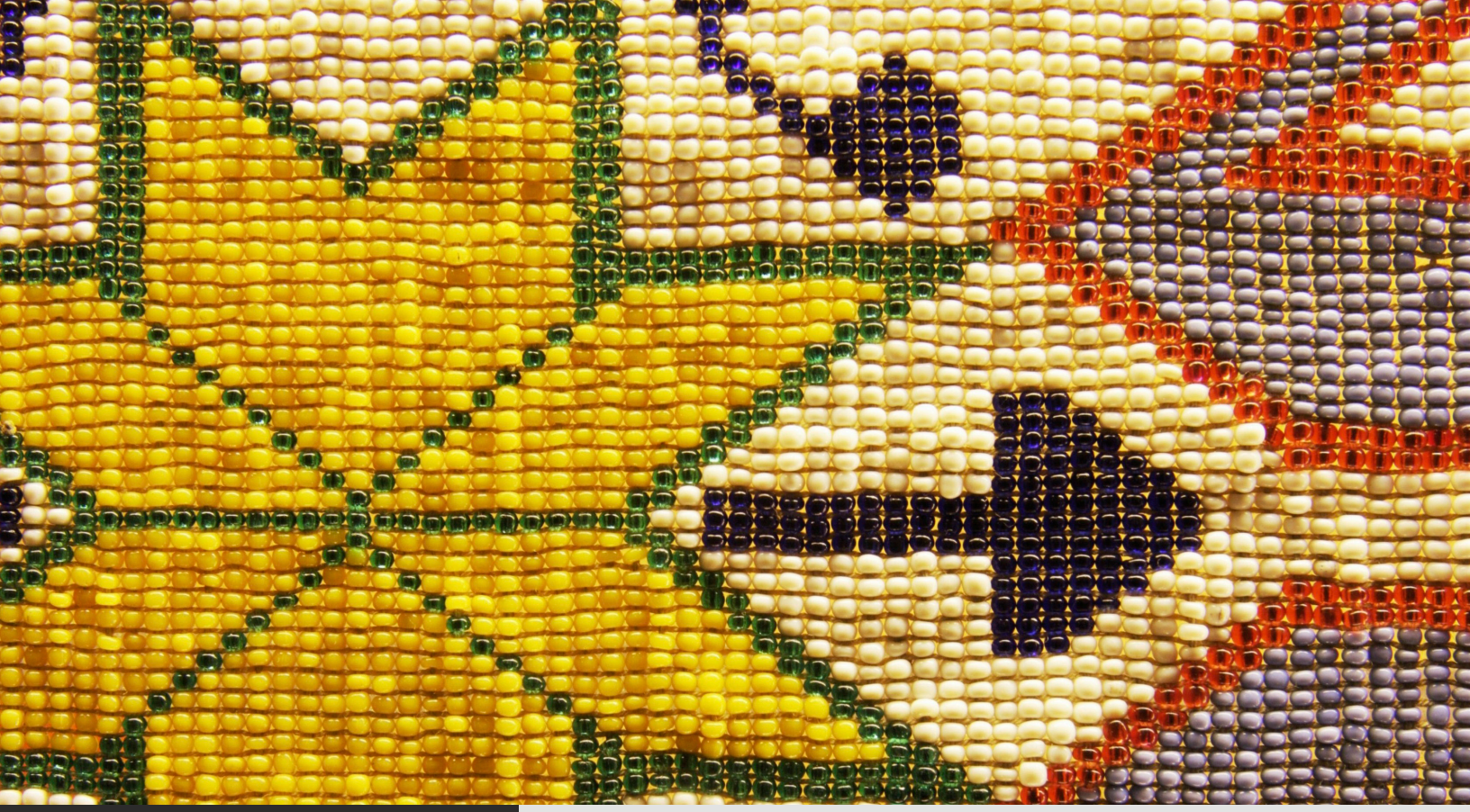
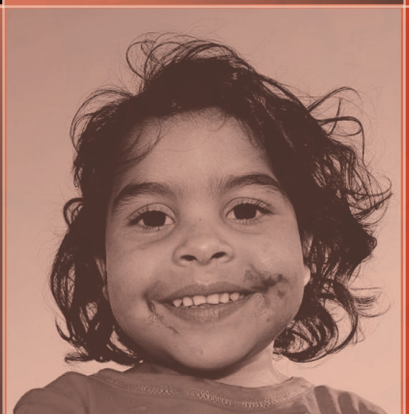


Urban Indian Health Institute
A Division of the Seattle Indian Health Board

A Profile of Urban Indian Health Organization Programming to Support Behavioral Health

August 2012

The mission of the Urban Indian Health Institute is to suport the health and well-being of urban Indian communities through information, scientific inquiry and technology.



This report was prepared by Jessie Folkman MPH, Julie Loughran MPH, Emma Robson BA and Emma Strick BA.

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TABLE OF CONTENTS

Please contact the Urban Indian Health Institute with your comments by e-mailing info@uihi.org, calling 206-812-3030 or visiting us online at www.uihi.org.

ACKNOWLEDGEMENTS

Urban Indian Health Institute
A Division of the Seattle Indian Health Board

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The UIHI would like to thank the staff at the Urban Indian Health Organizations for their input and acknowledge the excellent work they do on behalf of their communities.

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UNIVERSITY of WASHINGTON
Indigenous Wellness Research Institute
Center for Indigenous Health Research

Dear American Indian and Alaska Native Community Members and Allies,

"*Relations do not end at jurisdictional boundaries*."

Moroni Benally, Diné Policy Institute 2007

This quote by Dine Policy maker Moroni Benally speaks directly to the predicament of many American Indian Alaska Native (AIAN) urban residing citizens and descendants. Federal health and education services are not an "entitlement" but rather a contractual and moral obligation. They emerge from the totality of Native and Federal *Relations*—enacted in many treaties and agreements since the arrival of settler colonies in the 1700's to the present day. Some US tribes have had their land base encroached by urban areas that emerged surrounding traditional homelands. Other Indigenous peoples have been moving and/or sojourning to urban areas even before the widespread urban relocation produced by the 1959 Public Law 959 "*The Adult Vocational Training Program*". Today, hundreds of thousands of AIAN tribal citizens and descendants reside in urban areas, either permanently or for large portions of the year.

Access to urban health and social services for members and descendants of US Indian tribes, some in dire need of these services, is determined in large part by the urban Indian health clinics founded within the AIAN Civil Rights Movement of the 1960's and beyond. Supported (*but not enough!*) by Indian Health Service and other federal and state funding, these health, social service and in some cases, cultural centers are key strategic investments aimed at eliminating AIAN health disparities and creating health equity for US Indigenous peoples and others. Despite centuries of misguided federal and state policy towards both land based and urban AIAN populations, many Indigenous communities are strong, culturally intact and making smart policy decisions towards even more strength and success. This report is a "*slice-in-time*" snapshot of the community building and strengthening that is among the highest aspirations of urban Indian community leaders towards making the goals and objectives of Healthy People 2020 a reality.

As a social scientist and public health advocate, I am delighted to introduce the Urban Indian Health Institute's thorough and engaging report detailing the behavioral health services offered by the Urban AIAN services delivery system in the United States. This report "***A Profile of Urban Indian Health Organization Programming to Support Behavioral Health***" provides a description of the programs and services in use at Urban Indian Health Organizations (UIHOs). This report documents the ingenuity, resourcefulness and deep commitment of AIAN community leaders and members in the face of historical trauma, limited resources and apathy. It also verifies and sanctions the ingenious application of precious traditional medicine and ceremonial resources for healing. The service trends identified in this report are inspiring and are deserving of the validation and support of US health and political leaders, as well as all AIAN community leaders and members in the US. Please join me in congratulating the UIHI in this important achievement.

Sincerely yours,

B Dura

Bonnie Duran, Dr.PH
Director, Center for Indigenous Health Research, and
Associate Professor, Department of Health Services

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EXECUTIVE SUMMARY

Introduction

The purpose of this report is to provide a description of the programs and services in use at Urban Indian Health Organizations (UIHOs) to address behavioral health needs in urban American Indian and Alaska Native (AI/AN) communities. Specific services and programs addressed in the survey include depression screening, substance abuse treatment, suicide prevention, and therapy and counseling. This report also highlights four UIHO programs with the goal of sharing their experiences implementing innovative behavioral health programs with the network of UIHOs and the broader public health community. Lastly, recommendations are presented to support expansion of programs and services available to urban AI/ANs, and build on the strengths and achievements of UIHO's current behavioral health programs.

Methods

Data collection occurred between February and May 2011, and included surveys and key informant interviews of participating UIHO Executive Directors and program staff. Survey questions addressed: 1) behavioral health services offered by UIHOs; 2) incorporation of AI/AN culture into behavioral health services; 3) coordination of care; 4) resources used by UIHOs to inform program design and implementation; and 5) descriptions of successful strategies and achievements of behavioral health programs. Following survey implementation, the Urban Indian Health Institute (UIHI) contacted select sites to participate in key informant interviews to share additional information about programs and services at their agency. Findings from these key informant interviews were developed into brief program highlights, and are included throughout this report.

Results

Of the 32 UIHOs and one satellite site operating at the time of survey administration, 24 (73%) sites completed the survey. Four UIHOs participated in key informant interviews for this report.

Highlights of this report's findings include:

- Although the services varied by UIHO, every service addressed in the survey was available onsite or by referral at 90% or more of UIHOs. Services most frequently identified as "fully available" (onsite) included: depression screening, substance abuse screening and individual therapy or counseling.
- Nearly all survey respondents incorporate AI/AN culture into their services (95.9%).
- The majority of respondents coordinate care between departments in their organization and with other agencies or providers (65.2%).
- UIHOs draw from a diverse pool of resources and stakeholders to inform the design and implementation of their behavioral health programs and activities. The most frequently reported factors influencing program design and implementation include: literature, national programs, activities or models and input from clinical staff.
- Activities or program features that support program successes included: program and service characteristics such as cultural components, flexibility and coordination of care; staff attributes such as expertise, leadership, Native staff, and staff that are active in the community; transportation services; and partnerships.
- Examples of program achievements included: positive feedback, improved or expanded services; improved patient outcomes, improved patient participation, and organizational and administrative achievements.

EXECUTIVE SUMMARY

Discussion

Findings from the behavioral health survey and key informant interviews illustrate the multiple ways in which UIHOs are responding to the behavioral health needs of the communities they serve. This report describes the diverse range of services that are offered, the ways in which services are planned, delivered and coordinated, and the accomplishments that UIHOs have achieved. For example:

- UIHOs have implemented a diverse range of behavioral health services, either onsite or by referral. As a result, UIHOs are well positioned to implement coordinated systems of care with other agencies, and the systems for coordinating care within their organization are also extensive.
- Flexibility to provide services off-site when needed, to coordinate care between departments, and to co-locate services on-site, support UIHO's program success. These findings further suggest that access to care, including service delivery structure and the availability of direct support services such as transportation can play an important role in the provision of services and the achievement of successful outcome measures.
- Cultural components play an important role in the success of UIHO's behavioral health programs, and value is placed on cultural activities by clinic staff and patients alike. Expanding or incorporating cultural components may represent an opportunity to strengthen programming and support success.
- Administrative-level successes, such as accreditation, certification or increased staff preparedness, are also important indicators of UIHO's program success. Administrative-level successes are important to recognize and celebrate, as they build the capacity of the organization, and in turn, enable the organization to further support patient and community-level successes.

Recommendations

Based on UIHO survey responses, the following recommendations are made to strengthen programs in urban AI/AN communities to reduce behavioral health-related morbidity and mortality, and to support work toward achieving health equity in the overall health of urban AI/AN people.

- As behavioral health program funders and developers move forward with efforts to support and expand behavioral health services, the value and success of culturally appropriate services provided in urban AI/AN communities should be recognized. Additionally, flexibility in program structure and service delivery models that culturally appropriate services may require should be protected. Creating funding and programmatic opportunities that acknowledge the essential role of culture will help provide the resources to sustain and expand the unique role of UIHOs in providing culturally appropriate behavioral health services to the urban AI/AN population.
- Efforts to expand the representation of AI/ANs in the health workforce are critical to building this successful element of behavioral health programs. Pipeline program efforts should include not only directed recruitment and training, but also early education support for AI/AN youth, professional development for AI/AN adolescents, and establishment of pathways from colleges and universities to facilitate AI/AN placement in health care professions. Supporting the growth and expansion of the AI/AN workforce in health services will further strengthen the unique and valued qualities of care provided by UIHOs.
- While patient satisfaction is an important indicator of acceptability and utilization, there is a large gap in evaluation of UIHO programming to address behavioral health concerns. This gap is not

unique to urban AI/AN behavioral health programs but has been noted in behavioral health for AI/ANs in general.[1] An evidence-base for prevention and treatment of behavioral health concerns of urban AI/ANs must be built through funding, training and technical assistance for UIHOs to conduct outcome evaluations of their current practices. Resources for evaluation will improve understanding of what activities can contribute to positive outcomes and how those outcomes are achieved. Evaluations should also consider the comparative effectiveness of recommended approaches versus current standards of care to include cost-effectiveness as well as what works best for whom and under what circumstances. This evidence-base is also critical to secure funding from agencies and organizations that require grantees implement evidence-based best practices, most of which were not developed or tested in urban AI/AN communities.

INTRODUCTION

Urban American Indians and Alaska Natives

American Indians and Alaska Natives (AI/ANs) living in urban areas are a diverse and growing population. Over the past four decades, AI/ANs have increasingly relocated from rural communities and reservations into urban centers. According to the 2000 Census, this population now accounts for more than 67% of all AI/ANs living in the United States.[2] However, the needs of the nation's urban AI/ANs have been so infrequently addressed or recognized that the population has been referred to as "invisible".[3]

Urban AI/ANs are diverse and include members, or descendents of members, of many different tribes. Represented tribes may or may not be federally recognized, and individuals may or may not have historical, cultural, or religious ties to their tribal communities. The population as a whole is highly mobile; individuals may travel back and forth between their tribal communities or reservations on a regular basis. Urban AI/ANs are also generally spread out within the urban center instead of localized within one or two neighborhoods, and thus are often not seen or recognized by the wider population.

Health Care for American Indians and Alaska Natives

Numerous treaties, court cases, Executive Orders and laws such as the Snyder Act of 1921 and the Indian Health Care Improvement Reauthorization and Extension Act of 2009, define and affirm the U.S. federal governments' responsibility to provide health care services to members of federally recognized Indian tribes and Native Entities of Alaska, regardless of whether they live in urban or reservation areas. This responsibility has been delegated to the Indian Health Services (IHS), an agency within the federal Department of Health and Human Services. IHS is divided into three distinct health delivery models characterized as the I/T/U system. The "I" refers to hospitals and clinics run directly by IHS. The "T" applies to individual tribes or consortia of tribes that operate tribally managed hospitals and clinics under Indian self-determination and self-governance. The "U" signifies a discrete program created to improve access to health care for urban AI/ANs. In 2010, Tribally-run health services and IHS facilities received approximately 53% and 43% of the IHS budget respectively, while urban programs receive only 1% despite the fact that the majority (67%) of AI/AN reside in urban areas.[4] This funding discrepancy contributes to a number of factors limiting AI/AN access to health services. Additionally, eligibility criteria for IHS and Tribally-run facilities are more limiting than at Urban facilities, often excluding urban AI/ANs who are either not enrolled in tribes, are members of State-recognized tribes, or are members of tribes that are not recognized by the U.S. federal government.

INTRODUCTION

Urban Indian Health Organizations

Established through Congress under Title V of the Indian Health Care Improvement Act in 1976 and permanently re-authorized by the 111th Congress, Urban Indian Health Organizations (UIHOs) are private, non-profit, corporations that serve AI/AN people in select cities with a range of health and social services, from outreach and referral to full ambulatory care. UIHO are funded in part under Title V of the Indian Health Care Improvement Act and receive limited grants and contracts from the federal Indian Health Service (IHS). UIHOs are located in 19 states serving individuals in approximately 100 U.S. counties, in which over 1.2 million AI/ANs reside, according to the 2010 U.S. Census. Through traditional health care services and cultural activities the UIHO provide unique and culturally appropriate services for urban AI/ANs.

The Urban Indian Health Institute

In 2000, The Urban Indian Health Institute (UIHI) was established as a division of the Seattle Indian Health Board to study and document the striking health disparities affecting the urban AI/AN population. The UIHI is one of 12 tribal epidemiology centers and the only organization providing surveillance, research and analysis of data focused specifically on the urban AI/AN population living in UIHO service areas, nationwide. The mission of the UIHI is to support the health and well-being of urban AI/AN communities through information, scientific inquiry and technology.

Health Equity Project

Responding to the persistent inequities in health outcomes among urban AI/ANs, the UIHI launched its Health Equity Project in 2010. With support from the U.S. Office of Minority Health, the project is focused on identifying and disseminating culturally appropriate, successful models of care to prevent and reduce disease in urban AI/AN communities. The Health Equity project focuses on three diseases identified as critical focus areas for health improvement in urban AI/AN communities: cardiovascular disease, depression and a third community-identified disease topic: alcohol and substance abuse. Additionally,

INTRODUCTION

the Health Equity Project will provide tools, trainings, information, and facilitate partnerships to support UIHOs in delivering high quality services to their clients. The importance of documenting and recognizing effective, culturally-targeted programs is essential to achieving Healthy People 2020 goals and realizing the overall outcome of health equity for all.

Information in this report was gathered through a survey and interviews with Executive Directors and program staff of UIHOs. This report serves as an introduction and overview to behavioral health practices at UIHOs. We hope this report will serve as a source of ideas and inspiration, as well as an outline of strengths and opportunities in future behavioral health programming.

Background

Behavioral health, including substance abuse and mental health conditions such as depression and mania, are areas of concern in AI/AN communities. While there is not a definitive assessment of the prevalence of depression and other common behavioral health concerns among AI/ANs, available data point to AI/ANs experiencing high rates. For example, among AI/AN adults residing in urban areas, 15.1% reported at least 14 poor mental health days within the last month compared with 9.9% of the all races population.[5] Additionally, AI/AN adults have the highest rates of serious psychological distress and major depressive episodes compared with other adult populations (25.9% and 12.1%, respectively).[6]

Identifying and addressing mental health needs is critical to supporting and improving the health and wellbeing of the individual, family and community. Attending to mental health needs is also a critical step in addressing commonly co-occurring conditions such as diabetes and heavy drinking. It is also a critical step to preventing tragic outcomes such as suicide, which occurs at disproportionate rates in AI/AN communities (14.68 per 100,000 among AI/AN compared with 11.15 per 100,000 in the U.S., overall).[7]

Several challenges exist in addressing mental health needs in AI/AN communities. Some challenges are logistical, such as a lack of licensed providers, which has been noted to contribute to gaps in services such as pharmacotherapy services.[8] Other challenges reflect important holistic and cultural elements that are not addressed in current systems of care. For example, the common use of the Diagnostic and Statistical Manual of Mental Disorders (DSM) to categorize mental disorders does not take a personal or situational context into account when determining diagnoses, and has been criticized for being Euro-centric and not necessarily applicable across cultures.[9, 10] Additionally, conceptualizations of mental health problems may differ in AI/AN communities compared with mainstream Western concepts.[11, 12] The complex issues of traumas, including historical trauma, can influence mental health outcomes in AI/AN communities and are often not well understood, recognized or addressed in the current health care system.

INTRODUCTION

Despite these challenges, important work and progress is underway to describe and guide culturally appropriate services to meet the behavioral health needs of AI/AN communities. For example, indigenous-specific conceptual models such as the Indigenist Stress Coping Model describe the ways by which effects of trauma can be moderated by cultural buffers.[13] Conceptual models such as these serve an important role in guiding future work to address and incorporate cultural and historical components in behavioral health care approaches.[13]

This summary of needs, challenges and success is only an initial description of the breadth of information that informs the topic of behavioral health. An extensive environmental scan of the literature on this topic is available in a companion report titled, “Addressing Depression Among American Indians and Alaska Natives: A Literature Review.” The following report describes the current work and success of UIHOs across the county, and the important role of the UIHOs in meeting the behavioral health needs of the communities they serve.

METHODS

Survey Methods

In addition to learning about the type and availability of behavioral health services offered by UIHOs, we also wanted to learn about the extent of evidence-based and best or promising practices in use at UIHOs. We identified the following as important elements of an evidence-based and best or promising practice for urban AI/ANs, and incorporated these elements into specific survey questions:

1. Coordination of care
2. Influences on program design and implementation
3. Outcomes and successes
4. Incorporation of elements of AI/AN culture, traditions and perceptions of health

A staff member at a UIHO reviewed the survey during development and provided feedback on readability.

In February of 2011, an introduction to the project and invitation to participate in the survey was emailed to the Executive Director and select program staff of the 32 operating UIHO and one satellite site. The email included instructions for participating in the survey by phone, online or by completing a paper version that could be downloaded and printed from an email attachment. During the four weeks following the initial emailing, UIHI staff conducted two follow-up phone calls and one follow-up email to solicit participation from those who had yet to respond to the initial request. If at any time the Executive Director or program staff declined to participate in the survey, no further attempts to contact them were made.

Survey data were entered into a database and any responses that were contradictory either within an individual survey or between respondents for a given site were clarified via email with the site. Not all questions were answered within each completed survey; the number of respondents for each question is included with the reported results. Percentages reported were calculated using the number of respondents for the question as the denominator.

In the development of the survey, we strived to use clear language, examples, or definitions to provide clarity of the intent of the survey item. However, individual differences in interpretation of the survey items and language may have influenced the responses chosen.

Interview Methods

In addition to the survey, we also wanted to collect more in-depth accounts of how select programs were developed, how they are maintained, and the successes they have achieved.

Based on survey responses, select UIHO Executive Directors and program staff were invited to participate in an hour-long phone interview, conducted during the months of May and June, 2011. UIHI project staff developed vignettes focused on program highlights based on notes from the interviews and provided a draft to each organization to submit edits, comments, or feedback. A second, updated draft was returned to the participating sites for final approval by program staff, Executive Directors, and any relevant partners.

Programs highlighted throughout this report are characterized by outreach efforts and innovative strategies aimed at reducing or preventing depression. These programs are but a few examples of the excellent work conducted by UIHO across the country.

SURVEY RESULTS

Out of the 32 UIHO and one satellite site operating at the time of survey administration, 24 (73%) sites responded to the survey. Respondents included Program Directors and Coordinators (n=9), Medical Directors (n=5), Executive Directors (n=3) and other program staff (n=7).

Service Delivery Structure

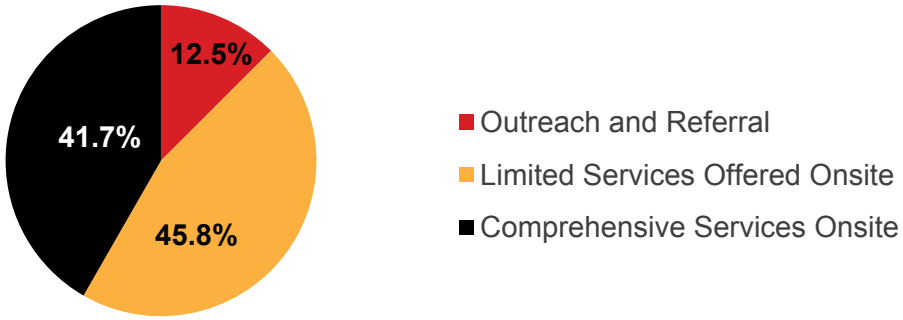
UIHO vary in service delivery structure and the scope of services provided. These structures include outreach and referral, limited onsite ambulatory care, and comprehensive onsite ambulatory care. The UIHI uses the following definitions to characterize service delivery structures of UIHO:

Outreach and Referral Site refers to organizations that provide education services and outreach to engage and connect urban AI/ANs to healthcare services. These agencies do not directly provide clinical care.

Limited Services Site refers to organizations that provide some clinical care onsite, as well as education and referrals to other community providers.

Comprehensive Services Site refers to organizations that provide a full range of medical and in some cases dental services.

Figure 1: Service Delivery Structure of UIHO (n=24)



Behavioral Health Programs and Services

In addition to the type of behavioral health services offered, the level of availability is also an important aspect of patient access to care. The following definitions were used to characterize the availability of behavioral health care:

Fully Available means that the service is available with little to no restrictions. Examples include: no limit on number of people who can access service; services available on most days; or that there is financial assistance available.

Limited Availability means that the service is available but with some restrictions. Examples include: there are a limited number of people who can access service; service is available on limited number of days; or economic barriers exist, like high co-pays.

Referral means that patients are provided information and/or support to access services the organization does not provide directly.

SURVEY RESULTS

PROGRAM HIGHLIGHT

UNITED AMERICAN INDIAN INVOLVEMENT, INC. (UAII) LOS ANGELES, CALIFORNIA

"Where do I come from? Where have I been? Where am I going? Where do I belong?"

These are the four questions that are the framework for the United American Indian Involvement's program "Walking In a New Direction" or W.I.N.D. Based on the American Indian medicine wheel, it is through these four questions that youth explore their personal and cultural history, focus on behaviors that promote emotional and spiritual well-being, set individualized goals and develop a sense of belonging. Central to all components of W.I.N.D. is introducing and connecting youth with American Indian cultural experiences and traditions.

Since 2009, UAII has received funding from Indian Health Service's Methamphetamine and Suicide Prevention Initiative to develop and implement the W.I.N.D. program. By incorporating resources from White Bison, Administration for Children and Families, Suicide Prevention Resource Center, and other local sources UAII conducts a series of workshops and activities to reduce methamphetamine use, reduce prevalence of depression and prevent suicide among American Indian youth ages 14 to 17.

W.I.N.D. consists of two primary components including educational workshops and treatment. The workshop series educates youth on the issue of depression to begin to overcome stigma associated with mental health topics. These workshops also help youth understand what depression is and what behaviors or environments can trigger it. A broad range of topics related to well-being are addressed, including healthy behaviors and relationships, violence prevention, gender identity and sexual orientation, continuing education and employment opportunities.

In addition to workshops, field trips, and presentations, events are also coordinated to allow youth to learn about the history of the American Indians of the region. Workshops are facilitated as open discussions to allow youth the opportunity to be teachers as well. After each workshop session, staff debrief to ensure that the curriculum is meeting the needs of the youth and to strategize ways to incorporate participant input and feedback. In this way the curriculum is dynamic, continuously evolving with the participants.

W.I.N.D builds on existing programming and infrastructure at UAII so that staff are also able to provide treatment services, such as counseling for depression and chemical dependency, and resources including referrals and assistance with funding for residential treatment. Youth participating in W.I.N.D. are screened for depression using the Patient Health Questionnaire – 2 Item Version. Youth that screen positive receive further screening and follow-up with a mental health counselor who is involved in the workshops.

One-page satisfaction surveys completed by the youth have shown that the majority of participants learned new information, enjoy the programming and would recommend W.I.N.D workshops to friends or family members. These successes, accomplished in part through the development of trust and rapport, have taken time. Recruitment and retention of participants was initially challenging. In addition to recruitment flyers at the UAII clinic, program staff recruit participants through existing UAII youth programs and other area agencies including the Los Angeles Unified School District Title 7 Indian Education Program, the County of Los Angeles Tribal Temporary Assistance for Needy Families and the Department of Children and Family Services. To encourage attendance and retention, W.I.N.D. offers incentives including meals, snacks and gifts cards to participants. An ongoing challenge and goal for program staff is to find creative solutions to overcome logistical barriers with transportation and outreach in such a large service area as Los Angeles.

For more information about UAII's W.I.N.D. program contact Al Garcia at (213) 202-3970 or agmidrunner1@aol.com.

SURVEY RESULTS

UIHOs offer a wide range of services to address the behavioral health needs of the communities they serve. These include services that are preventive-focused (e.g. screening programs), as well as services that are treatment- and management- focused (e.g. substance abuse treatment programs, therapy or counseling, medication management). Services are provided through onsite (full or limited availability) and referral mechanisms.

Figure 2: Type and Availability of Depression Related Services

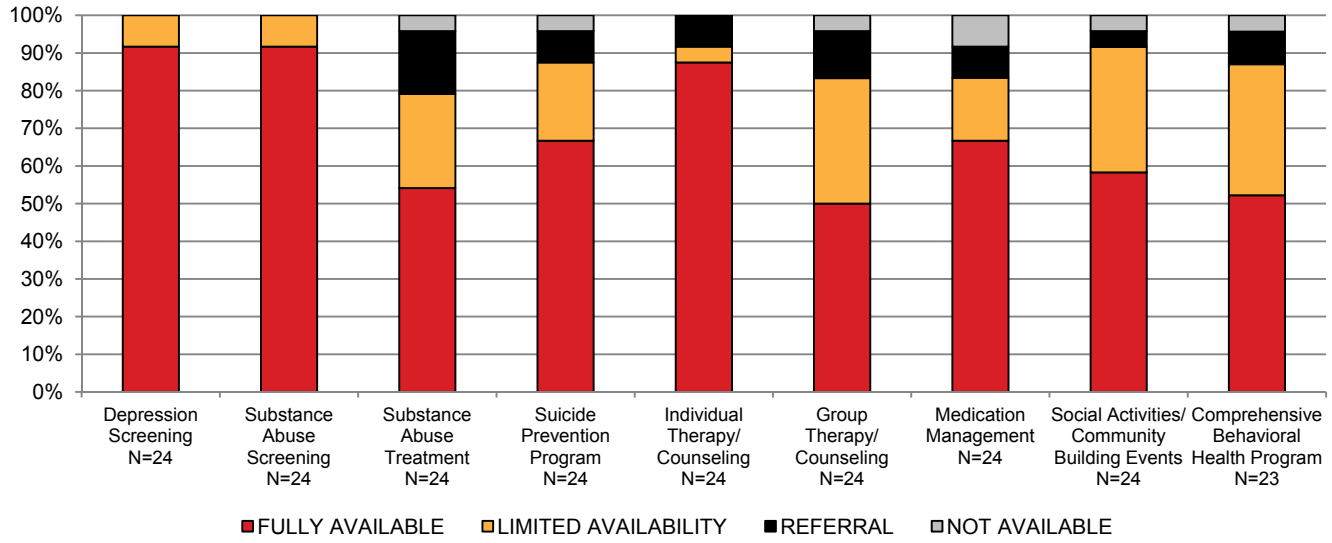


Figure 2 illustrates the availability of various behavioral health services and activities. Although the provision of services onsite or by referral varied by UIHOs, each of the services addressed in the survey was reported as available onsite or by referral at more than 90% of UIHOs. However, the extent of support to ensure follow-up for referrals or access to referral organizations and providers is unknown. They are likely varied and may introduce additional barriers and challenges.

Depression screening, substance abuse screening and individual therapy or counseling represent the most widely available services, with 88-92% of responding UIHOs reporting these services as fully available and 100% of responding UIHOs offering these service either on-site or through referral. While more UIHOs identified medication management as not available compared with other services, it remained as either a fully- or limited- available service at more than 80% of responding UIHOs (Figure 2).

In addition to the services listed in Figure 2, respondents also described a variety of other behavioral health related services offered at their organization. Some of the services identified included cultural activities such as sweat lodge ceremonies and access to traditional healers; programs for anger management, domestic violence batterers and domestic violence survivors; Alcoholics Anonymous groups; kids club; parenting curriculum; and a variety of groups such as women's wellness and a young men's group.

SURVEY RESULTS

PROGRAM HIGHLIGHT

NEBRASKA URBAN INDIAN HEALTH COALITION, INC. (NUIHC) OMAHA, NEBRASKA

The Nebraska experience provides an example in which clinic staff observed an issue among their patient population, created a measurement system for identifying those with the health issue or early warning signs, and took steps to integrate this measurement system into its standard patient intake procedures using existing resources and staffing.

In 2005, staff at the Nebraska Urban Indian Health Coalition (NUIHC) noticed that many adolescents participating in community events seemed withdrawn and quiet. Informal discussion amongst providers and clinic staff found that many of the youth they were seen in primary care were exhibiting signs of depression. As a group, NUIHC staff committed to identify those with depression and empower them to take steps to improve their wellbeing and manage their depression. Clinic leadership and staff prioritized integrating depression screening into primary care.

After researching depression screening tools used in family practice settings and consulting with the regional mental health center, NUIHC tested a two question survey among clients to make sure it was understandable and acceptable. There was initial resistance from parents and guardians to having minors complete this questionnaire. However, through a series of community meetings that addressed the epidemic of depression among American Indians and Alaska Natives (AI/AN), simple steps that can be taken at home to reduce depression and resources that are available to families, NUIHC was able to secure support of these key stakeholders.

Since its implementation, all patients ages 12 and older are asked to complete this brief screening tool at every point of entry into the clinic and at every visit. Patients are given a private space to complete this questionnaire and reassured of their confidentiality.

Providers score the responses and provide appropriate follow-up during the visit. Through a partnership with Community Mental Health, NUIHC is able to connect patients with mental health providers that offer services on a sliding scale fee system. However, finding mental health professionals that offer free services or accept Medicaid/Medicare is difficult and those that do often have long waiting lists. In response, NUIHC has developed a Depression Action Plan that providers can use as an immediate intervention. The Depression Action Plan focuses on empowering patients by educating them about steps they can take at home to manage their depression and helps them to map out healthy responses to their symptoms.

NUIHC tracks the number of screenings conducted, patients diagnosed with depression, referrals to mental health providers, and patients on medication in a depression registry. This registry is an index card system that includes all of the patient's pertinent information and their Action Plan. This level of information supports staff follow-up, which sometimes involves a home visit. Patients have the opportunity to provide feedback regarding all clinic services through monthly satisfaction surveys, a feedback box, and participation in patient advisory committees. This feedback is used to ensure patient-centered care and as well as make adjustment to any practices that may not be working well for patients.

Consensus among dedicated staff to address depression in their patient population enabled the development of NUIHC's depression screening tool. By integrating this tool into already existing clinic structures and processes NUICH has been able to achieve 100% depression screening of all patients ages 12 and older without any supplemental funding.

For more information about NUIHC's depression screening contact JoAnne Scott, BSN, MSN Clinic Administrator and SDPI Project Coordinator at 402-434-7177 or jscott@nuihc.com. More information about the Action Plan used by NUIHC can be found here:

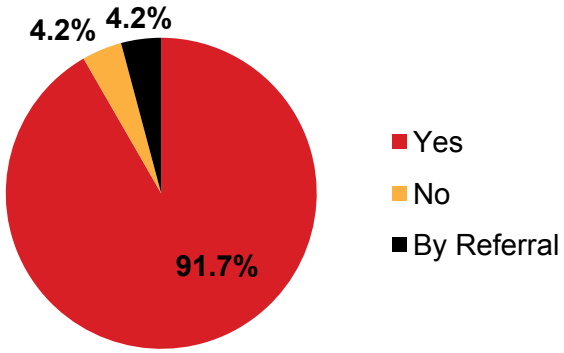
http://www.depression-primarycare.org/clinicians/toolkits/materials/patient_edu/self_mgmt_2/

SURVEY RESULTS

Incorporating AI/AN Culture

Culturally tailored interventions are shown to be significantly more effective in improving health outcomes and providing accepted programs.[14-17] Incorporation of cultural practices and traditions into programming is also important for addressing social isolation and supporting cultural identification among urban AI/ANs. Social isolation – a combined isolation from resources, support networks, job networks, and cultural and spiritual groups – increases stress and stress related health behaviors that negatively impact health outcomes.[18]

Figure 3: Incorporation of AI/AN Culture Into Behavioral Health Services (n=24)



There are many ways that AI/AN culture may be incorporated into services. Examples include drumming, storytelling, promoting Native culture and arts, or peer mentorship. When asked if AI/AN culture was incorporated into depression related services, nearly all survey respondents (95.9%) reported that they were doing so, either directly through the services they provide (91.7%) or through referral to other programs or to traditional healers (4.2%).

SURVEY RESULTS

PROGRAM HIGHLIGHT

NATIVE AMERICAN HEALTH CENTER || FAMILY & CHILD GUIDANCE CLINIC (FCGC)
OAKLAND, CA

Monitoring and evaluating program outcomes has increasingly been emphasized to secure program resources and support. Creativity and knowledge of Native traditions are required to develop methods that capture the impact of traditional approaches to improving health. The Native American Health Center's Family and Child Guidance Clinic (FCGC) shows their commitment to improving programming to best meet the needs of their community while simultaneously maintaining accountability to funders through the successful ongoing work of an evaluation team.

Over the last ten years, FCGC has conducted program evaluation by ensuring a portion of funding from all grants be allocated to a dedicated evaluation and data management team. This evaluation team works collaboratively with clinic staff to develop and implement monitoring and evaluation tools. All members of the FCGC staff receive training from the organization's cultural facilitator to support a culturally competent approach to their work.

While the team matches specific evaluation methods to the diverse activities the clinic offers, respect for clients is always central. To overcome initial challenges with community reluctance to participate in evaluations, clinic staff and the evaluation team are always transparent with clients about evaluation efforts, the benefits of participating in evaluations for the clinic and for the individual, where the data will go, who will see it and how it will be used. FCGC uses everyday language to involve clients in evaluation efforts early and often. When funding allows, FCGC will include incentives for clients participating in evaluations. Additionally, once the data has been analyzed the evaluation team makes sure to return the results to the community at Advisory Council meetings, through reports and through one-on-one conversations.

FCGC has employed a variety of both quantitative and qualitative techniques to paint a picture of the impact of their services. Some standard tools are required by funders, such as GPRA, but the evaluation team has also developed their own tools to track cultural connectedness and trauma. Approaches such as focus groups, intake and three to six month follow-up interviews allow the clinic to have a deeper understanding of program outcomes. The team is now starting to work with digital media and photography to incorporate storytelling and images into their evaluations.

In addition to techniques that respect Native historical and lived experiences, evaluation staff recommend starting at the end when designing an evaluation; thinking about what you want to show and how to get there. Having a clearly laid out plan and logic model, while remaining flexible to the input received from the clients and community, has helped the FCGC conduct successful evaluations.

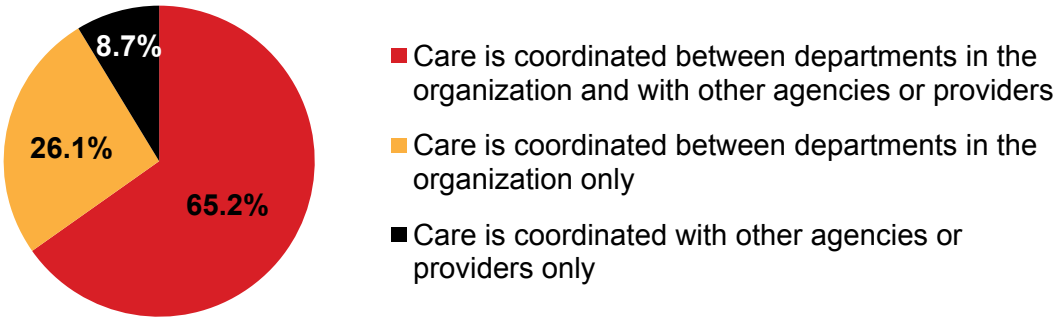
For more information about FCGC's evaluation team contact Serena Wright at 510434-5464 or serenaw@nativehealth.org.

SURVEY RESULTS

Coordination of Care

Coordination of care is critical for improving patient access to comprehensive services and realizing improvements in health outcomes. A collaborative, on-going process, coordination of care assures smooth transitions between systems and services for patients.[19] Not only is coordination of care an opportunity to increase patient satisfaction, but it helps support patient compliance.[20-22] Additionally, studies examining the benefits of coordinated care for depression treatment have shown significant improvements in measures such as depression-free days, and treatment response and remission outcomes.[23, 24]

Figure 4: Coordination of Care for Behavioral Health Services (n=23)



Survey respondents were asked if and how the behavioral health services at their organization were coordinated with other services or care. All respondents (100%) indicated that care was coordinated at their agency. The majority of respondents coordinated care both between departments in their organization and with other agencies or providers (65.2%), while 26.1% reported that care was only coordinated between departments in their organization and 8.7% reported that care was only coordinated with other agencies or providers.

SURVEY RESULTS

PROGRAM HIGHLIGHT

NATIVE AMERICAN COMMUNITY HEALTH CENTER, INC. DBA NATIVE HEALTH

PHOENIX, AZ

With a highly mobile client population, including patients moving throughout the city as well as between reservations and the city, it can be challenging for UIHO providers to locate patients for required follow-up. The experience of the Native American Community Health Center (Native Health) provides an example in which clinic staff recognized the utility of new technology and social media to address this ongoing challenge.

New forms of media, such as social networking websites and blogs, offer users the ability to instantly share and update information, are accessible to the public at no cost, are easy to use, have the ability to reach one targeted individual or larger audiences, and can transform communication campaigns into interactive dialogues. Access to the internet is widespread and is a source that many Native Health patients go to get information. Twitter, a mini-blog of 140 characters that broadcasts information to subscribers, is also increasingly being integrated into communication strategies. Advocates for the use of Twitter and Facebook at Native Health emphasize that this is another tool to reach the community in a non-invasive, non-threatening way. It respects the patients' ability to opt-out, while still raising awareness of often stigmatized conditions such as depression or HIV.

Four years ago, ambitious staff at the Native Health realized that many of the youth involved in their behavioral health programs were utilizing Facebook. Staff recognized the value of Facebook as a free account, accessed by youth no matter where they were and began to use this approach for patients in follow-up under an HIV grant.

Since this first use of Facebook to locate and engage young patients thought to be lost-to-follow-up, social media use at Native Health has expanded to the entire agency and is used to publicize events and services, as well as share health education messages to the broader patient population. In preparation for this expansion, staff took every opportunity to learn more about social media from free webinars, trainings and sessions at national conferences as well as from government agencies such as SAMSA, CDC, HRSA and NMAC. To compliment the Facebook page and Twitter, Native Health keeps an active website, including links to clinical forms that patients can fill out before coming in for an appointment.

All communication through Facebook, Twitter and the website are managed by one staff member. Once a week this staffer collects information from the all clinic departments about services, events and timely relevant health messages they want to get out to the community. This staff person then posts this information to the various media outlets and ensures the website is accurate and up-to-date. Centralizing the distribution of communication helps to make the messages consistent and clarifies responsibility for this task.

Supportive leadership has been essential in making sure that staff have adequate time to maintain the website, Facebook page and Twitter, and keep information up-to-date so as not to lose regular visitors. While it can be time consuming to respond to comments or posts, staff recognize that it ultimately increases the community's engagement with services. Native Health tracks the number of hits and followers on the various social media sites and website links; data that helps staff tailor events and information to community members' interests. Currently, Native Health has over 6,000 users subscribing to their newsletter. Just three months in to the agency's use of social media, they have 38 Twitter followers and 108 friends on Facebook with these numbers growing. Looking to the future, Native Health would like to continue to expand their reach by developing text message alerts and reminders for patients.

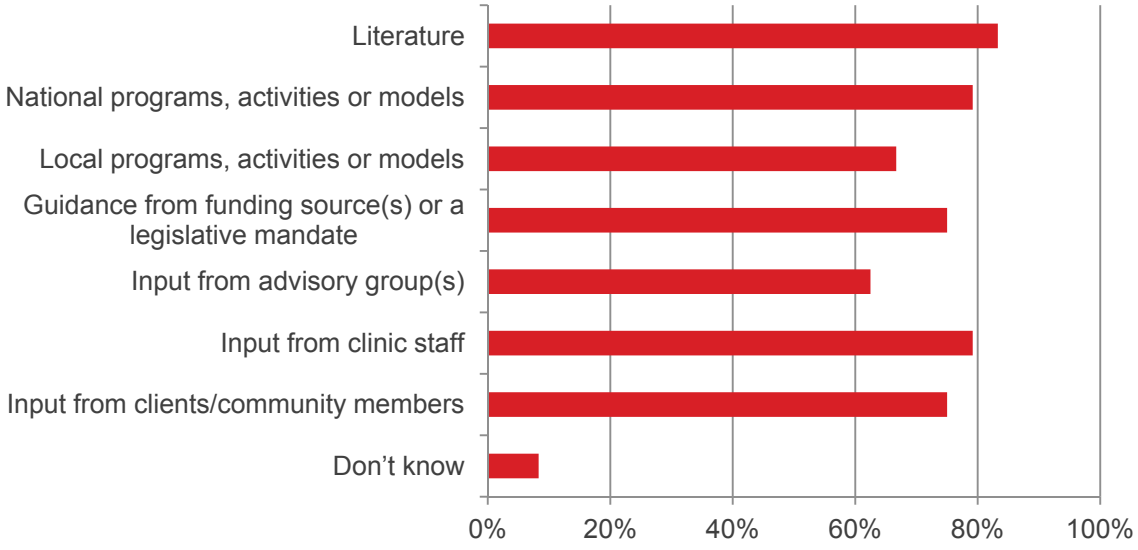
For more information about Native Health's social media contact Dennis Huff at 602-279-5262 ext. 3201 or dhuff@nachci.com or Orenda Hill at 480-309-8942 or ohill@nachci.com.

SURVEY RESULTS

Influences on Program Design

Increasingly, public health and health care funding sources require that grantees implement evidence-based or best practice interventions as a stipulation of funding. This requirement can pose challenges for UIHO since most evidence-based practices were not developed or tested in the AI/AN population. As a result, these interventions may not be culturally appropriate or effective for use within urban AI/AN communities and UIHOs may have to look broadly to multiple sources or adapt evidence-based interventions to inform and direct their program work.

Figure 5: Reported Factors that Influenced Program Design and Implementation (n=24)



Survey respondents were asked to identify which factors influenced the design and implementation of their behavioral health programs or activities. Most frequently identified factors included literature, national programs, activities or models, and input from clinical staff. Each source was reported to be used by more than 60% of survey respondents. Local culture specific to the region was also noted by one respondent to be a factor that influenced program design and implementation.

What Makes a Program Work?

Using an open-ended question format, UIHOs were asked to identify specific factors that support their behavioral health programs' successes. Responses are summarized below to describe effective strategies and share lessons learned.

Program and Service Characteristics

Respondents most commonly identified specific elements, or characteristics, of programs and services as contributors to the success of their behavioral health efforts. Most frequently identified of these characteristics was the integration of **cultural components** into programs and services such as youth programs, recovery programs and other behavioral health services. Examples of culturally-based activities included traditional drumming and singing, group activities and peer mentorship.

Another frequently identified program and service characteristic supporting success was **flexibility** and a client-centered approach, which not only includes the participation of patients in their care, but the provision of services to meet the individual needs of the patient.[25] Examples of this flexibility included

provision of services off-site, when needed, and the prioritization of patients' needs over what was easiest for the program.

An additional element identified as contributing to program and service success was **coordination of care**. A cited mechanism for this coordination was integrated teams with representation from behavioral health, chemical dependency, mental health and medical departments, and the availability of **services on-site and the co-location of services on-site**. The availability of services on-site and the co-location of services provide opportunities for coordination of care between disciplines and were also noted to increase attendance for services.

Staff

Many respondents noted the importance of their staff as a contributing factor to behavioral health program success. Key among staff attributes noted by respondents was staff **expertise**. Also cited was staff **longevity** at the agency, **leadership** from staff and the agency board of directors, and **teamwork**. Value was also placed on having **Native** staff members and staff who were **active and credible in the community**.

Transportation

Respondents frequently identified elements that supported access to behavioral health services as key components to success. Most common among these elements was **transportation** support, often noted as a very important factor that improved attendance and supported attendance consistency.

Partnerships

Several respondents identified the importance of **partnerships** and collaboration as a contributor to the success of their behavioral health programs and services. Partners identified included community agencies, Indian Health Service, tribes and universities.

Achievements

An open-ended survey question asked UIHO to share successes from their behavioral health programming. Themes from these responses describe examples of what success looks like and the achievements UIHO behavioral health programs are reaching. The themes below summarize UIHO responses to this question.

Feedback

Survey respondents frequently reported positive feedback as a successful outcome of their behavioral health services and programs. Positive feedback included **client reports** of feeling welcomed and respected, expressing appreciation for the programs and services, and a desire for the programs and services to continue operation. It also included acknowledgment of the positive role of programs' **cultural components** and **Native staff** in helping people feel connected, contributing to long-term successes, and increasing people's understanding of their addictions. Positive feedback also included a positive **reputation in the community**, positive **feedback from other organizations**, and **referrals**.

Services

Survey respondents frequently identified **program or service improvements** as successful outcomes of their programming. Increased and expanded depression **screening** was commonly identified**,** including

an increase in the number of patients screened, the number of departments conducting screenings, and milestones such as implementation of 100% depression screening for all patients.

Patient Outcomes

Survey respondents identified a variety of patient-level outcomes as successes. These included **lifestyle and behavior changes**, such as positive, sustained lifestyle changes, improved quality of life and decreased substance abuse. Respondents also reported successes in patient's **clinical outcomes**, such as decreased depression and anxiety.

Participation

A number of sites identified positive changes in patient participation in behavioral health programs and services. Indicators of improved participation included a **high demand** for services, **low no-show** rates, and client **follow-through** in accessing services.

Organizational and Administrative Achievements

It is important to recognize success on the organizational level as well as the participant level. Organizational level successes reported by respondents included increased staff **preparedness**, expanded clinic **certification** and achievement of **accreditation**.

DISCUSSION

Findings from the behavioral health survey and key informant interviews illustrate the multiple ways in which UIHOs are responding to the behavioral health needs of the communities they serve. Information collected exemplifies the diverse range of services that are offered, and the ways in which services are planned, delivered and coordinated.

Services

It is important to recognize that despite limited funding, UIHOs successfully implemented a diverse range of behavioral health services, either onsite or by referral. Services more commonly identified as "not available," such as medication management or comprehensive behavioral health programming, may represent areas with unique implementation challenges and potential areas where expansion or support may be beneficial.

In addition to coordination of care within their agencies, survey results indicate that UIHOs are also well positioned to implement coordinated systems of care with other agencies. The current service delivery structure (45.8% of UIHOs offering limited services onsite and 12.5% of UIHO offering outreach and referral services) suggests that relationships may already be in place to support coordinated care with other agencies. Additionally, 65.2% of respondents indicated that care was coordinated within the organization and also with other agencies or providers, and an additional 8.7% indicated that care was coordinated with other agencies or providers only. These inter-agency relationships may be important starting points for further efforts to build collaborative partnerships and coordinated systems of care between agencies.

Organizations also have successfully incorporated AI/AN culture into services, with nearly 92% of survey respondents indicating that AI/AN culture was integrated into on-site behavioral health services. When respondents discussed program successes, the incorporation of AI/AN culture into services and the provision of on-site coordinated services were identified as elements that positively affected patient satisfaction and outcomes. Cultural components may represent important elements for future program success and strengthening.

Survey findings also indicate that UIHO are drawing from a diverse pool of resources and stakeholders to inform the design and implementation of their programs and services, but the extent to which models have been adapted to AI/AN communities is unclear. As we look to the future, it will be important to include urban AI/AN in research that informs evidence-based practice, and simultaneously recognizes additional stakeholder groups such as community members and advisory councils as valuable contributors to inform programs and services.

Achievements

Cultural components were most frequently identified by survey respondents as a factor that supported behavioral health program successes. Similarly, positive feedback from clients - reported by respondents as a successful program outcome - often acknowledged cultural components and Native staff as program elements that contributed to their positive outcomes and achievements. These consistent findings indicate the important role that cultural components play in the success of behavioral health programs, and the value that is placed on cultural activities by clinic staff and patients alike.

When asked to identify factors that supported their program success, respondents also frequently identified program characteristics that likely impact access to care. For example, several respondents noted that flexibility to provide services off-site when needed, to coordinate care between departments,

DISCUSSION

and to co-locate services on-site, all supported their program's success and resulted in increased client attendance. Transportation was also identified as a factor that supported program success by improving attendance. Activities and structures that improve access in turn may lead to some of the indicators of success reported, including increased attendance and consistent attendance among patients. In fact, when asked to identify indicators of program successes, respondents often noted client participation, including a high demand for services, low no-show rates, and client follow-through, as a success. These findings suggest that access to care, including service delivery structure and the availability of direct support services such as transportation plays an important role in the provision of services and the achievement of successful outcome measures.

Finally, while success often focuses on patient-level measures such as attendance rates and positive clinical or behavioral outcomes, it is also important to recognize administrative-level successes. For example, respondents noted the programmatic achievement of 100% screening rates for depression among patients as a contributor to their program success, and identified the achievement of accreditation or increased staff preparedness as a programmatic success. These administrative measures are important to recognize and celebrate, as they build the internal capacity and strength of the organization, and in turn, enable the organization to further support patient and community-level successes.

Over the years, UIHOs have experienced many great successes, and have implemented a number of programmatic measures and administrative practices to achieve such success. While these successes mark important milestones for UIHOs and behavioral health programs, they also serve an important role in informing next steps for future program growth, adaptation and implementation. As UIHOs continue to strive to meet the behavioral health needs of the communities they serve, it will be beneficial to build from past work and lessons learned to help inform ongoing efforts and future planning.

RECOMMENDATIONS

Findings in this report provide information on the services, structures and accomplishments within the UIHOs' behavioral health services and programs. To build on the strengths and achievements of these behavioral health programs, more funding must be invested in urban programs to support AI/AN workforce development, evaluation efforts and delivery of culturally-tailored prevention and treatment services.

The chronic underfunding of the urban programs continues to restrict access to services for urban AI/ANs. Despite over two-thirds of AI/AN people living in urban areas, UIHOs receive less than 1% of the federal IHS funding. These funds pay for more than just behavioral health services, making the financial contribution to address behavioral health issues highly deficient. Additionally, traditional health services are not considered a reimburseable service by public or private insurance. The small grant funds used to support these services are not easily attained or stable enough to warrant a sustained service strategy.

Additional funding to support the development of the AI/AN workforce is also essential as Native staff directly offering behavioral health programs was frequently identified as an important component of program success. Efforts to expand the representation of AI/ANs among behavioral health professionals are critical to enhancing the successful implementation of behavioral health programs. Building a pipeline program to recruit and train more Indian people to work in these fields is essential. Early education support for AI/AN youth, professional development for AI/AN adolescents, and establishment of pathways from colleges and universities to facilitate AI/AN placement in health care professions is crucial. Supporting the growth and expansion of the AI/AN workforce in health services will further strengthen the unique and valued qualities of care provided by UIHOs.

Finally, funding to support evaluation efforts at UIHOs is severely lacking. While patient satisfaction is an important indicator of acceptability and utilization, there is a large gap in evaluation of UIHO programming to address behavioral health concerns. An evidence-base for prevention and treatment of behavioral health concerns of urban AI/ANs must be built through research, training and technical assistance for UIHOs. Conducting outcome evaluations of current practices and using these findings to expand services and demonstrate their value is needed. Resources for evaluation will improve our understanding of what activities contribute to positive outcomes and how those outcomes are achieved. Evaluations should also consider the comparative effectiveness of recommended approaches versus current standards of care that include cost-effectiveness as well as what works best for whom, under what circumstances. This evidence-base is also critical to secure funding from agencies that require that grantees implement evidence-based best practices, most of which have not been developed or tested in urban AI/AN communities.

UIHOs play a unique and valuable role as a source of culturally appropriate health care and preventive services for urban AI/AN communities. The value of these services cannot be overstated, and were further reinforced with the findings of this report. Efforts to support and expand behavioral health services must recognize and appreciate the value that culturally appropriate services provide in urban AI/AN communities. Funding agencies of all types, grantors and insurers, must give consideration to the incorporation of AI/AN perspectives on wellness and the application of cultural practices and traditions in care. Program structure and service delivery models must allow for flexibility in and adaptability to be culturally appropriate. Creating funding and programmatic opportunities such as these will help to assure the resources to sustain and expand the unique role of UIHOs in providing culturally appropriate behavioral health prevention and treatment services for the urban AI/AN population.

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APPENDIX A

SURVEY INSTRUMENT

Addressing Cardiovascular Disease and Behavioral Health:
A Survey of Urban Indian Health Organizations

This survey asks about the cardiovascular disease (CVD) and behavioral health programs and services your organization provides. By taking this survey, you will help us understand what is being done to help reduce the burden of CVD and depression in our community. This information will be used to inform a report highlighting the best practices among urban AI/AN and lay the groundwork to strengthen the services available to your clients.

This survey is voluntary and will take about 10-20 minutes to complete. All responses will remain confidential; however we may contact you to request clarification or further information.

If you don't know the answer to some of the questions in the survey, we encourage you to answer as best as you can and seek further information from others in your organization.

When complete, please email this survey to juliel@uihi.org or fax to 206.812.3044.

Surveys will be accepted until February 22, 2011

1. Please tell us a little about yourself.
   Name:
   Job Title:
   Contact information:
      a. Phone:
      b. Email:
   City:

2. What is the name of your organization?

3. Please select the option that best describes your organization:

☐ Outreach and referral agency
☐ Limited direct services provided on-site
☐ Comprehensive direct services provided on-site

Questions 4-10 focused on cardiovascular disease and are not included here.

We are also interested in services you CURRENTLY provide related to the prevention, treatment or management of depression.

11. For each of the following behavioral services, please check if the service is **fully available** at your organization, your organization has **limited availability**, your organization provides **referral**, or **not available.**

Fully Available means that they are available with little to no restrictions. Examples might be that there is no limit on number of people who can access service; services available on most days; or that there is financial assistance available.

APPENDIX A

Limited Availability means that they are available but with some restrictions. Examples are: there are limited number of people who can access service; service is available on limited number of days; or economic barriers exist, like high co-pays.

Referral means that you provide patients with information and/or support to access services your organization does not provide directly.

	Fully Available	Limited Availability	Referral	Not available
Screening for depression	☐	☐	☐	☐
Screening for substance abuse	☐	☐	☐	☐
Substance abuse treatment	☐	☐	☐	☐
Suicide prevention program	☐	☐	☐	☐
Individual therapy/counseling	☐	☐	☐	☐
Group therapy/counseling	☐	☐	☐	☐
Medication management	☐	☐	☐	☐
Social activities/community building events	☐	☐	☐	☐
Comprehensive behavioral health program	☐	☐	☐	☐

12. Please describe any behavioral health activities or services your organization provides *not listed above*.

13. Do any of your behavioral health programs/interventions incorporate elements of American Indian/Alaska Native culture? For example, do you use the medicine wheel to address addiction?

☐Yes ☐No ☐By referral

14. Are the behavioral health services at your organization coordinated with other services or care?

☐ Services are coordinated **within organization** (i.e. coordination of client's care between departments within your clinic)
☐ Services are coordinated **with other agencies/providers** (i.e. coordination of client's care between your site and referral sites)
☐ Services are not coordinated
☐ Don't know

15. What factors influenced the design and implementation of your behavioral health programs or activities? Please check all that apply.

☐ Literature
☐ National programs, activities or models
☐Local programs, activities or models
☐Guidance from funding source(s) or a legislative mandate
☐ Input from advisory group(s)
☐Input from clinic staff
☐ Input from clients and community members
☐ Don't know
☐ Other (specify)

APPENDIX A

16. What factors do you think contribute to the success of your behavioral health programs or activities? For example, has providing transportation increased attendance at programs?

17. What successes have you seen from the behavioral health programs or activities? For example, has there been an increase in the number of people screened for depression or have you gotten positive feedback from participants?

18. In the upcoming months and years, there may be opportunities to collaborate with other agencies, including the UIHI, to support your work in these two areas. Are you interested in partnership opportunities?

☐ Yes
☐ No
☐ Maybe

[redacted]

Thank you for completing this survey! Your feedback is essential to the work that we do.
If you have any questions or comments, please feel free to contact Julie Loughran at 206.812.3042 or by email juliel@uihi.org.

APPENDIX B

INTERVIEW QUESTIONS

Section 1: Background

1. Can you tell me a little about the history of [name of program]?
    a. When did you first start offering this program?
    b. Where did the idea for [program] come from?
    c. How did you decide to focus on [activity type, topic, etc]?
    d. Why was this approach taken?
    e. Where did funding come from?
    f. Do you partner with any other agencies or organizations on this program?
2. Can you tell me more about [program] itself?
    a. Who is the target population?
    b. Are there written goals or objectives? If so, what are they?
    c. What activities are a part of the program? (For staff and for clients)
    d. Why did you choose these activities?
    e. What elements of program make it a good fit for urban AI/AN?

Section 2: Monitoring and Evaluation

3. What do you consider to be the key indicators of success for this program?
4. How do you track what the program is accomplishing?
5. What outcomes do you measure through this program?
6. How does staff collect and record outcomes information (checklists/forms/other instruments)?
        i. How often is this information collected?
7. Are there any mechanisms in place for participants to provide feedback? If so, what are they?
        i. How often is this information collected?

Section 3: Lessons Learned

8. Can you tell me about the greatest challenges you faced in implementing [program]?
        i. What have you done to overcome these challenges?
9. What barriers have you encountered in maintaining [program]?
        i. What have you done to overcome these barriers?
10. What changes have you made to [program] since it was first implemented to make it work better for staff? What about for clients?

APPENDIX B

11. What are key recommendations you would make for other UIHOs that would like to implement a similar program?

12. What are specific considerations UIHOs should take into account when deciding if this is a good approach for them?

13. Are there any resources you would recommend to UIHOs interested in implementing a similar program?

Section 4: Closing

14. Is there any else you would like to share about [program]?

15. Could we list [program name]'s contact information for questions? If "yes": What is the best information to list?

16. Do you have any written materials, brochures or publications about this project you can share with me