect of mental health.

Systems

- Implement a Statewide crisis text and chat service to engage individuals that would rather reach out through alternative methods compared to the telephone.

Rural & Urban Underserved Health

Health Professional Shortages

Communication & Resources

- Build opportunities and fairs that focus and prioritize diverse student bodies about becoming a provider and serving in rural areas here in AZ.
- Increase access to financial aid information (some people just don't know where to look) & offering scholarship application assistance where we can help people fill those applications out because they can be daunting.
- Make child care more accessible to parents who are continuing their education.
- Provide resources and initiatives to "Grow our Own" providers. Let's invest in our fellow Arizonans.
- Develop a mentorship in various areas (regionally and professional field) to help disseminate passion and insight for their community needs.
- Create clubs/scholarships for students who want to work in healthcare and encourage those aspirations through scholarships. Also, create mentoring programs that pair current diverse providers with people from their communities.
- Improve availability of housing in Rural AZ for those looking to work in those communities. People need a place to live if they are going to work in Rural AZ and tribal Communities.
- Promote the importance of health careers.
- Develop communications to notify persons in underserved areas of scholarships, mentorships, etc.

Partnerships

- Include oral health and mental health providers are included in these strategies.
- Provide guidance to Governing Boards in IHS/tribal/Urban to develop their policies and procedures pertaining to incorporating CHW/CHR as clinical outreach in their respective communities. (ITCA)
- Recruit in home providers especially in my more rural areas (as well as educating them in early childcare) so that child care becomes accessible to all communities across Arizona. (Child Care Resource & Referral)

Education

- Education and socialization of children of those working in rural healthcare in very small communities must be a part of authentic conversation.
- Provide community college students seeking health careers with the assistance of mentors from their respective institutions and the rural and urban underserved communities would benefit from engaging in community work at the local level.
- Provide continuing education and training opportunities to increase skill sets and knowledge. Increase opportunities for employee career advancements by possibly developing training programs in partnership with health professional schools and training hospitals.
- Increase focus on customer service skills, interpersonal skills, nonverbal communication and cultural competency.
- Work with high schools in targeted areas to explain health care career opportunities.
- Organize an underserved professional school student round table to gain their feedback on the action plan.
- Invest in STEM / Health education at every level of education; make sure people from underrepresented groups have access to the tools and resources they need to succeed in high school and college, not just graduate medical education.
- Leverage Health Education Centers and Community Health Centers to demonstrate career opportunities.

- Implement programs to support college debt relief.
- Obtain data on Foreign Medical Graduates without license in AZ who might be looking for a path for licensure or seeking a path for other medical professions.
- Include public education and housing advocates in recruiting health professionals and their families to rural areas.
- Educate and socialize the children of those working in rural and small communities.
- Present scholarship options and application assistance to High School Seniors in rural/underserved communities - like a seminar/rally.

Systems & Data

- Recognize the limitations for clinicians who serve in the IHS/tribal system as these systems can employ providers who are licensed in states other than AZ. This data will be difficult to acquire
- Collect demographic information on healthcare providers and staff to align with patient populations, set inspirational goals, and track diversity improvements.
- Collect demographic data of students and instructors currently in health professions education programs across schools.
- Leverage a new healthcare workforce repository that is up and collecting data for DOs, MDs, nurses and behavioral health providers that will be collecting demographic information and will be very helpful for these tactics.

<u>Community Health Workers/Community Health Representatives</u>

Communication & Resources

- Fund CHW/CHR positions in primary care.
- Fund CHW workforce training and certification.
- Provide a solid source of reimbursement (not grant funded) to CHWs.
- Share ideal modeling health care clinics on the advantages of the CHW and how to best implement into their work force.
- Pilot the bundling certificate programs for CHWs (i.e. diabetic educators, interpreters, etc...) as a financial strategy.

Partnerships

- Engage with the Cancer Support Community to explore opportunities to partner with others across rural Arizona.
- Developing partnerships with workforce boards, colleges, np and JTEDs can help with costs.
- Work with AZCHOW to talk to current CHWs about their needs and ways to recruit more people.
- Develop a community of practice for CHWs.
- Promote use of CHW's in Rural Health Clinics.
- Elevate CHWs/CHRs visually in clinical settings as well as in their communities.
- Host a round table with AzCHOW and CHR to review strategy and action steps.

Education

- Develop an educational curriculum for CHWs/CHRs instituted at community college level so they can prepare for 4 year institutions and advance their careers.
- Coordinate with community colleges to ensure their programs align with needs
- Certify all CHW on National Diabetes Prevention Program (NDPP).
- Some focus should also include customer service skills, interpersonal skills, nonverbal communication and cultural competency.
- Provide application assistance, high school seniors, for available scholarships or education programs. Maybe working with the state and initiating a tax break for internet companies to set up in rural areas so that access to these programs/scholarships is more available to that

underserved community and so that underserved/rural communities have access to online school.
- Certify CHW on NDPP to help manage the obesity epidemic. First step would entail legislation approving reimbursement on Medicaid.
- Recruit specific healthcare colleges - privately run - to set up in rural communities.
- Align CHW training with peer support specialists.

Systems & Data
- Inventory what hospitals and insurers are already doing to reimburse CHWs - it is happening.

Improve Indian (IHS/tribal/Urban) Health

Communication & Resources
- Ensure grant requirements through ADHS to the Tribes are not overburdensome.
- Incorporate traditional cultural practices in existing health and wellness programs.
- Provide support or funds to purchase up to date equipment.
- Create a weekly/monthly shuttle system to nearby cities/health care providers. For example, Peach Springs (Hualapai tribe) has a bus shuttle system that is coordinated with banking, Health care, and doctors.
- Leverage Medicaid dollars to help fund trauma informed services - tribal and under-resourced areas are hit hard with these issues.
- Provide equitable funding to Native American tribes to help strengthen their CHR programs.
- Provide incentives for individuals and families participating in preventative care and medicine to increase participation.
- Assist with financial support to the community for them to have more access to clean water, internet for virtual health visits, etc.
- Develop a public health campaign aimed to increase people's comfort level in using telehealth.
- Develop a campaign to help AI to understand that IHS will not meet 100% of needs.

Education & Training
- Create, support, and advocate for culturally appropriate training like the training given by Eric Hardy's presentation at the Maternal Mortality Summit and build on it more.
- Train customer service skills, interpersonal skills, nonverbal communication and cultural competency.
- Provide training to state and tribal leaders of the AzHIP plan.
- Develop and communicate webinars on how tribes have increased access to care-highlighting best practices at the tribal level. then develop case studies to be shared with other tribes.
- Offer telehealth in the form of remote/virtual workshops, education offerings, community support groups etc... collect what all is already being offered and capitalize on them.

Partnerships
- Advocate, and collaborate with government and non-government entities, to reduce food deserts in tribal/urban communities and provide incentives for individuals and families participating in preventative care and medicine.
- Leverage Prop 207 money coming to ADHS to focus on reducing health disparities in these tribal and under-resourced areas.
- Create and hire an ADHS Tribal Epidemiologist.
- Understand federal/ state/ tribal relationships
- The Triad State System is important to address-Arizona, Utah, New Mexico.
- Obtain tribal input prior to submission of grants.
- Engage Cancer Support Community and utilize their outreach and workshops through telehealth options on the zoom platform.

- Engage MHIP (Tribal Maternal Health Innovation Program Manager) and work closely with Tribal partners.

Systems & Data

- Reduce Internet expenses.
- Implement audio only services (in the absence of broadband and digital literacy).
- Expand Telehealth services and reimbursement to Telehealth.
- Provide technical assistance for telehealth infrastructure development and improve digital literacy.
- Assess community members' data minute limits and online learning as a potential barrier for telemedicine.
- Ensuring audio-only telehealth parity with audio-visual.
- Develop and implement mobile telehealth services via satellite internet availability.
- Provide data on specific tribes' health issues or concerns.
- Address the lack of devices in many tribes.

Maternal Health

Communication & Resources

- Activities/events should concentrate on being community- based and culturally appropriate. Not one activity will fit for all communities. Trust the communities to tell us what would work for them.
- Consider how to assist mothers when accessing services. For example, providing transportation or child care while she is receiving services.
- These action steps are very much in alignment with the Surgeon General's Call to Action to Improve Maternal Health that was released in December.
- It would be helpful to call out opportunities to raise awareness among pregnant women about the harm of using marijuana during pregnancy.
- Weave in trauma informed care, as well as stigma reduction for SUD. Without this it will be a barrier to access for some.
- Presumptive eligibility is an option that states can use to allow authorized providers to begin treating pregnant people when they first seek prenatal care rather than waiting until after their Medicaid eligibility is reviewed and determined, which can take several weeks.

Education & Training

- Include mental health initiatives within well women annuals and encourage positive maternal cultural practices that allow the individuals' family and friends to offer needed support during pre/post birth. Also assess parental needs and family dynamics.
- Oral health for the mother and baby are also very important.
- Education of young women regarding the requirements for the healthy growth of a baby's brain before birth is critical, and must start before pregnancy. This includes issues of nutrition and exercise, as well as the serious negative impact of alcohol, tobacco, and marijuana, etc - following on Kim's statement.
- Implement an implicit bias training requirement for health care professionals working in perinatal services.
- Stigma reduction for providers and community.
- Incorporation of breastfeeding support and practices along with training on recognizing warning signs. The breastfeeding support person may be someone working with a family closely throughout the postpartum period before the mother visits the primary care provider (PCP) or Health Care Practitioner (HCP).
- We need to focus on prenatal education. It should become a standard high school and Freshman college curriculum.

Partnerships

- Many Rural and Tribal communities have prenatal services in communities closest to their homes then get transported out to a L&D, leaving the patient and midwife on another. We need to work on those relationships for new moms especially if she has underlying health issues such as hypertension.
- L&D facilities and Drs should embrace Doulas to assist them in their work.
- Bring back deliveries to hospitals that have dropped the services because of the expense.
- Need to change hospital policies in allowing Doulas and Midwives to practice within hospital facilities, especially in Rural AZ where hospitals are few and far between.
- Systemic Racism has driven how we implement programs, need to address these barriers.
- Identify the structural barriers that lead to poor outcomes, particularly among women of color.
- More diverse and inclusive hospital policies around birthing. Also more implicit bias training for ALL medical staff.
- Considering that AHCCCS covers half of all births in our State, we should work with the agency to develop a Section 1115 waiver that will improve maternal health outcomes. Lots of opportunities here.
- Continue to support MHIP funding to Navajo and ITCA. Plus develop relationships with tribal colleges.
- Partner with well child visits to support mothers.