Promising Practice

Developer/Adapter Method: A Community-Based Approach to Improve Health in Indigenous Communities

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ARTICLE INFO

Keywords:

Indigenous health

Developer/Adapter method

Aging in place

Community-based participatory action research

Relational axiology

<https://doi.org/10.32799/ijih.v16i2.33082>

ABSTRACT

The purpose of this paper is to provide a narrative of our experience with community-driven change using our “Developer/Adapter” research method in Northern Ontario, Canada, so it can be explored in other First Nations contexts. The goal of our currently funded research is to identify community solutions and knowledge and implement community-developed interventions to better support older Indigenous persons, especially those in rural and remote communities, to “age in place” and remain independent in the community through timely access to relevant care. Our Developer/Adapter research method was developed in response to the community-identified need for self-determination to overcome the limitations of traditional Western approaches and effectively plan and execute change in Indigenous communities. Our approach commits to supporting a self-determining voice for Indigenous people and working collaboratively to develop wholistic care interventions. We believe this approach can generate compelling data for policy and practice change in both Canada and Australia.

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Acknowledgements

We thank the communities for their generous contributions and commitment to developing the WISE Care and MInD Care projects for their communities. It was truly inspiring. This work was supported by CIHR grants CDI-150622 and PJT-152992.

Introduction

The Case for Improving Health Outcomes for Older Indigenous People

Canada

Indigenous (First Nations, Inuit, and Métis) people make up 4.3% of the population in Canada, and the health needs of older Indigenous adults continue to grow (Caron Malenfant & Morency, 2011). As a result of colonization and its ongoing impacts, compared with other ethnic-racial groups in Canada, Indigenous people experience more severe health, social, and economic issues. Some chronic diseases and related disability have become epidemic among Indigenous people. Indigenous individuals aged 55–64 report three or more chronic conditions at a rate 3.5 times higher than non-Indigenous people (Wilson et al., 2011). Multiple chronic conditions (MCC) are a significant driver of disability: 45% of First Nations people aged 65 years and older report their health as fair to poor, and 69% experience activity limitations (First Nations Information Governance Centre [FNIGC], 2012). Many of those aged 65 years and older may have attended residential school and therefore have poorer health as result. More research is needed to examine the proportion of Elders who attended residential school. In Northern Ontario, as in many other parts of Canada, the challenge of health care delivery to rural and remote First Nations communities further contributes to the health disparities experienced by these communities (DesMeules et al., 2012; Reading & Wien, 2009). In light of the health burdens faced by First Nations people, and the failure of Western science to improve First Nations health, it is imperative to engage communities to identify strategies for healthier aging, consistent with the self-determination goals of First Nations (Government of Canada, 1986).

Social determinants of health are major risk factors for cardiovascular diseases, diabetes, and mental illness (Public Health Agency of Canada, 2015) and contribute proportionately more to health disparities in First Nations compared to non-First Nations people (Anand et al., 2001; Lyons et al., 2014). Despite this, many First Nations people and communities show remarkable resilience. How this resilience develops is incompletely understood, but it is viewed as a key buffer against health risk factors and appears to involve strong connections with culture, language, and spirituality (Public Health Agency of Canada, 2015). Wilson (2008) and Pillow (2003) summarize the relational ontology that is current and evident in collaborative research initiatives and reinforces Indigenous cultural resiliency. Social capital and social cohesion in First Nations communities is a critical component of health and aligns with First Nations customary practices and beliefs (Public Health Agency of Canada, 2015). In a number of First Nations communities in Canada, such beliefs include the medicine wheel philosophy, which recognizes the interconnectedness and importance of physical, mental, emotional, and spiritual

aspects of health. However, there are significant challenges attributable to the continued tensions between First Nations and non-First Nations people and the continued colonial policies governing access to services (Reading & Wien, 2009). Research has documented the need for sustained and reciprocal dialogue between service providers and community members before positive changes can occur (Jacklin et al., 2015; Smith et al., 2011). Our work started in collaboration with Australian researchers who had developed interventions to improve community care for frail older people and their caregivers (LoGiudice et al., 2012).

Australia

There are two wide but distinctive groups that make up Australia's First Nations Peoples. They are the Aboriginal Peoples and the people of the Torres Strait Islands. Neither of these terms arise from this continent; rather, they are the language of the colonizers. The preferred collective term for the sovereign peoples of mainland Australia and Tasmania, as well as Torres Strait Islander peoples, the sovereign peoples of the islands between Cape York and Papua New Guinea, is Australia's First Peoples. There are approximately 500 Aboriginal Nations and 17 inhabited islands in the Torres Strait. The term *Indigenous* can mean any person born in, or flora or fauna originating from, a particular country, but is often used to refer to Aboriginal and Torres Strait Islander Peoples (Jackson Pulver et al., 2019). Many of Australia's First Peoples dislike the term *Indigenous*, and we use it here only in the international context. Within Australia's First Peoples there are over 250 spoken and signed languages that are unique and distinctive. Each of these groups have their own laws, lore, and customs that characterize individual and family membership (Jackson Pulver et al., 2019).

Australia's First Peoples make up 2.8% of the Australian population, and this proportion is growing (Australian Bureau of Statistics, 2017). There remain difficulties in how people are counted in the national census, despite the intercensal increase of the proportion of people identifying (Chino et al., 2019). In the earliest days of colonial endeavour, the First Peoples of Australia were actively excluded from the census counts of the nation. It has only been in recent decades that Australia's First Peoples have been counted (Madden & Jackson Pulver, 2009).

Challenges of Western Methods to Improve Health Outcomes for Older Indigenous People

Western research tends to value systematic methods that other researchers can replicate to establish that the results are consistent, reliable, and unaffected by contextual variables. Yet these contextual variables are at the core of Indigenous health research that understands that each community is unique. This second, justice-based approach values variations both within and between communities as well as appropriate standardization between communities (Ellison, 2014). Western approaches to addressing the health disparities experienced by Indigenous Peoples lack cultural and contextual specificity (Chouinard & Cousins, 2007; FNIGC, 2012; Reading & Wien, 2009). "Best practice" in the Indigenous context has been replaced by the term "wise practice" as a way of dealing with an implied level of standardization that may be undesirable for First Nations (Wesley-Esquimaux & Calliou, 2010). Implementing wise practices informed by research relies on resources to support community-based participatory action

research (CBPAR) and “aims to develop equal partnerships between researchers and participants and to create knowledge that leads to action and positive social change” (Wallerstein & Duran, 2010) and fosters capacity and sustainability (Reilly et al., 2007; Tsey et al., 2007). This approach addresses the frequent lack of congruence between necessary culturally sensitive approaches and the evaluation criteria of the funders and supports a pathway that satisfies both Indigenous needs and the need for contemporary rigour in evidence.

The “Developer/Adapter” Method

The Developer/Adapter (D/A) method was developed in collaboration with First Nations communities in Northern Ontario as part of the WISE Care and MInD Care projects to address their sense that an intervention/control experimental approach was inconsistent with self-determination. The D/A method aligns with the theoretical framework of CBPAR, builds on strengths and resources within the community, and promotes co-learning and capacity building among all partners (Israel et al., 2005). The participatory process is educative and empowering, involving a dynamic approach to problem identification, planning, action, and evaluation (Waterman et al., 2001). This framework aligns with developmental evaluation methods to develop new care pathways, or use or modify existing ones, and to evaluate how context affects intended or unintended consequences. Developmental evaluation is particularly useful for early stages of social innovation (Dozois et al., 2010; Fagen et al., 2011; Gamble, 2008; Patton, 2011) and in environments that are complex and challenging (Dozois et al., 2010; Gamble, 2008; Patton, 2011). It emphasizes real-time learning where the health system and the community (not individuals) are the focus (Fagen et al., 2011) and there are multiple stakeholders (Patton, 2011). The purpose of developmental evaluation is to assess what is learned as the intervention is being implemented, the effect of the intervention on the recipient of the intervention, and to assist partnerships in developing and adapting interventions to the community context, not just validating a single approach (Patton, 2011). We therefore used developmental evaluation in alignment with the Ways Tried and True Framework to ensure a comprehensive, wholistic approach to health improvement (Public Health Agency of Canada, 2015; see Figure 1).

Figure 1

The Ways Tried and True Framework

Note. This figure was reproduced from *Ways Tried and True: Aboriginal Methodological Framework for the Canadian Best Practices Initiative* (Public Health Agency of Canada, 2015), © Her Majesty the Queen in Right of Canada, as represented by the Minister of Health, 2015. The reproduction was not produced in affiliation with, or with the endorsement of, the Government of Canada.

The Developer/Adapter (D/A) method can be used for research, quality improvement, and knowledge mobilization. By understanding change as a social process in environments that are often changing and unpredictable, and by taking a strength-based, community-led approach, this method builds upon characteristics of developmental evaluation (Dozois et al., 2010), realist evaluation (Goodman et al., 2017), CBPAR (Wallerstein & Duran, 2010), and asset-based community development (Boyd et al., 2008). The D/A method was developed by the research team to support community engagement, the community-based identification of the needs of Elders, and community partnerships with Indigenous health service agencies in the development of community-based interventions. It is structured to address health issues identified through and solved by sustained engagement with multiple Indigenous communities that have identified common health concerns. Working with health service workers and the researchers/project team, community members

- identify health issues that matter to Elders and caregivers in the community;
- decide whether to participate as Developer communities (typically those with an existing structure for strategic dialogue between community members and health care providers, and experience with research, to identify, develop, enact, and evaluate new opportunities); or as Adapter communities to adapt successful strategies to their local context; and
- contribute tools and experience to a “Toolbox” for future use as new issues are identified.

Several principles have guided our approach to academically sound, culturally relevant research programs that aim to improve the health of older Indigenous adults. First, we know that the paternalistic, colonial traditions of Western methods must give way to a deep acknowledgement and active support of a determining voice for Indigenous health leaders and communities in both research processes and implementation strategies (Public Health Agency of Canada, 2015). Second, Western clinical methods that validate findings through controlled trials involving experimental and control groups are often an anathema to Indigenous ways of knowing and being. Communities do not readily accept care strategies generated outside their own context and experience. Moreover, when new practices developed in a contextual vacuum fail to be implemented or to demonstrate the anticipated effects, Indigenous communities are blamed for their inability to effectively implement and achieve the expected outcomes of the work. Third,

we see “context” as a crucial consideration—“one size fits all” thinking that is prevalent in Western, evidence-based implementation science is not appropriate. We see practice change as a social process that can best be facilitated by coming up with ideas and methods for how “best” (or “wise”) practices can be made “fitting” (contextually appropriate) and further “improved” as system changes are enacted (Briggs & McElhaney, 2014).

Our D/A method (see Figure 2) beginning in the east door (yellow circle) assists communities in defining or discerning their interest in any given topic; it assures a determining voice for Indigenous Peoples by establishing community research advisory committees (CRACs) in Developer communities. The CRAC advises and directs project staff; hires staff locally to support the project; and as far as possible, ensures research funds support community leadership and participation. Shared leadership, reciprocal learning, and mutual benefit drive the partnership between communities and institution-based researchers. Depicted at a high level in Figure 2, the goal of this method is to support meaningful, community-defined change strategies that are locally relevant and that support nimble and continuous improvements toward “wise practices” (Dozois et al., 2010). Shared lessons and stories among Developer communities throughout the research process facilitated knowledge exchange and cross-learning while maintaining support for local variations to emerge. Throughout these research cycles, communities and research teams contribute methods and evaluation strategies to the collective Toolbox of stories, methods, and measures that can also be used in Adapter communities (Wesley-Esquimaux & Calliou, 2010). Respectful teaching and learning supports all communities to choose the evaluation tools most relevant to their context and contribute their own stories, methods, and measures to the Toolbox. Through a narrative of two of our current projects, we will illustrate how this approach

Figure 2

Developer/Adapter Method for Indigenous Health Research

moved us from a Western academic way of thinking to an approach that is academically rigorous and culturally aligned with Indigenous ways of knowing.

The D/A method strengthens the capacity of the community to independently conduct research projects through reciprocal learning and mutually beneficial consultation with researchers. Real employment opportunities and ongoing training and development supports bi-way learning in the partnership between research teams and communities to change the structural and service issues that are affecting the quality of care for their people (Tsey et al., 2007). We stress the importance of reciprocal learning and mutual benefit to ensure researchers avoid the seduction of “benevolent paternalism,” whereby they believe they are “helping” but have little to learn themselves.

Developer/Adapter Community Processes

The D/A method is divided into three Developer phases, an Adapter phase, and Toolbox development (with the associated activities summarized in Table 1):

1. Developer Phase 1: *Gather wisdom within the community through iKT (integrated knowledge translation) teams.* Gather Indigenous knowledge in Phase 1 on the community’s perception of the health issue to be addressed. For example, a focus on resilience “to lovingly care for people” (Elder Betty McKenna) is more important as a healthy aging strategy from an Indigenous perspective, compared to Western medicine approaches to preventing frailty as a complication of MCC. Similarly, recognizing how community and family caregivers support Indigenous persons living with dementia “to sing, to dance, and love our minds” (Elder Betty McKenna) is prioritized over Western medicine approaches of specialty consultation for assessment, diagnosis, and treatment of dementia.
2. Developer Phase 2: *Design locally relevant care models for early stages of social innovation.* Use an asset-based approach in each community in Phase 2 to ask: What do we do best now? What resources do we have to help with this? (People, skills, facilities, technology, etc.). Community-based study protocols are developed by the iKT teams and submitted for ethics approval. Semi-structured interviews are conducted according to the Phase 2 study protocol through an informed consent process with individual community members. Qualitative analysis of these data informs the proposed care model to be implemented in Phase 3.
3. Developer Phase 3 and Beyond: *Explore/adapt the model’s merit for continuation, or adapt for use in a new context.* The iKT teams develop study protocols that include both Developer and Adapter communities and submit them for ethics approval to begin recruitment and establish baseline characteristics of participants in the study. This approach, compared to an intervention/control community design, ensures that all participating communities will benefit from the care model developed. Formative evaluations using outcome indicators selected by the iKT teams are initiated in the early stage of implementation in the Developer community to ensure that critical

elements of the care model have been established. Formative evaluation supports the notion that “we could do this here—we would only need to make small changes and it would make a real difference to our community.” Summative evaluations of the effect of the intervention are initiated in Phase 3 when the Developer communities are ready to test the merit of the care model. Changes in health status (according to selected outcomes and outcome indicators) as a result of the intervention in Developer (intervention) community participants are compared to Adapter (control) community participants. At the end of Phase 3 implementation, changes in health status (outcomes, outcome indicators) are assessed as group comparisons according to Developer versus Adapter communities. During the implementation of the care model, Developer communities may also elect to use semi-structured interviews as part of the formative and summative evaluations of the care model in their communities.

4. Adapter Phase: *Adapt the model for use in new communities or contexts.* The Adapter communities implement the care model using the knowledge mobilization strategies.
5. Shared Toolbox: An initial set of tools for both qualitative and quantitative assessments of study participants and the care models have been added to the Shared Toolbox. Ongoing reviews of the literature and feedback from the participating communities will be used to *develop/refine information models and tools* to characterize study participants to conduct formative and summative evaluations of the care models.

Table 1

Step-by-Step Approach to the Developer/Adapter Method

Phase	Activities	Anticipated outcomes
Phase 1 Community discernment and engagement	Submit ethics application for community engagement (CE)	Ethics approval secured for CE
	Seek First Nation’s permission to begin CE	Approval for CE in specific communities
	Initiate CE to understand how community members understand and experience targeted health issue	Community decision to participate as a Developer or Adapter community
	Identify community research advisory committee (CRAC) in Developer communities	CRAC established in Developer communities
	Negotiate research agreements with Indigenous Knowledge User community partners	Research agreements in place and community-based research staff hired
	Confirm that Indigenous Knowledge is produced by community members	Self-determination of communities to participate throughout the project

Table 1 con't

Phase	Activities	Anticipated outcomes
Phase 2 Structured community and health care provider dialogues for change	Hold structured conversation(s) between CRAC, health care providers, and researchers in Developer communities	Initial identification of opportunities for improved community-based care
	Develop protocol for semistructured interviews involving patients, families, and care teams	Initial development of community-specific care protocols
	Submit community-developed ethics amendment for semistructured interviews	Ethics approval secured for semistructured interviews
	Conduct and analyze semistructured interviews	Community-specific care protocols identified in Developer communities
	Develop draft indicators and measurement methods	Measures applied and added to Toolbox
Phase 3 and beyond Development of ideas and methods for improving health and measuring desired outcomes	Amend ethics agreement to allow implementation of care protocols specific to Developer communities	Approval obtained to implement protocols, including process, outcome, and impact indicators in Developer communities
	Implement and refine community-specific care protocols using process indicators	Protocols modified through formative evaluation in Developer communities
	Initiate summative evaluation strategies in Developer communities	Process, outcome, and impact measures applied and added to Toolbox
	Continue to adapt protocols and practices in Developer communities	Developer communities continue to evolve their model
	Amend ethics agreement to engage Adapter communities	Ethics approval secured for engagement with Adapter communities
	Seek band council approval to initiate protocol modification in Adapter communities	Band council resolution approval to proceed in Adapter communities
	Adapter communities begin adapting protocols and lessons learned by the Developer communities	Protocols adapted and implemented in Adapter communities
	Initiate formative and summative evaluation	Summative evaluation finalized in Developer and Adapter communities
	Support Developer and Adapter communities for knowledge mobilization (KM)	KM strategies implemented

The Developer/Adapter Method in Practice

Supporting Healthy Aging for Indigenous People Through WISE Care and MInD Care

The D/A method was developed in collaboration with First Nations communities in Northern Ontario within the WISE Care and MInD Care projects. WISE Care supports healthy aging for Indigenous persons living with MCC through care that is Wholistic (encompasses mind, body, spirit, emotion); Integrated (recognizes the complementary nature of Western and Indigenous healing practices); Safe (culturally safe, recognizes the therapeutic relationship as one of mutual respect, humility, and inquiry); and Effective (in terms of both the individual and the health care system). MInD Care addresses the challenges of caregivers supporting Indigenous

persons living with dementia (both persons in this dyad often living with MCC) by developing Models for Indigenous Dementia Care. These projects are currently funded by the Canadian Institutes of Health Research (CIHR) and are in progress. However, interventions must be funded by local services, as this is not an allowable expense under CIHR funding policies.

Phase 1: Community Discernment and Engagement

To support a self-determining voice for Indigenous Peoples, we identified and worked with community leaders and community-based research assistants to identify a CRAC. The CRACs are supported by research coordinators and Western and Indigenous scholars, including Elders, as an iKT team. The CRAC's role is to consider the impact of MCCs and dementia in their community and determine whether finding ways to improve care for these problems is a community priority. The use of storytelling as a method gives strength, currency, adaptability, and energy of the core self-definition of "scientist" in the emerging culture of translational research with a shift toward a practical outcomes based, integrated approach to research application (Kotarba et al., 2013). We used digital storytelling to engage with persons living with or at risk for developing dementia, their family caregivers, and other care providers to tell their stories and raise awareness within their communities. We also provided Indigenous methodology research training.

Studies in Australia led to the development, evaluation, and implementation of a pilot model of care, "Lungurra Ngoora," in the remote community of Looma, Australia. This program sought to improve community care and support for frail aged and younger people living with disabilities and mental illness, and their caregivers (LoGiudice et al., 2012). Although a sense of empowerment was reported, it became apparent that methods for community engagement were an area for further development, particularly among people caring for family members and friends (LoGiudice et al., 2012). We found that digital storytelling was an effective community-engagement strategy by giving people a chance to tell their stories of living with or caring for persons with dementia.

Following the community decision to participate, CRACs engaged with many more community members in the transition to Phase 2.

Phase 2: Structured Community and Health Care Provider Dialogues for Change

In Phase 2, we initiated the formal processes to enter into research or project agreements and structure the project team of community health leaders and research/project support staff. Working with the CRAC, the project team arranged conversations with and between the community and health care providers to identify the contextual factors that contribute to the health issues and barriers to care and consider ways to improve care through service improvements. The development of the community-specific intervention uses evidence-based approaches and qualitative methods for the initial identification and evaluation of collaborative practices and models to be tested and further refined in Phase 3. Just-in-time training in

research/project methods was provided in response to the needs identified by the community-based research teams as necessary to support the community-driven processes.

Researchers studying dementia in Australia's Aboriginal and Torres Strait Islander population examined the dementia experience through artwork of the brain and dementia, as well as concrete descriptions of caregiving and the significance of caregiving in dementia, to give meanings that resonate with lived experience in Aboriginal families (Arkles et al., 2020). The D/A method could be used to incorporate the cultural and contextual specificity of this work into health care practices serving Indigenous people (Chouinard & Cousins, 2007).

Phase 3: Development of Ideas and Methods for Improving Health and Measuring Desired Outcomes

The proposed community-specific intervention uses the work of Phase 2 to engage health care providers to identify collaborative practices to be refined, translated, and applied through formative (process) evaluations in Developer communities and then summative (impact) evaluations in all participating communities (Patton, 2011). As an example, communities have talked about the challenges of travel required to access specialty care, particularly in the context of patients with MCC and dementia. To respond to this identified challenge, we have initiated discussions with community-based physicians regarding ways of using collaborative practice teams to address dementia in the context of MCC in the primary care setting. This approach is designed to complement medical specialty care and move care closer to home using digital technology to connect primary care collaborative practice teams with medical specialists as needed. The community continues to drive this strategy through direct involvement in identifying outcomes and indicators they feel are most relevant to demonstrating the effectiveness of the community-developed care intervention. Each community has access to tools, methods, and stories currently in the community Toolbox and is encouraged to add their own stories, methods, and measures.

The Growth and Empowerment Measure, used in Australia to measure processes and outcomes of empowerment in Indigenous community intervention evaluations (Kinchin et al., 2015) of emotional empowerment, confidence, and "self capacity" (Haswell et al., 2010), has been included in the D/A method Toolbox.

Evaluation, Adapter Process, and Knowledge Mobilization (Completion of Phase 3 and Beyond)

The evaluation of the effectiveness of the D/A method will be based on the ability of the communities to demonstrate the success of implementing the care model or practice in their community. We anticipate that Developer communities will select both qualitative and quantitative evaluation methods from the Toolbox, and these will differ from one community to the next. We will also evaluate how these methods would be used by Adapter communities to select and adapt care models or practices to their own context. These communities are able to consider what has worked for others and determine if the same or an adapted strategy would also work for their community. We will also evaluate the effectiveness of the D/A method,

particularly in those Adapter communities with limited research experience and resources due to the small size or remoteness of their community. Knowledge mobilization occurs throughout all phases of the project through sharing of lessons learned in each community by the community-based research team and through meetings involving all participating Developer and Adapter communities. Time series analysis compares health outcomes in Developer and Adapter communities at the start of implementation in Developer communities, at the start of implementation in Adapter communities, and at the completion of implementation in Adapter communities. Thus, contemporary analytical rigour is maintained in a process that also meets the needs of self-determination and contextual specificity for Indigenous communities.

Ethical Considerations Supporting Self-Determination of Indigenous Peoples

All research processes in Canada must be compliant with the Tri-Council Policy Statement, Chapter 9, “Research Involving the First Nations, Inuit and Métis Peoples of Canada” (Panel on Research Ethics, 2018). The Indigenous Knowledge Keeper for the WISE Care and MInD Care projects was the nationally appointed steward for the Tri-Council Policy Statement from 2015 to 2018. Consistent with the development of ethical codes of conduct for research in Indigenous communities and the rights of Indigenous Peoples to be partners in research affecting their well-being (Brant Castellano, 2004), we have adopted a multistage approach to the ethics approval process starting with approval of the process for community engagement (Phase 1), then approval by individual communities as Developer communities, and related protocols and consent processes (Phase 2), and finally approval of individual community study protocols for care model or practice implementation (Phase 3). Knowledge mobilization strategies include our work with Adapter communities and support for all communities to publish and present their work at local, national, and international meetings.

Limitations

The benefits of the D/A method are that it involves continuous engagement with Indigenous communities from project conception, to submitting the proposals for funding the project, to supporting self-determination within the individual communities beyond what is negotiated in the partnership agreements. The drawbacks are that one has to recognize the need to approach and work with each community independently. This means that there may well be unique features for each community. This can also be seen as a strength, since individualization is at the core of the approach. However, the engagement process can prolong timelines, which should be kept in mind when deciding on and evaluating project milestones and goals. This flexibility in timelines and outcome metrics allows for meaningful engagement, which is not necessarily consistent with typical non-Indigenous projects and funding/reporting mechanisms according to predetermined project milestones. We believed it was important to give every community the opportunity to participate independent of their size or experience with CBPAR projects and build Indigenous community-based research teams that would support these communities. Finally, the D/A model can be applied to other Indigenous groups but would need to be validated in Métis and Inuit communities.

Discussion

Relationship Building as a Critical Tenet of the Model

The process for preparing the grant application for the WISE Care and MInD Care projects involved a physician and an Indigenous CBPAR scholar as co-principal investigators, a sweat lodge ceremony led by Elder Betty McKenna to seek the wisdom of the Ancestors, and engagement with Indigenous community health directors who provided partner letters of support for the grant applications. The initial proposed method was an intervention/control study design, but through the engagement of health centre teams and advisory groups, it became apparent that this model was not appropriate for the communities that they served—no community wanted to be the “test” group, nor did they want to be the “controls” who received educational materials only. Thus, we moved to the Developer/Adapter method so that communities could decide whether they wanted to be a lead Developer community or an Adapter community that would benefit from the learnings in the Developer phase and could adapt the models to their own community context. This change in the methodology was approved by the CIHR Indigenous research review panel.

This model will absolutely not work without a lot of front-end engagement with key stakeholders and community involvement that we worked hard to establish before anything was created. This included the creation of job descriptions for community-based research coordinators and research assistants who would report to the health directors, and once hired, the identification of their training needs for this project. Research agreements with the directors of Indigenous health centres involved multiple rounds of discussion to identify what would be needed to establish new independent community research programs that would work with the academic partners at Health Sciences North Research Institute. Collaborative initiatives to implement the stepwise approach to ethics approval for each phase of the project, and support for professional development and sharing of personnel between the health centres and the Health Sciences North Research Institute, took anywhere from 1 to 2 years before beginning the process of obtaining band council resolutions, establishing individual CRACs, and identifying processes for engagement of community members to identify needs that could be addressed under the WISE or MInD Care projects. There were important challenges with travel to engage with First Nations communities, but face-to-face meetings with individuals were identified as being critical to the success of the project. The social interactions, attendance at community-held events, and efforts to understand the unique needs of each community helped to build and strengthen trust and respect from both sides. The effort was to create equity so community members were able to participate fully and communicate their frustrations with negotiating their way through a health care system that did not recognize the complexity of their needs and their wholistic view of health. We aimed to clearly communicate that we were not there to appropriate the community's traditional medicines and teachings, but rather to appreciate the power of these medicines and other traditional healing approaches and how they could complement Western approaches to disease management.

Conclusion

We have designed the D/A method to support Indigenous self-determination in research, improved quality of care, and knowledge mobilization, so that more Indigenous people can age in place. The D/A method supports strong community and wholistic approaches to practical health care options and encourages collaborative practices that support Indigenous persons and their caregivers to make informed choices about treatment priorities. We also seek to increase access to culturally appropriate care closer to home. The development of a Toolbox of stories, methods, and metrics related to these objectives supports Indigenous communities to select processes most relevant to their community. This approach could promote faster adoption of new diagnostic and therapeutic care processes at the point of care as part of a larger movement toward ensuring culturally safe health care practices for Indigenous Peoples.

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