

GLITEC GAZETTE

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GREAT LAKES INTER-TRIBAL EPIDEMIOLOGY CENTER



***“Tell me and I’ll forget.
Show me, and I may not
remember. Involve me, and
I’ll understand.”***

Native Proverb



USING DATA TO SUPPORT YOUR CAUSE...WHAT IF THEY STILL DON'T BELIEVE YOU?

How often have you prepared for a meeting or presentation, developed your position, listed your reasons, thought ahead about potential arguments and convincingly articulated your request only to hear in response, **“Where are the numbers?”** Well, most of us now realize the

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importance of having the numbers (data) to support a request, prove a point, state a case, and make a claim or line up a defense. We have also learned the importance of citing the source. The use of credible and reliable sources can make the difference between a trusting or a suspicious audience (audience can be many or one person).

Do you present the data first, state your rationale and then make your request? Or, do you make your request, state your rationale and then present the data? You may have discovered which works best for you and shift the order depending on the situation. You may have witnessed that neither makes a difference regardless of a trusting or suspicious audience. In other words, a suspicious audience is an unbelieving audience. Unfortunately, sometimes we think that collecting and presenting **more** data will change a suspicious audience into a trusting audience, or the audience will believe us more. This thinking might be missing an important point.

So, in some cases, why wouldn't the use of objective data achieve the desired impact? Here are some things to examine:

- The data you present contradicts an existing value; believing your data might mean giving up a deeper value. Example: *Data demonstrates that smokers are at higher risk for cancer and you request support for smoke free policy. The audience disclaims the data responding that many things cause cancer. The unspoken and deeper value is “free choice”.*

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- The data you present places the audience in an embarrassing or dangerous situation if they express agreement or belief. Example: *Data illustrates that preparation for a disease outbreak is warranted to save lives and cost. The audience knows they just eliminated the staff allocation dedicated to disease surveillance from the budget.*
- The data you present diminishes the interest and investment of the audience in their own cause creating competing causes. Example: *The data presented supports the addition of a new community health worker. The audience realizes the budget won't permit two new positions and champions their need for an administrative assistant.*

Well, what can you do about it? It's frustrating to gather good data from good sources only to feel defeated when the audience doesn't respond in the manner you would like, or challenges your intentions. In these situations, you would benefit from asking a different set of questions. Instead of, "How can I use/present the data to influence the decision?" Or, "How can I change the audience's belief?" Try, "How can get the audience to see what I see?" Or, "How can I involve the audience in understanding the data and constructing *their* conclusion?"

I recommend the following:

1. Learn something about your audience.
2. Invite the audience to hear and see the data, ask clarifying questions and then ask "What do you think this suggests?" "What do you think it means?" "What do you think should be done?"
3. When you encounter a negative response to the data, imagine that the response is just the tip of the iceberg. The roots of the response lie beneath the surface. Look for the possible reasons and develop a data strategy to address the roots.
4. Ask questions like, "What do you think is missing in the data?" "What story is the data leaving out?" "What should be added in order to complete the picture?"
5. Pay attention to your sources and any potential root conflicts the source may provoke.
6. Ask collaborative questions like, "How should **we** approach these data?" "What can we do to move forward to get our needs met?" "What other data should we include?"



Be prepared to set the data aside in order to seek understanding and acknowledge contradictions and conflicts. Once the audience feels unjudged and understood, the data negativity may go away.

Remember that data is a useful and compelling tool to document and convey objective findings, only if you create and maintain a trusting, accepting and understanding relationship. So, work on the "people" part and the "numbers" part will make a difference.

SUN SETTING FOR OUR COMMUNITY TRANSFORMATION GRANT

It is with sorrow that I write this article for our newsletter.

While the Community Transformation Grant (CTG) was originally funded through dollars appropriated from the Affordable Care Act's Prevention and Public Health Fund, the funding for CTG through The Centers for Disease Control Prevention (CDC) was removed from the 2014-2015 federal budget. The budget was passed and signed into law which means that our CTG grant will be ending in September of 2014, two years earlier than expected. At least eleven staff at GLITC and the Tribes are funded in whole or in part with CTG funds.

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The CTG grant gives communities the opportunity to develop and implement initiatives to prevent chronic diseases, the leading causes of death and disability. The program's goal is to create healthier communities by making healthy living easier and more affordable where people work, live, learn, pray, and play. The grant has five main focuses 1) commercial tobacco-free living, 2) healthy eating and active living, 3) controlling blood pressure and cholesterol, 4) social and emotional well being, and 5) healthy and safe physical environments.

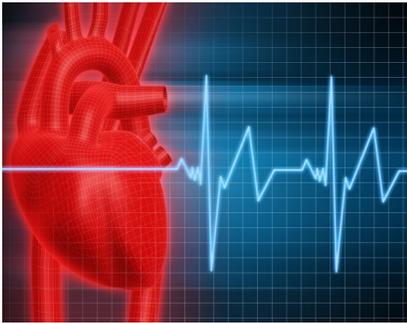
We have partnered with four Tribal communities in Wisconsin who have worked hard and mobilized their communities. They have completed community wide needs assessments and begun pilot projects. We are already beginning to see the effects of their valiant efforts. In one community that is beginning the construction on a new addition to their casino, they have committed to making the casino smoke-free everywhere but the gaming floor. In another community they were able to have Tribal employees granted leave to participate in their coalition and in daily exercise time.



While this grant is ending abruptly, we realize that this is part of the life of working with grants and in accepting "soft" money. However, we can look to the future. From our current experiences we have gained knowledge and worked with communities to help move their members in a healthier direction. We also can use the knowledge and data we have gained to apply for other grants. In fact, the CDC is planning on announcing two grants this coming fall that we are eligible to apply for. One is a Racial and Ethnic Approaches to Community Health (REACH) grant and one is a community based prevention grant. Our hope is to apply for those and continue our work where CTG left off. In many American Indian languages there is no word for "goodbye," only, "see you later." Staying true to that belief we will continue our work and look to a future where our communities are transformed to be healthier and happier.

EVIDENCE-BASED PRACTICES

Since its establishment in 1996, GLITEC has witnessed advances in medicine and technology, while disparities in health care access, resources, and health outcomes for American Indians have persisted. These disparities have been brought into the spotlight more recently by American Indian communities' who have become increasingly sophisticated in their understanding and use of data. Federal and state agencies



have also become more sophisticated over the years in their understanding and evaluation of the effectiveness of interventions tasked with combating complex health problems. Because of limited funds for public health initiatives that can be scrutinized by other entities, many federal and state agencies' require grantees to use individual or population level evidenced-based interventions that have been rigorously tested and deemed "effective" in tackling complex health problems.

At the same time it is important to highlight some of the challenges Tribal communities face when implementing individual and population level evidenced-based interventions. Generally, individual evidenced-based interventions rarely include American Indian populations; if they do the numbers are usually very small, often they have not been implemented in rural areas. In addition the theory of change behind some evidenced-based interventions is actually misappropriated Indigenous intellectual property (Great Lakes Inter-Tribal Council, Inc., 2012). Research has shown population level evidence-based interventions, such as Policy, System, or Environmental Changes (PSEs) might actually increase health disparities between populations. Because of these issues in addition to the stringent research requirements, complex statistical analysis, mistrust and fear of data being misused, many interventions Tribal communities have successfully used for years are never formally recognized as "evidenced-based" although they create positive outcomes and improve individual's health.

After the Oregon legislature passed a law that required the use of evidence-based programs and practices, all of the nine Tribes in Oregon worked together to create a process and criteria to determine what was or was not "evidenced-based." They did this by coming together, working with the state, and a non-profit organization that the state hired to create the Tribal Best Practices. Similarly, in collaboration with the Minnesota Department of Health (MDH) and American Indian communities in Minnesota, the Great Lakes Inter-Tribal Epidemiology Center (GLITEC) will



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conduct the *Stakeholder Input Process: American Indian Community (SIPAIC) project* to determine how evidence-based practices and other promising practices can be culturally adapted for American Indian communities to address obesity, commercial tobacco abuse/exposure, and other chronic diseases. Additionally, GLITEC will assist MDH in improving the grant making model for American Indian communities. GLITEC hopes to work with MDH in building the bridge of understanding for effective strategies to improve the health of American Indians living in Minnesota.

Reference

Great Lakes Inter-Tribal Council, INC. (2012). Great Lakes Inter-Tribal Council's Inter-Tribal Prevention Strategic Plan funded by Substance Abuse Mental Health Services Administration's Center for Substance Abuse Prevention Strategic Prevention Enhancement Grant #18649. Lac du Flambeau, Wisconsin.

CDC MEDIA RELEASE

Death records show that American Indian and Alaska Native (AI/AN) death rates for both men and women combined were nearly 50% greater than rates among non-Hispanic whites during 1999-2009. The new findings were announced through a series of CDC reports released online by the American Journal of Public Health.

Correct reporting of AI/AN death rates has been a persistent challenge for public health experts. Previous studies showed that nearly 30% of AI/AN persons who identify themselves as AI/AN when living are classified as another race at the time of death.

“Accurate classification of race and ethnicity is extremely important to addressing the public health challenges in our nation, said Ursula Bauer, PhD., M.P.H, director of CDC’s National Center for Chronic Disease Prevention and Health Promotion. We must use this new information to implement interventions and create changes that will reduce and eliminate the persistent inequalities in health status and health care among American Indians and Alaska Natives.”

CDC’s Division of Cancer Prevention and Control led the project and collaborated with CDC’s National Center for Health Statistics and other CDC researchers, the Indian Health Service, partners from tribal groups, universities and state health departments.

Key findings:

- Among AI/AN people, cancer is the leading cause of death followed by heart disease. Among other races, it is the opposite.



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- Death rates from lung cancer have shown little improvement in AI/AN populations. AI/AN people have the highest prevalence of tobacco use of any population in the United States.
- Deaths from injuries were higher among AI/AN people compared to non-Hispanic whites.
- Suicide rates were nearly 50% higher for AI/AN people compared to non-Hispanic whites, and more frequent among AI/AN males and persons younger than age 25.
- Death rates from motor vehicle crashes, poisoning and falls were two times higher among AI/AN people than for non-Hispanic whites.

WISCONSIN STATE AND TRIBAL COLLABORATION

The Wisconsin Department of Health Services (DHS) Division of Mental Health and Substance Abuse Services (DMHSAS) was awarded a two year Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Prevention Framework Partnership for Success II (SPF PFS II) State Epidemiological Outcomes Workgroup (SEOW) Grant; Great Lakes Inter-Tribal Epidemiology Center (GLITEC) was included in the grant to provide epidemiological consultation, and serve as a liaison between the Tribes and the state. The goals and objectives of the WI SEOW grant are:

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Goal 1: Continue collaboration among state, Tribal and local agencies, organizations and individuals in order to fill data collection and reporting gaps.

Objective 1: Increase the number of mental health indicators in Wisconsin's Alcohol and Other Drug Abuse (AODA) surveillance system.

Objective 2: Increase the number of shared risk factor indicators in Wisconsin's AODA surveillance system.

Goal 2: Increase the use of data to track progress, detect trends, re-direct resources, and guide and promote behavioral health.

Objective 1: Increase local community capacity for identifying available data and using that data to leverage resources for behavioral health services.

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Objective 2: Increase the availability of epidemiological and needs assessment reports that include both substance abuse and mental health indicators.

Objective 3: Increase data availability and quality with regard to underserved populations.



Since each Tribe’s capacity to collect, store, and use behavioral health data are unique, and because generally American Indians are either not sampled or under-sampled in many state and federal surveillance systems, GLITEC invited all of the Tribes in Wisconsin to nominate a representative to join the WI SEOW Project. The invitation was sent to Tribal health directors, Tribal behavioral health directors, and Tribes chairs asking them to nominate a representative from their Tribe, who was knowledgeable about Tribal specific behavioral health data issues and willing to collaborate to create potential solutions. Although the WI SEOW Project is just beginning, we envision representatives might be asked to collaborate to access local behavioral health data, contribute to tools that other Tribes and communities could use, review reports, etc.

GLITEC is happy to announce, at the time this article was written, eight of the 11 Tribes in Wisconsin have nominated a representative to collaborate on the WI SEOW Project. Also, our first conference call between the Tribes and staff from the DHS DMHSAS and Population Health Institute at the University of Wisconsin, Madison, will take place the first week in March.

If you are interested in learning more about the WI SEOW Project, please contact GLITEC’s Behavioral Health Epidemiologist, Jacob Melson.

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To support Tribal communities in their efforts to improve health by assisting with data needs through partnership development, community based research, education and technical assistance



PROGRAM DIVA'S HEALTHY EATS

Creamy Garlic Pasta With Shrimp and Vegetables

Ingredients

- 6 ounces of whole-wheat spaghetti
- 12 ounces of peeled and deveined raw shrimp, cut into 1-inch pieces
- 1 bunch of asparagus, trimmed and thinly sliced
- 1 large red bell pepper, thinly sliced
- 1 cup of fresh or frozen peas
- 3 cloves of garlic, chopped
- 1 1/4 teaspoons of kosher salt
- 1 1/2 cups of nonfat or low-fat plain yogurt
- 1/4 cup of chopped flat-leaf parsley
- 3 tablespoons of Lemon juice
- 1 tablespoon of extra-virgin olive oil
- 1/2 teaspoon of freshly ground pepper
- 1/4 cup of toasted pine nuts (see Tip; optional)

Directions

1. Bring a large pot of water to a boil. Add spaghetti and cook 2 minutes less than package directions. Add shrimp, asparagus, bell pepper and peas and cook until the pasta is tender and the shrimp are cooked, 2 to 4 minutes more. Drain well.
2. Mash garlic and salt in a large bowl until a paste forms. Whisk in yogurt, parsley, lemon juice, oil and pepper. Add the pasta mixture and toss to coat. Serve sprinkled with pine nuts (if using).



Tip

To toast pine nuts, place in a small dry skillet and cook over medium-low heat, stirring, until fragrant, 2 to 4 minutes.



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