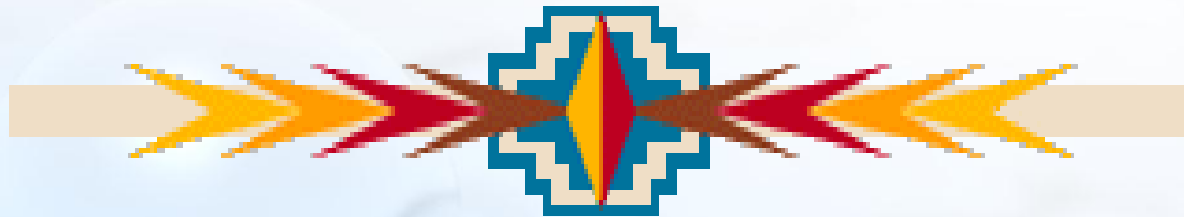




COMMUNITY ENGAGED RESEARCH

Dr. Donna Grandbois;
Fargo Moorhead Urban Indian Community

**“A NATIVE AMERICAN COMMUNITIES
JOURNEY TO ACHIEVE CULTURALLY
APPROPRIATE HEATH CARE”**



KEY PREMISES

POINT 1

The Community has the Expertise

POINT 2

The Indigenous Worldview Matters!

POINT 3

Our Cultures Hold Our Medicine

POINT 4

Care Must Be Community-specific

POINT 5

The Community is Dynamic

POINT 6

Cultural Humility & Respect is Intrinsic

THE PROBLEM

Healthcare services do not exist for urban Indians w/o insurance in North Dakota:

- ❑ **Indian Health Services are not within easy driving distances**
- ❑ **Many Urban Indians do not have tribal IDs**
- ❑ **There are no FQHC for Urban Indians in ND or Title V funding for services**
- ❑ **Fargo FQHC has not welcomed Native clients**
- ❑ **Lack of data contributed to the problem**
- ❑ **Low health literacy**

Demonstrated Need for Community-Specific Data:

North Dakota was ranked “#1” by both Gallop & Healthway’s for the highest “well-being scores” across the US.

Rankings were based on 6 Measures:

- a) Access to basic needs**
- b) Healthy behavior**
- c) Work environment**
- d) Physical health**
- e) Emotional health**
- f) Life evaluation & optimism**

(Dakota Nurse, v 12, 2, Spring 2014; p. 15)

The Stark Reality for North Dakota's Indian People: Cradle to grave inequities

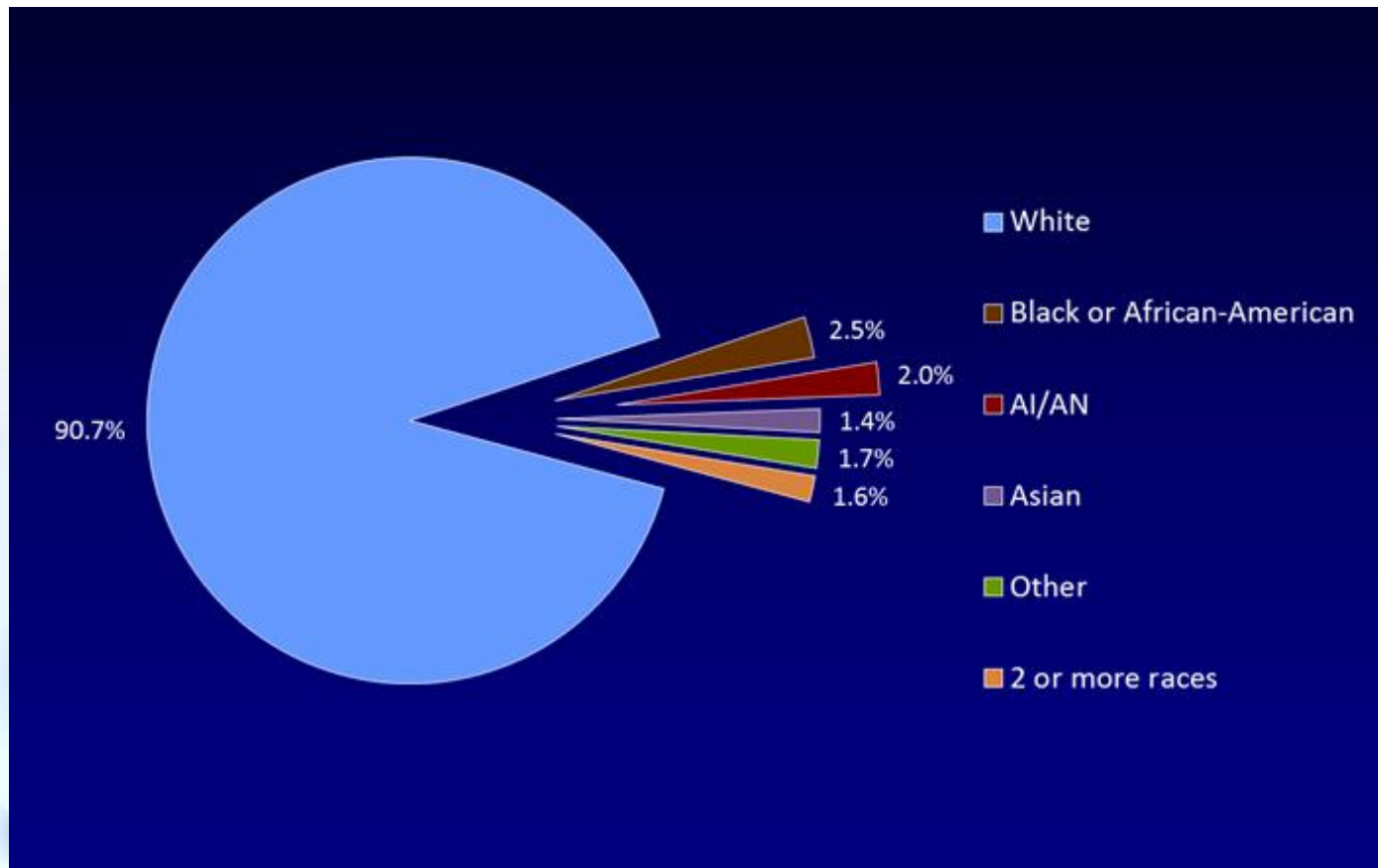
NATIVE AMERICANS

- **Approximately 42,000**
- **Median household income: \$25,255 (49.7% below 200% FPL)**
- **Unemployment: 14%**
- **High rates of disability at every age**
- **The lowest High School Graduation rate in the country**
- **Infant mortality rate 13.5**
- **Life Expectancy 54.7 years**

NON-NATIVE POPULATION

- **Approximately 672,000**
- **Median household income: \$48,670**
- **Unemployment: 3%**
- **Low disability rates**
- **Among the highest High School Graduation rates in the country**
- **Infant mortality rate 7.5 (US)**
- **Life Expectancy 75.7 years**

Race in the Northern Plains



Source: US Census Bureau, 2006-2008, American Community Survey
ND, SD, Iowa, & Nebraska

BACKGROUND

- **Urban Indian Health & Wellness Center
Established with 6 Native Board Members**
- **Held community forums & dialogues**
- **Greater Fargo Moorhead Community Health
Needs Assessment Collaborative (CHNAS)
(20 members; in response to 2010 healthcare
reform mandate)**
- **Only 2 Natives completed the CHNAS survey**
- **Native American City commission funded the
Native American survey; using the same tool**
- **7-8 Native community members IRB certified
to collect data (101 surveys/88 Native)**

COMMUNITY STRENGTHS

F/M AI Health & Wellness Center

Public Health, Cultural, and Social Services

Native American Center 501(c)3
(building & services coordination)

Daughters
of the
Earth

Sacred
Spirits

F/M AI
Health &
Wellness
Center

Native
American
Coalition

Greater F/M Community Health Needs Assessment Collaborative

C. Fuglesten-SE Human Services

C. McLeod- Sanford Health

**D. Watne- Dakota Medical
Foundation**

D. Grandbois- American Indian Pop.

G. Nolte-Clay County Public Health

K. Olson-State Data Center

K. Dulski- Essentia Health

K. Schwarzwalter-NDSU

**K. Lipetzky- Fargo Cass Public
Health**

M. Miller- Center for Rural Health

**M. Henderson- Family Healthcare
Center (FQHC)**

P. Patrone: Family Healthcare Center

R. Danielson-NDSU

R. Rathge- NDSU

**R. Bachmeier- Cass County Public
Health**

S. Thomsen-United Way Cass/Clay

S. Borgen- Essentia Health

T. Hill- United WAY

What is CBPR?

“... a ***truly collaborative approach to research*** that ***equitably involves all partners*** in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community and has the ***aim of combining knowledge with action*** and achieving social change ***to improve health outcomes and eliminate health disparities.***”

Source: Kellogg Health Scholars Program. [cited 2012 November 13]. Retrieved from: <http://www.kellogghealthscholars.org/about/community.cfm>

Community-engaged Research Principles

- ❖ **Recognizes community as a unit of identity**
- ❖ **Builds on strengths and resources**
- ❖ **Facilitates partnership in all phases of research**
- ❖ **Promotes shared learning to solve social inequalities**
- ❖ **Addresses health from positive and ecological perspectives**
- ❖ **Disseminates findings and knowledge to all partners**
- ❖ **Involves long-term commitment by all partners**

Source: Adapted from : Israel, BA, Schulz, AJ, Parker, EA, Becker, AB, Allen, AJ, and Guzman, JR. "Critical Issues in developing and following CBPR principles," *Community-Based Participatory Research in Health*, Minkler and Wallerstein (eds), Jossey Bass, 2000.

METHODS

A mixed-method community-based participatory research (CBPR) collaboration with the F/M Urban Indian community was implemented.

Phase I: Urban Indian volunteers were IRB certified by NDSU

Native American City Commission funded the survey

Survey was conducted by community members

Both paper & computer access to the survey were provided.

Group Decision Center, NDSU, was used to collect the surveys and provide a report on the results

PHASE I

Began with Relationship Building & Community Service.

Relationships were built with:

- **Community Coalition**
- **Grass-roots community organizations**
- **Native & Non-Native Leadership**
- **Community Dialogues & Forums were held**
- **Key Native Elders**

Phase One included the community-wide survey & the community-specific survey

PHASE II: Building on Phase I

- **Adapt the survey tool to be Native specific**
- **Define culturally appropriate care for “this” community**
- **The voices of the Elders must be sought out & included in focus groups**
- **American Indian Community Leaders must be asked to participate**
- **Semi-structured focus groups and individual interviews will be conducted to further define, clarify, and provide future direction**

OUTCOMES; SO FAR!

- **Capacity to generate their own data as needed**
- **Awareness of biopsychosocial and economic status**
- **Determine & set priorities to address specific needs**
- **Support community focused grant applications**
- **Community buy-in with the larger community: Be recognized as a viable partner in key community health and socioeconomic strategic plans**
- **Monitor their own progress toward becoming a healthy community**

Outcomes; Possibilities, & Dreams

- **Native community leaders can support and make a case to local, state, and federal policy-makers and legislators, using the data, to meet community needs**
- **With ACA, more urban Indians will have insurance;**
- **Therefore, access issues toward culturally compatible healthcare services may need to be re-envisioned.**

Finally: Community Empowerment

The data and the development of community cohesiveness, partnerships, and collaborations are vital as this urban Indian community works to build a healthy, welcoming community.

A Ways To Go!

SOCIAL JUSTICE

“Enables people to claim their human rights, meet their needs, and have greater control over the decision-making processes that affects their lives”

HUMAN RIGHTS COMMISSION

North Dakota Human Rights Coalition (NDHRC) was formed as recently as 2002. There is Native representation!

**THANK YOU FOR YOUR TIME & ATTENTION! WE
WILL RESPOND TO QUESTIONS AT THE END OF
BOTH PRESENTATIONS?**

