"Using our best indigenous knowledge and science:

The powerful effects of voice and choice on the wellness and healing of American Indian urban communities"

By the end of this session you will be able to…

1. Recognize how the unquestioned implementation of evidence-based practice can be a potential source of health inequity for American Indians when the “evidence” is not aligned with their worldview.
2. Consider how community-based participatory research engages urban American Indians in acquiring indigenous and community-defined evidence.
3. Identify and apply engagement strategies to activate collective approaches for resolving pressing health concerns of American Indians in the urban setting.

Evidence-Based Practice

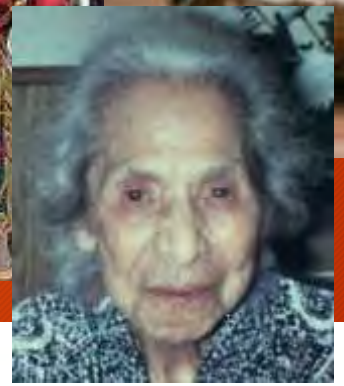
"Evidence-based practice (EBP) is an approach to health care wherein health professionals use the best evidence possible, i.e. the most appropriate information available, to make clinical decisions for individual patients…decision-making is **based not only on the available evidence but also on patient characteristics, situations, and preferences…**Ultimately EBP is the formalization of the care process that the best clinicians have practiced for generations".

(McKibbon , KA . 1998. Evidence based practice. Bulletin of the Medical Library Association 86 (3): 396-401)

Which doctor do you want?

William Osler, 1900

Smart young doctor



Which doctor do you want?

Wise & experienced smart young doctor

Source: Professor Paul Glasziou, Centre for Evidence-Based Medicine, University of Oxford, Sept 2009. Viewed at: http://www.cebm.net/index.aspx?o=1083

Agency for Healthcare Research & Quality: 13 Evidence-Based Practice Centers (Dec 2014)

Brown University
Duke University
ECRI Institute—Penn Medicine
Johns Hopkins University
Kaiser Permanente Research Affiliates
Mayo Clinic
Minnesota Evidence-based Practice Center
Pacific Northwest Evidence-based Practice Center—Oregon Health and Science University
RTI International—University of North Carolina
Southern California
University of Alberta
University of Connecticut
Vanderbilt University

Reports are used by Federal and State agencies, private sector professional societies, health delivery systems, providers, payers, and others committed to evidence-based health care.
http://www.ahrq.gov/clinic/epc/

Source: Evidence-based Practice Centers (EPC) Program Overview. Content last updated November 2015. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.ahrq.gov/research/findings/evidence-based-reports/overview/index.html

E-BP Center Reports: 2004 & 2016

Johns Hopkins, Strategies for Improving Healthcare Quality: Evaluating the effectiveness of specific interventions was challenging for several reasons…Very few studies involved Hispanic populations, and

- **none included American Indians/Alaska Natives …**

Source: Beach MC, Cooper LA, Robinson KA, Price EG, Gary TL, Jenckes MW, Gozu A, Smarth C Palacio A, Feuerstein CJ, Bass EB, Powe NR. Strategies for Improving Minority Healthcare Quality. Evidence Report/Technology Assessment No. 90. (Prepared by the Johns Hopkins University Evidence-based Practice Center, Baltimore, MD.) AHRQ Publication No. 04-E008-02. Rockville, MD: Agency for Healthcare Research and Quality. January 2004.

Update: Minnesota EBP Center: Comparative Effectiveness Review – Improving Cultural Competence to Reduce Health Disparities (Mar 2016) – "Large segments of vulnerable or disadvantaged populations…including Native Americans or Alaskan Native – remain essentially invisible in the cultural competence literature."

Source: Butler M, McCreedy E, Schwer N, Burgess D, Call K, Przedworski J, Rosser S, Larson S, Allen M, Fu S, Kane RL. Improving Cultural Competence To Reduce Health Disparities. Comparative Effectiveness Review No. 170. (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-2012-00016-I.) AHRQ Publication No. 16-EHC006-EF. Rockville, MD: Agency for Healthcare Research and Quality; March 2016. www.effectivehealthcare.ahrq.gov/reports/final.cfm.

Community-Defined Evidence

- A set of practices that communities have used and determined to yield positive results as determined by **community consensus** over time and which may or may not have been measured empirically but have **reached a level of acceptance by the community.** (CDEP Working Group, 2007)

- CDE includes **world view, contextual aspects and transactional processes** that do not limit it to one manualized treatment but is usually made up of a set of practices that are culturally rooted.

Source: www.nami.org/Content/.../EBPandMulticulturalMentalHealth.ppt (Dr. Ken Martinez)

Integrated Health Care

A health service delivery trend

Depression Prevalence

- AI/ANs ages 18+ had the highest rate of a serious psychological distress within the last year, 25.9%, and the
- Highest rate of a current major depressive episode (MDE), 12.1%
- AI/ANs ages 12 to 17 had the highest lifetime MDE prevalence, 13.3%, and the highest MDE prevalence in the last year, 9.3%
- Across all urban Indian health organizations (2005-2010), 15.1% of AI/ANs reported 14 poor mental health days in last 30 days, compared to 9.9% for all races.

Source: Urban Indian Health Institute, Seattle Indian Health Board. (2012). *Addressing Depression Among American Indians and Alaska Natives: A Literature Review.* Seattle, WA: Urban Indian Health Institute.

Using CBPR to Gather Indigenous Community-Defined Evidence about Depression & Depression Care (2008-2011)

Consumer Survey

Mental & Behavioral Health in NM: Native American Consumer Survey Results N=129
(Approximately ½ did not want MH services in primary care.) (Funding: NM Indian Affairs Department, Tassy Parker, PI, 6 AI communities as Co-Is)

Community Advisory Board – AI Women's Depression Study

8 AI women, biweekly meetings x 6 months: NEW ROAD (Native Empowered Women Reaching Out About Depression), Community dialogue of AI women to confirm major themes
(Funding: UNM HSC CTSC & Center for Participatory Research, T Parker & K Waconda-Lewis, Co-PIs)

12 In-depth Interviews – Depression: Beliefs & Treatment

AI women in an off-reservation community in the Northern Plains (Funding: NIAAA admin supplement to Tassy Parker)

Community Advisory Board – Integrated Care Study

3 focus groups of off-reservation AIs, 1 female group, 2 male groups; Surveys: Primary Care & Behavioral Health administrators/staff
(Funding: RWJF Center for Health Policy at UNM, Tassy Parker, PI; John Oetzel, Co-PI; Karen Waconda-Lewis, Co-I)

Depression Care Beliefs & Care Preferences by Gender

AMERICAN INDIAN FEMALE	AMERICAN INDIAN MALE
Primary care: "Get to trust" Scared – Medicine - CBT	Primary care: "No way!"
Need an advocate – CHR*	Need an advocate – Tribal & Community Leaders
Need education – CHR & other AI women	Need education – kiosks & other AI men
Traditional healing	Medicine men, sweats
American Indian providers	American Indian providers
Broken promises, historical trauma	Broken promises, historical trauma
Need a place to gather	Need a place to gather
Need opportunities for education, enough food	Need jobs, housing, transportation, nutrition & exercise
Racism & Discrimination	Racism & Discrimination

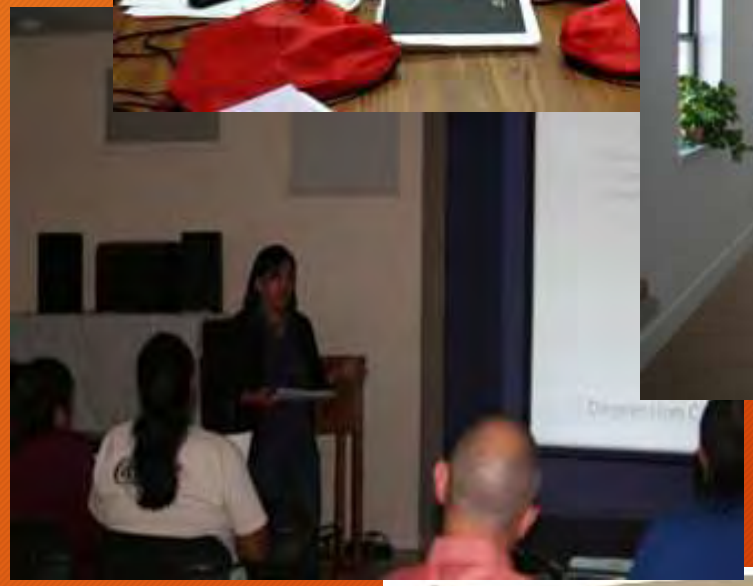
* CHR = community health representative

Source: *https://www.pinterest.com/sondray/native-american/*

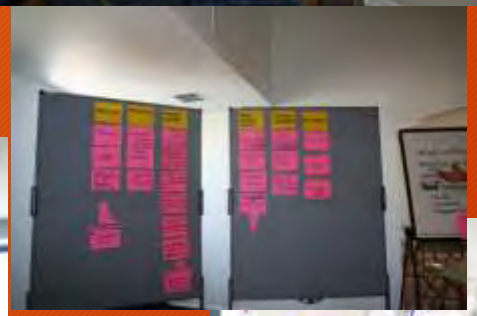
"When They Took Their Power Back"

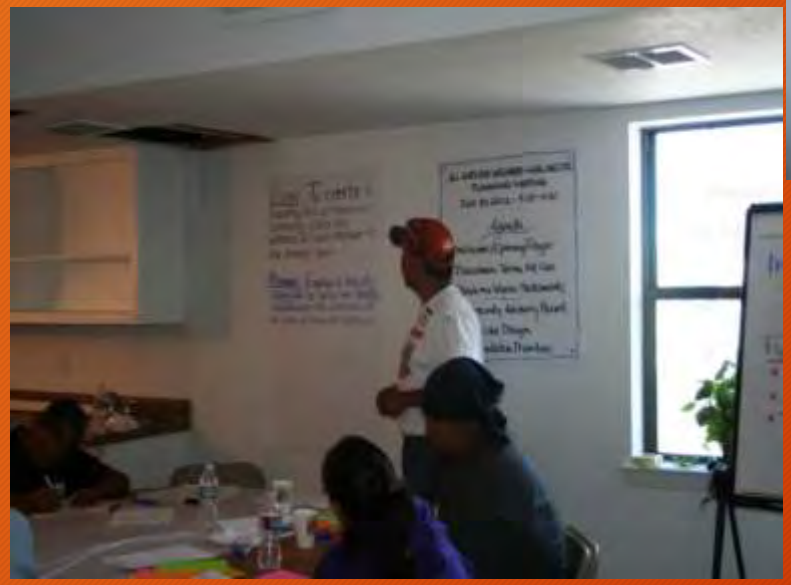
A 5-minute digital story about engaging research, indigenous & community-defined evidence, and the creation of an Indigenous road to healing in the Albuquerque, NM urban American Indian community.

"It is empowering to know that we are being listened to and to be able to design our own healthcare program."



- Professionally Facilitated
- Mission & Vision Statements
- Desired Qualities of ANWHC Advisory Board Members
- Physical Design of ANWHC





Creating a Community-Defined Therapeutic Landscape with the Albuquerque Urban American Indian Community!

Vision for All Nations Wellness & Healing Center (ANWHC) Services/Programs

Core Values

- All spiritual beliefs honored
- Intergenerational Interactions
- Community volunteers to provide services
- Cross-cultural learning about other tribes & traditions
- No duplication of services

ANWHC PROGRAM AREAS (BY PRIORITY)

{What are the priority services/programs for the ANWHC?}

Cultural Health Justice	Housing & Essential Resources	Indigenous Nutrition	Youth Development & Opportunities	Health Access	Career Development	Computer Literacy & Access	Physical Wellbeing	Civic Engagement
Traditional Counseling, training as peer mentor, counselor, lead talk groups	Housing Needed	Potluck gatherings	Outreach to local schools to engage youth	Legal Counseling on-site adults/youth	Job Opportunities Info, Counseling	Technology access IPad, computer stations	Place to just rest	Local tribal community reps. to present on politics, resources
Traditional Medicine/Healing	Crisis service referrals, safety net services	Community garden, agricultural connections for resources	Safe space for youth	Western counseling training as peer mentor, counseling	Higher Ed Financial Aid Instruction	Computer Literacy Skills	Sports-Recreation for youth/adults, Pow-Wow	Relationship with other Indian organizations
Stress Class	Social worker available	Learn food preparation	Academic tutoring for students	Health services – establish main care	Job Seeking Skills		Fitness Class	Voter education & registration
Cultural programing – arts & crafts	Identify & engage homeless Natives	Food, snacks available	After school programming – structured learning		Motivational speakers - adult/youth			
	Promote free clothing program esp. children	Cultural foods preparation – community kitchen	Language Tutoring Youth/Community		Education opportunities- UNM,CNM, etc.			
	Transportation (Bus Token)				GED Classes			
	Emergency funds/resources							

Six Engagement Strategies for Gathering Indigenous and Community-Defined Evidence

1) Listen. The answers are already in the community.

2) Consider historical, environmental, cultural contexts of consumers & communities and advocate for strengthened self-determination and trust-building.

3) Seek authentic dialogue with community and consumers about how, when, where, what types of, and by whom health services are provided and advocate for the alignment of services with preference and worldview.

4) Collaborate to develop American Indian health professionals and access to traditional healers, advocate for their inclusion and funding.

5) Identify the Knowledge, Skills, and Abilities needed to engage and activate the AI consumers and community in creating culturally-congruent, effective interventions and prevention strategies.

6) Establish & Monitor effectiveness through self-evaluation, consumer /community trust and satisfaction, and evaluation of health outcomes.

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