TRADITIONS OF HEALTH

Policy Change Strategy & Sustainability Plan

CCUIH
CaliforniaConsortiumforUrbanIndianHealth
StrengtheningTheOrganizationsThatStrengthenOurCommunities

A project funded by Blue Shield of California Foundation

August 2015

Traditions of Health: Policy Change Strategy and Sustainability Plan

Introduction

The goal of the Traditions of Health Policy Change Strategy and Sustainability Plan is to transform policies and systems to incorporate and sustain Traditional Healing services into health and social systems serving American Indians in California.

The California Consortium for Urban Indian Health's (CCUIH) wrote the Policy Change Strategy and Sustainability Plan as an accompanying document to the Culturally Relevant Integration Model for Urban Indian Health Organizations (UIHO) in California. This Strategy and Plan aims to promote and transform health systems to meet the funding necessary to implement and sustain the Model. It will be necessary to read both documents to understand the complementary approach to achieve goals. The Policy Change Strategy and Sustainability Plan was informed by CCUIH's Traditional Health Taskforce, Behavioral Health Peer Network, and Traditional Healer Advisory Committee. Additional ideas and recommendations were collected through participation in relevant conferences, stakeholder meetings, and pointed interviews.

The following tables outline five (5) Strategic Directions complete with goals, objectives, action steps, responsible parties, and timelines:

I: Exercise Self-Determination
II: Utilize ACA Opportunities
III: Increasing UIHO capacity
IV: Grassroots Advocacy for Traditional Healers
V: Sustainability for Traditional/Cultural Health

Strategic Direction I: Exercise Self-Determination

The Indian Self-determination and Education Assistance Act (Public Law 93-638) ended federal dominance over Indian programs and services by empowering tribes and all Indians to plan, conduct and administer services. Congress agreed to provide support in the development of these programs and for the first time declared that Indians know what is best for their people. This federal obligation and commitment, coupled with expanded resources resulting from the permanently reauthorized Indian Health Care Improvement Act (Public Law 94-437), are the platforms through which all national advocacies should be conducted.

Strategic Direction I: Exercise Self-Determination

Goal: Advocate for federal accountability to uphold rights established through the Indian Self-determination and Education Assistance Act and the Indian Health Care Improvement Act.

Objectives:

- Call for congressional and Indian Health Service accountability to rights and political status established through Indian Self-Determination and the Indian Health Care Improvement Act.

	Action Steps	Responsibility	Timeline
I. A	Provide Testimony to Congress requesting increased allocations within the Indian Health Service budget specifically with respect to the Urban Indian health line item.	NCUIH, UIHO Leadership	Annual
I. B	Utilize conferring sessions to advocate for the use and sustainability of Traditional Healing Services.	NCUIH, CCUIH, UIHO Leadership	Annual or by request
I. C	Activate tribal partnerships to assert the Urban Indian and UIHO perspective in tribal consultations.	NCUIH, CCUIH, UIHO Leadership	Ongoing
I. D	Hold Indian Health Service accountable for the action items listed in the "National Behavioral Health Strategic Plan."	NCUIH, CCUIH, CRIHB, CAO IHS, Tribes	December 2015
I. E	Actively participate in NCUIH to strategize around legislative priorities	UIHO	Ongoing

Strategic Direction II: Utilize ACA Opportunities

The Affordable Care Act requires health delivery systems to move toward an integrated healthcare model. This is an opportunity, at the state level, to exercise tribal consultation and urban conferring to assert cultural specifications to changing legislation, policies and implementation. Current state legislation and pending waivers addressing health delivery transformation and payment reform have the potential to positively impact culturally relevant integration work. For example:

Payment Reform Pilot Program for Federally Qualified Health Centers - SB 147 (Hernandez) will create a three-year alternative payment methodology pilot for Federally Qualified Health Centers (FQHC) in California. The shift toward capitated monthly payments, and away from fee-for-service per-visit reimbursements, will provide UIHOs with greater flexibility to deliver healthcare to the patient in a manner that best meets the patient's needs, including incorporating same day visits, group visits, and traditional healing into the treatment model.

Improving Access to Behavioral Health Services - AB 858 (Wood) will increase Californians' access to mental health services by permitting Marriage and Family Therapists (MFT) services at an FQHC or RHC to be reimbursed on a per-visit basis, just as services provided by other mental health professionals are reimbursed. The expansion of MFTs as billable providers at UIHOs not only values the role of mental and behavior health providers, but also makes culturally relevant integration more sustainable with allowances for lower cost providers.

Health Home Program - State Plan Amendment 15-017 The Department of Health Care Services (DHCS) has proposed to create a health home program (HHP) for Medi-Cal members with multiple chronic and complex conditions. The HHP will create a health team model that integrates the patient and family members into health protocols and treatment decisions. The proposed HHP also contains an emphasis on community health workers (CHWs) as part of the Multi-Disciplinary Health Home Team. This emphasis on CHWs presents an opportunity to insert definitional language to include "Natural Helpers" and "Traditional Healers" to the HHP Multi-Disciplinary Health Home Team.

Drug Medi-Cal (DMC) Organized Delivery System (ODS) 1115 Bridge to Reform (BTR) Demonstration Waiver Amendment The Department of Health Care Services (DHCS) has proposed to create a DMC organized delivery system by establishing a comprehensive continuum of care for AOD services by delegating contracting authority and oversight to the counties. CCUIH was successful in adding American Indian specific language to the DMC-ODS Waiver through the inclusion of a separate statewide Indian DMC delivery system. This effort was based upon the concept that Indian country should be considered California's "59th county". The statewide Indian DMC delivery system will create parallel resources and access to culturally specific and appropriate AOD treatment services for American Indians.

Teaching Credential: American Indian Language-Culture Credentialing- AB 163
On July 13, 2015, Governor Jerry Brown signed an amendment to the existing law that allows for the credentialing of American Indian language teachers to be authorized through the Commission on Teacher Credentialing. This law allows California federally recognized tribes and/or tribal governments to recommend a candidate to receive credentialing through the commission. The amendment now allows for a distinction between language credentialing and/or cultural credentialing. The addition of the culture teaching credential offers an opportunity for Traditional Healers to become state certified for the services they conduct. It will be important to advocate for the inclusion of UIHOs as entities capable of recommending candidates to receive this credential.

Strategic Direction II: Utilize ACA Opportunities

Goal: Maximize the impact of health care reform for American Indians.

Objectives:
- Increase visibility of American Indian cultural specifications within all state policy/systems changes.
- Promote sustainability of traditional/cultural practices through policy advocacy.

	Action Steps	Responsibility	Timeline
II. A	Use DMC-ODS expansion as an avenue to promote increased capacity for UIHO and tribal substance use continuum of care.	CCUIH, IHS, CRIHB, IHP, HHS, UIHO Leadership, Tribes	January 2016
II. B	Use the success of the Indian DMC-ODS as an opportunity to promote the consideration of Indian Health Programs as the 59th county in terms of program expansion, fund distribution, and managed care.	CCUIH, CRIHB, CAO IHS, IHP, UIHO Leadership, Tribes	Ongoing
II. C	Advocate for the reinstatement of the state Indian Health Program.	CCUIH, CRIHB, CPCA, IHP, UIHO Leadership, Tribes	Ongoing
II. D	Advocate for the inclusion of natural helpers and traditional healers into the payment reform pilots and health home program.	CCUIH, CRIHB, UIHO, Tribes	January 2017
II. E	Conduct American Indian visibility outreach and education to inform government entities, academics, communities, allies and key stakeholders	CCUIH. CRIHB, UIHO	January 2017
II. F	Utilize American Indian language-culture credential program as an avenue to include Traditional Healers as cultural teacher, and advocate for inclusion of UIHOs as recommending entities	CCUIH, UIHO	January 2017

Strategic Direction III: Increasing UIHO Capacity

Strengthening UIHO capacity to influence policy change and sustainability to ensure American Indian voices are heard in decision-making forums.

Strategic Direction III: Increasing UIHO Capacity

Goal: Active engagement of UIHOs in policy advocacy efforts and support for traditional/cultural practices.

Objectives:

- Improve UIHO readiness to engage in policy advocacy.
- Strengthen collaborative efforts to influence policy change.
- Lead the implementation of culturally relevant integration.

Action Steps		Responsibility	Timeline
III. A	Increase capacity for policy advocacy by adding a Policy Advocate to current staffing structure, or by adding this role to an interested and capable staff member's responsibility.	UIHO Leadership, Tribes	Ongoing.
III. B	Create a policy peer group to inform policy priorities, and to facilitate engagement of UIHOs in policy advocacy.	CCUIH	January 2016
III. C	Increase participation in stakeholder meetings at local, state and national levels.	CCUIH, CRIHB, UIHO, Tribes	January 2016
III. D	Implement the Culturally Relevant Behavioral Health Integration Model.	UIHOs	January 2017
III. E	Expand collaborations with entities that address social determinants of health, i.e. domestic violence service providers, medical-legal partnerships, and justice and education systems.	CCUIH, CRIHB, UIHO Leadership, Tribes	January 2017

Strategic Direction IV: Grassroots Advocacy for Traditional Healers

Traditional Healers and cultural service providers can build networks and mobilize to advocate for policy changes to support the integration and sustainability of their services into health care delivery systems.

Strategic Direction IV: Grassroots Advocacy for Traditional Healers

Goal: Increase capacity of Traditional Healers' networks, advocacy efforts, and business models.

Objectives:

- Support and empower individuals/networks of Traditional Healers to operationalize their services as a business.
- Support and empower individuals/networks of Traditional Healers to become policy advocates.

	Action Steps	Responsibility	Timeline
IV. A	Support and empower Traditional Healers to expand their statewide network.	CCUIH, CRIHB, CAO IHS	January 2017
IV. B	Support interested Traditional Healers in operationalizing their practices by offering training on various business models i.e. social enterprise, alliances, networks, and standard nonprofits.	CCUIH, CRIHB, CAO IHS	Ongoing
IV. C	Support Traditional Healers in their advocacy efforts to become individual state credentialed providers.	CCUIH, CRIHB, Tribes	Ongoing

Strategic Direction V: Sustainability for Traditional/Cultural Health

CCUIH identified existing policy and sustainability models for American Indian traditional health practices and analyzed these models with input our Traditional Health Taskforce, Traditional Healers Advisory Committee, and Behavioral Health Peer Network. Summaries and analysis for each model can be found in Appendix B.

Strategic Direction V: Sustainability for Traditional/Cultural Health

Goal: Provide avenues for the sustainability of traditional/cultural health services within UIHOs and public health systems.

Objectives:

- Apply innovative approaches to incorporate traditional/cultural practices into current funding structures.
- Advocate for the inclusion of traditional/cultural practices into future funding modalities.

	Action Steps	Responsibility	Timeline
V. A	Begin building Traditional Healers into any reimbursable mechanism that is inclusive of peers, health educators, natural helpers, etc.	CCUIH, CRIHB, UIHO, Tribes	Ongoing
V. B	Advocate for Urban Indian inclusion in the 100% Federal Match Percentage for Medicaid.	NCUIH, CCUIH, UIHO	Ongoing
V. C	Begin assessment of practices that are similar to other billable practices, i.e. talking circles as group therapy, Positive Indian Parenting as perinatal program component, etc., and conduct cultural adaptation.	CCUIH, CRIHB, UIHO, Tribes	July 2016
V. D	Begin conversations with managed care plans to assess willingness to implement a reimbursement model for Traditional Healing services. (Similar to the New Mexico Traditional Healers reimbursement model or managed care reimbursement for MFTs)	CCUIH, CRIHB, UIHO, Tribes	January 2016
V. E	Share all developed billing models with American Indian peers, consortia, and collaborations to avoid duplication in models and increase data to inform necessary adaptions.	UIHO, CRIHB, CCUIH, IHP, CAO IHS	Ongoing
V. F	Participate in all funded research efforts designed to establish traditional/cultural practices as evidence-base, community defined, or best practices.	CCUIH, CRIHB, UIHO, Tribes, Academics	Ongoing
V.G	Apply cost savings from AB 858 resulting from lower cost providers becoming PPS billable to pay for traditional healing services.	CCUIH, CRIHB, UIHO, Tribes	January 2016

Conclusion

This Policy Change Strategy and Sustainability Plan was designed not as a step by step directive, but as categorical recommendations that can be implemented as opportunities arise. Some of these actions steps are translatable for tribal communities and other marginalized groups seeking to insert cultural specifications into broader policy changes. These cross-cultural opportunities are most prevalent in Strategic Direction II. In fact, the more cultural communities work together to emphasize the value of culture in healing, the more effective we will be in impacting the sustainability of Culturally Relevant Integration.

Appendix A

Key Terms

Urban Confer: Congress has specifically declared that it is the policy of the United States "to ensure the highest possible health status for Indians and urban Indians" (USC § 1602(1)). The Department of Health and Human Services is committed to working with urban Indian communities to meet this policy. The Indian Health Service uses a conferring policy to ensure that the health care needs of the Urban Indian population are considered at the local and national levels, when implementing and carrying out the Indian Health Care Improvement Act.

Tribal Consultation: The United States has a unique legal and political relationship with American Indian tribal governments, established through and confirmed by the Constitution of the United States, treaties, statutes, executive orders, and judicial decisions. In recognition of that special relationship, pursuant to Executive Order 13175 of November 6, 2000, executive departments and agencies are charged with engaging in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have tribal implications, and are responsible for strengthening the government-to-government relationship between the United States and Indian tribes.

Responsible Parties

CCUIH: The California Consortium for Urban Indian Health an alliance of direct service Urban Indian health organizations that supports health promotion and access for American Indians living in cities throughout California through community health organizing, training and technical assistance, public education and civic engagement, and policy advocacy.

CRIHB: The California Rural Indian Health Board is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian people of California, through providing advocacy, shared resources, training, and technical assistance.

IHP: Indian Health Program is a Department of Health Care Services program set up to improve the health status of American Indian living in urban, rural and reservation or Rancheria communities throughout California.

CAO IHS: The California Area Indian Health Service provides the healthcare delivery system to the State of California.

NCUIH: National Council on Urban Indian Health is the national 501(c)(3) organization devoted to the support and development of quality, accessible, and culturally competent health services for American Indians and Alaska Natives living in urban settings.

Appendix B

CCUIH's Policy Analysis of
Established Policy Change and Sustainability Models for
American Indian Traditional and Cultural Practices

Below is a list and overview of established Policy Change and Sustainability Models from other tribal communities and government systems. CCUIH reviewed these models with input from the Traditional Health Taskforce.

Oregon Tribal Cultural Best Practices

"Like the whale hunters of Alaska saying that the solution to hunger is the Whale and that the people of Plains must hunt whale, or that the corn growers of the Southwest will only receive whaling boats and harpoons as implements for over coming hunger in their communities." T. Tafoya

The adoption of SB 267, requiring that the state's Commission on Children and Families, Department of Corrections, Department of Human Services/Office of Mental Health and Addiction Services, Oregon Criminal Justice Commission, and Oregon Youth Authority spend an increasing amount of funding on evidence-based practices by the Oregon legislature, brought concerns about inequities in service delivery to Oregon AI communities. SB 267. This requirement causes agencies to bypass programs developed through tribal consultation, in favor of evidence-based programs (EBPs). EBPs are problematic for AI communities because they impose a linear approach that is greatly at odds with the circular worldview held by most AI people and do not allow communities to implement programs that they have used since immemorial.

In response to this requirement, advocates were able to get the agencies disclosed in SB 267 to use a Tribal Practice Approval form, which allows tribes to better express the validity of their practices. This form includes a key for Evidence Basis for Validity of the Tribal Practices including: Longevity of the Practice in Indian Country, Values incorporated in Practice, Principles incorporated in Practice, Elder's Approval of Practice, and Community feedback/evaluation of Practice. This form also allows the organization to demonstrate the risk and protective factors, health outcomes, and socioeconomic outcomes that are addressed by the practices. The use of a form like this in California could expand UIHO and tribal access to collaborations with state agencies and state funds.

Advocates provided three additional recommendations that are relevant to California. First, Oregon Tribes should be allowed time to design research and evaluation tools relevant to their communities, and AI researchers and evaluators should be consulted on culturally appropriate methods. UIHOs and California tribes are already implementing programs that would greatly benefit from formalized evaluation and research, so that these programs can be sustainably funded and duplicated to increase accessibility. Second, tribes should be allowed to classify programs as being culturally validated and culturally replicated by a panel of AI researchers, resulting in "practices based on evidence", i.e. programs AI people have been doing for generations, as well as recent programs that are viewed as culturally relevant and effective. Lastly, tribes should be given a thorough briefing on the intent of SB 267 and its potential impacts on prevention and treatment services within tribal communities. Similarly in California, tribes are often

given the opportunity to consult with government agencies regarding new laws and policies.

Key Points for Consideration:

1. Identify government departments that contain key supporters and programs that have windows of opportunity for systems changes.
    a. CCUIH has identified opportunities within the Drug Medi-Cal Organized Delivery System (DMC-ODS) Demonstration Waiver Amendment to advocate for an Indian Health Program Delivery system. We have partnered with Indian Health Service Are Office and DHCS Department of Indian Health Programs to create an amendment to the current DMC-ODS Waiver, which will outline a comprehensive Indian Continuum of Care, and potentially include a reimbursement for Traditional Healing.
    b. CCUIH is doing similar advocacy related to the 1115 Waiver.
2. Oregon's model set precedence for the validity of community-defined practices as equal to Evidence-based practices.
    a. CCUIH has actively been involved in the Community Reducing Disparities Projects' Native Vision Report, which builds on much of the ground work done by Oregon related to advancing the use of Community-defined practices.
3. Focus on outcomes and evidence
    a. Again, CCUIH is utilizing the work of the CRDP projects to strengthen the validity of Community-defined practices through culturally competent evaluation.
    b. CCUIH has also created an annotated bibliography, which is a living document to capture relevant research and studies to validate Traditional Healing as viable practices.
4. Create a community approval panel
    a. The Traditional Health Taskforce does not feel that this is a viable option for California. They believe that because Oregon is a small area with a Tribal Concentration in one area, and because they had already established collaborative systems and shared practices, that this worked for them. However, California is far from shared Tribal systems, and we have a high concentration of American Indians living in Urban areas so they recommended that we focus on strengthening the Sovereignty of tribes and the Self-determination of American Indian Organizations to develop validation systems that work for their communities and to advocate for the sustainability of their programs instead of building a certification body.
5. Create an American Indian research and evaluation body to be a resource to government systems and tribal Communities.
    a. The Traditional Health Taskforce thought this was a good idea, again not to be a defining entity, but advance public knowledge of Traditional Health systems. To create an academic journal focused on American Indian Healing Modalities.
6. Decide on a classification system for community-defined practices.
    a. The Traditional Health Taskforce did not want us to focus on fitting into a western categorical design, and they felt that it was not a good idea to homogenize traditional practices because it could risk maintaining the integrity of the practice and the intellectual property of Tribal communities.

VA Central California Health Care System

This policy, written in March of 2007, made American Indian traditional services available to patients to the extent that the patient's primary care provider approved the services as part of the overall treatment plan. The policy includes Talking Circles, use of traditional sacred objects, one-on-one counseling, group counseling, sweat lodge participation and any several tribal ceremonies. The services were made available to patients and residents of the VACCHCS through fee-for-service arrangements. According to Pete Molina, member of VACCHCS, traditional healers who provided these services were required to register as clergy members (personal communication, 2014). This requirement is in opposition to efforts to provide a culturally appropriate system of care and consequently, Traditional Healers could be discouraged from participating. Additionally, the requirement that patients must receive a referral from their doctor could be a barrier for patients who may not want to describe their need for traditional healing to a doctor who may not necessarily be culturally aware. This policy demonstrates the willingness of some government institutions to integrate traditional healing into their care provision.

Key Points for Consideration:

1. This was an example of a government health system that was willing to compensate for traditional healing practices.
    a. We found a similar example within the family court system in California.
    b. One issue is that government systems are often willing to include alternative modalities in public health systems if you are capable of fitting it into their model. This is something to consider in advocacy efforts. It will be important to recognize where compromise is viable and where the insertion of sovereignty might be a better option.

SB 52 and Native American Training Associates

In 1975, SB 52 was signed, creating the Indian Health Program under the California Department of Health Care Services (DHCS). In the regulations adopted by DHCS at this time, Traditional Healers were specified as individuals who could provide technical assistance to the program. DHCS contracted with the Native American Training Associates (NATA) to develop recommendations for a statewide plan for addressing traditional or sacred activities as they relate to fostering and protecting traditional Indian health practices. NATA compiled a report, with the advice of many California Indian elders and traditional people, but unfortunately their recommendations never came into fruition.

These recommendations are stipulated on three acknowledgements. First, that land is the basis for culture and religion and is necessary for the practice of traditional activities. Second, that the state offices and agencies can either enhance an over all state policy towards Indian traditional health or be destructive to traditional Indian values. The third is that Indian elders are essential in the development of traditional health, and should be given the resources to optimize their contributions.

NATA recommends that a traditional health component should be included in the administrative structure of the DHCS Indian Health Program, this unit should be responsible for the development of a five year traditional health plan that includes authorization for planning, implementation, monitoring responsibilities and application review. A Committee of Indian traditionalists should be formed, in addition to an Inter-

Agency Committee of offices that have any jurisdiction over Indian land, in order to maximize services, benefits, and eliminate damage. The offices participating in this Inter-Agency Committee should set aside a percentage of funds for traditional health development. NATA recommends that no less than 5% of the DHCS Indian Health Program budget should be spent on the traditional health component. NATA also recommends that the traditional health component focus on compensating traditional healers, facilitating research that can inform the development of a traditional health program for tribal youth, a developing a plan to protect plants used for traditional healing. These recommendations are focused on California Tribes, and since the time they were written the AI community in California has become increasingly urban.

This state-level Indian Health Program was under the Traditional Clinic Programs, which were unfortunately cut by Gov. Schwarzenegger in 2009. In it's last year of funding, the Indian Health Program provided $6.4 million in vital infrastructure grants to 75 UIHO and tribal clinics.

Key Points for Consideration:

1. It is important to build upon work that has already been done.
    a. In CCUIH's advocacy to restore the Indian Health Program funding, we will use NATA's recommendations, in addition to specific Urban program considerations, to advocate for the funding and integration of traditional healing within the restoration of the Indian Health Program.
    b. Also, CCUIH has developed an annotated bibliography that is a living document to incorporate and analyze attempts such as this to build upon and inform strategies for change.

First Nations Health Program at Whitehorse General Hospital in Canada

Whitehorse General Hospital is an inpatient facility, which evolved from concepts devised by a panel of elders. It is a model for integration that values and offers Traditional Healing in the same way they offer other services.

*CCUIH is still in the process of evaluating this model.

AB 163. Teaching credential: American Indian language-culture credentialing.
On July 13, 2015, Governor Jerry Brown signed an amendment to the existing law that allows for the credentialing of American Indian Language teachers to be authorized through the Commission on Teacher Credentialing. This law allows California Federally Recognized Tribes and/or Tribal Governments to recommend a candidate to receive credentialing through the commission. The amendment now allows for a distinction between language credentialing and/or cultural credentialing.

Key Points for Consideration:

1. The newly established amendment opens a window for state-level credentialing of Traditional Healers, as they are considered cultural teachers.
2. This credentialing process includes high-level background checks, etc. because it was designed to credential individuals working with youth. This is beneficial because it keeps that responsibility within state systems.

3. It will be important to advocate for the expansion of entities that are qualified to recommend candidates beyond Federally Recognized Tribes and Tribal Governments to include Urban Indian Health Organizations particularly for individuals providing services within their community health systems.

Traditional Healing and Managed Care Plans- New Mexico Model

Through advocacy efforts conducted through the Robert Wood Johnson Foundation's Center for Health Policy at the University of New Mexico and through Dr. Eliseo Torres' leadership. There is currently a $100 allowable reimbursement for Traditional Healing services through the United Health managed care plan.

Key Points for Consideration:

1. This model should be explored and duplicated to meet the Traditional Health needs of California American Indians.

Pilot Billing Models

The California Rural Indian Health Board was funded through SAMHSA to create their CRIHB CAIRS project, which included a pilot, billing model for Traditional and Cultural Practices. *CCUIH is in the process of collecting community input to identify the success and weaknesses of that project.

Dr. Carrie Johnson at the United American Indian Involvement was funded through a Los Angeles County Innovations Project to produce a pilot, billing model to be utilized within her Behavioral Health Program. *CCUIH is also reviewing this model with the Traditional Health Taskforce.

CCUIH's member organization, The Fresno Indian Health Project has just receive System of Care Funding through SAMHSA, and as a component of that project, they have asked the Traditional Health Taskforce to inform the development of a billing model.