



NATIONAL COUNCIL *of* URBAN INDIAN HEALTH

Recent Trends in Third-Party Billing at Urban Indian Organizations: Thematic Analysis of Traditional Healing Programs at Urban Indian Organizations and Meta-Analysis of Health Outcomes

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EXECUTIVE SUMMARY

This report serves as an update to the National Council of Urban Indian Health's previous reporting on recent trends in third-party billing.¹ This report focuses on how Urban Indian Organizations (UIOs) administer, evaluate, and fund traditional healing services. UIOs rely on Medicaid claims revenue to maintain services, but many UIOs have reported difficulty receiving reimbursement for traditional healing services. Recognizing the importance of culturally appropriate care, four states have initiated efforts to expand reimbursement for these services at Indian Health Service facilities, Tribal Health Centers, and UIOs. Arizona, California, Oregon, and New Mexico have submitted Traditional Healing reimbursement proposals to the Centers for Medicare & Medicaid Services (CMS) using Section 1115(a) demonstration waivers.

For the thematic analysis, NCUIH interviewed eight UIOs on their traditional healing programs and their ability to bill Medicaid for these activities at their clinics. Interviewed UIOs expressed that traditional healing programs and their holistic approach to health were popular with the patients they served. UIOs utilized pan-tribal traditional healing activities to sustain cultural connection and enhance community wellness in their multi-tribal urban AI/AN service population. Traditional healing programs were not stand-alone programs but integrated into all aspects of care by a staff member trained in traditional healing. Popular activities for traditional healing were talking circles, smudging, sweat lodge ceremonies, indigenized substance use recovery programs, and traditional food and diet programs.

However, funding was a recurrent barrier to providing traditional healing. Most states did not allow Medicaid reimbursement for traditional healing activities, which hindered the ability of most UIOs to meet the community demand for a more robust traditional healing program. Additionally, UIOs indicated there was a mixed consensus in their communities of the appropriateness of tracking health outcomes for traditional healing. UIO staff interviewed were generally in support of a limited and culturally appropriate approach to observing traditional health outcomes. However, they also expressed concerns that any outcomes research needs to protect patient privacy and respect the sacredness of traditional healing.

¹ NCUIH's prior reports regarding third-party billing can be accessed at <https://ncuih.org/research/third-party-billing/>





For the meta-analysis, NCUIH screened 14,791 articles and located 19 articles with quantitative estimates of traditional healing practices on health outcomes. NCUIH pooled these estimates using the *meta* statistical package, a meta-analysis program for the R 4.1 analysis software. All articles were divided into their outcome types (mental health, physical health, and substance use). Outcomes were also grouped by the nature of their measure (continuous or binary).

- We identified nine articles with traditional healing interventions on continuous mental health outcomes (four talking circle interventions, four sweat lodges, and one traditional food intervention). For continuous mental health measures, we estimated a pooled effect size of 1.29, indicating a “large” positive effect.
- We identified two articles with a total of three traditional healing interventions on binary substance outcomes. All three interventions were sweat lodge ceremonies. For binary substance use outcomes, we estimate that traditional healing interventions are three times as effective at substance use cessation as compared to standard interventions.
- The effect of traditional healing on all three outcomes analyzed together was between ($g = 0.58$) and ($g = .82$), indicating a “medium” to “large” effect size.

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I. INTRODUCTION TO URBAN INDIAN ORGANIZATIONS (UIOs)

The United States' trust responsibility to American Indians and Alaska Natives (AI/ANs) requires that the government provide services and resources to improve the health of AI/AN citizens (25 U.S.C. 1601(1), 2011). Furthermore, a "major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services" (25 U.S.C. § 1601(3)). In fulfillment of its trust responsibility and national goal, it is the policy of the United States "to ensure the highest possible health status for Indians and urban Indians and **to provide all resources necessary to effect that policy**" (25 U.S.C. § 1601 (1), 2011).

The federal trust responsibility for healthcare extends to all AI/ANs regardless of where they live. The United States, through the Indian Health Service (IHS), contracts with Urban Indian Organizations (UIOs) to fulfill its trust responsibility AI/ANs living in urban areas (25 U.S.C. § 1651, 2011; Indian Health Service, Office of Urban Indian Health Programs, 2022). UIOs were founded in the 1950s by urban AI/AN community leaders with the support of Tribes to provide a variety of services to AI/ANs living in urban areas. With the further support of Tribal leaders, UIOs were formally incorporated into the Indian health care system in 1976 with the passage of the Indian Health Care Improvement Act to help ensure AI/ANs living in urban areas received the healthcare required by the federal government's trust and treaty responsibilities. The creation of the Office of Urban Indian Health Programs was necessitated by frustration of Urban Indian communities with the bureaucratic and culturally hostile atmosphere at non-Indian hospitals in large cities (Fixico, 2000).

UIOs are essential to fulfilling the federal government's responsibility to provide health care for AI/ANs. They are an integral part of the Indian health system, which is comprised of IHS, Tribes, and UIOs (collectively the I/T/U system). Currently, there are 41 UIOs who receive annual funding through contracts awarded by IHS, pursuant to the Indian Health Care Improvement Act (IHCIA) (Indian Health Service, Office of Urban Indian Health Programs, 2022). UIOs provide "a wide range of culturally sensitive programs to a diverse clientele" and "are an important support to Native families and individuals seeking to maintain their values and ties with each other and with their culture." (National Urban Indian Family Coalition, 2008).

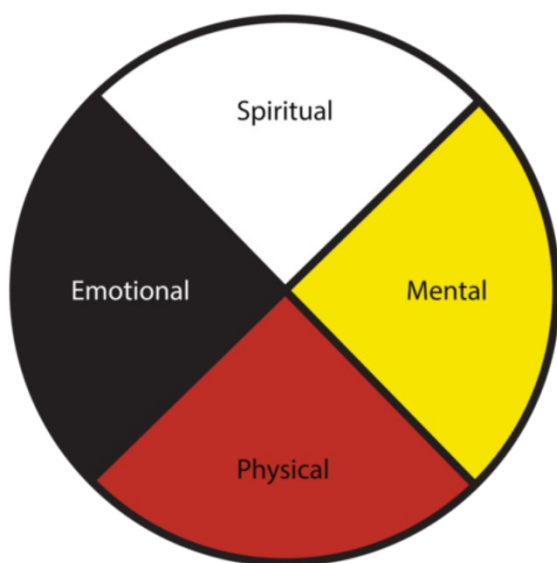




II. TRADITIONAL HEALING

Today, there are 574 federally recognized Tribes in the U.S. and many more that are state recognized or unrecognized by governing bodies of the United States. (*Tribal Leaders Directory | Indian Affairs*, n.d.). Each has unique beliefs, customs, and traditional healing (TH) practices, that are comprised of sacred ceremonies that have been practiced for centuries. Despite this vast diversity between Tribes, TH can take a pan-Indian approach with common values maintaining a harmonious balance of health and wellness through the four cardinal aspects of health—physical, spiritual, mental, and emotional health (Moghaddam et al., 2015). One way to depict this is the Medicine Wheel, which is used by various Tribes for health and healing purposes (*Native Voices- Medicine Ways: Traditional Healers and Healing*, n.d.). Different Tribes interpret the Medicine Wheel differently, but it typically is divided up into four intersecting quadrants representing four balanced forces, with each force represented by a distinctive color, such as red, yellow, black and white (*Native Voices- Medicine Ways: Traditional Healers and Healing*, n.d.). These forces can be representative of the four seasons, the four directions, the elements, stages of life, and components of wellbeing (*Native Voices- Medicine Ways: Traditional Healers and Healing*, n.d.). As shown in Figure 1, the Medicine Wheel can be used to support TH as a visual depiction of the importance of interconnectedness by balancing emotional, mental, spiritual, and physical health.

Figure 1. The Medicine Wheel Depicting the Four Aspects of Wellbeing and Health (United South and Eastern Tribes, Inc., n.d.)





Under the pan-tribal approach to TH, when the four components of health in an individual are disconnected or imbalanced, illness can arise (Broome & Broome, 2007; Vemireddy, 2020). Traditional healers act as stewards of AI/AN health who help individuals restore this delicate balance through ceremony and other Traditional Health Interventions (Broome & Broome, 2007). Traditional healers may be sought out for services not only related to physical healing, but also spiritual guidance, healing, reassurance, cleansing, and more (Marbella et al., 1998).

TH varies from Tribe to Tribe, but in general there are certain ideological differences between TH and Western Medicine. AI/AN community members served by a non-profit health center in an urban Midwestern region illustrated these differences by detailing their views on the difference between traditional healing and Western medicine (Moghaddam et al., 2015). This community specified that Native medicine addresses an individual's entire body, including the mind, whereas Western medicine treats specific and localized ailments. This community view is demonstrated by the following interview quote:

When you go to a medicine person, they not only treat you for whatever your illness may be, they believe in treating the whole body. Because there's also...the psychological...there's the exercise. It all is included in Native medicine. It includes the whole body, not just the area of illness. And they believe the whole body is affected so they cure the whole body if you do go to a medicine person. (Moghaddam et al., 2014) Despite these differences, Western and TH do not oppose each other. They can be used in tandem to comprehensively address a patients' health and wellness needs (Johnston, 2002; McLaughlin, 2010). Western treatment options can be combined with personalized TH services. Combined treatments can be effective at improving health outcomes, especially in urban environments where patients come from diverse indigenous backgrounds (Moghaddam et al., 2015). Health and wellness can be viewed as a continuum of physical, emotional, spiritual, and mental health concerns, in which both traditional and Western medicine can be combined to cover all needs across the spectrum of wellbeing (Marbella et al., 1998; Moghaddam et al., 2015).

Traditional Healing and AI/AN Health

TH practices address physical, emotional, spiritual, and mental health needs (Bargfeld & Cronkite News, 2022). Despite decades of federal efforts, including forced assimilation, termination, and relocation, AI/ANs have maintained their TH practices to address modern day health disparities and to also address historical trauma associated with former federal policies aimed at erasure of AI/AN identity (Bassett et al., 2012). While TH practices vary among Tribes and communities, some common forms of TH include herbal medicine, sweat lodges, ceremonies, talking circles, and smudging (Marbella et al., 1998; Pomerville et al., 2023). TH practices also include the growing, harvesting, and consumption of traditional foods as medicine. However, these practices are rarely covered by Medicaid or other health insurers. Lack of coverage and reimbursement can create barriers to accessing care for AI/ANs who prefer TH practices.





There is tremendous benefit in TH, traditional medicine, and other traditional practices for Native patients. According to the Minnesota Department of Health, “[r]esearch consistently points to the value of TH practices designed and delivered by American Indians, for American Indians,” and, “traditional healing for American Indians has outcomes equivalent to conventional interventions in other populations.” (Minnesota Department of Human Services, 2020). TH practices are proven to:

- Address whole health and the root cause of inter-generational trauma;
- Promote self-esteem and resiliency;
- Keep families intact;
- Help with identity formation and/or reclamation;
- Be utilized as a coping skill;
- Connect children, adults and elders and promote positive community integration and presence; and
- Helps assign meaning and purpose to life (Minnesota Department of Human Services, 2020).

By contrast, AI/AN-run health care systems are showing that medical care which integrates social, cultural, and spiritual connectedness into the health care system can create better outcomes for individuals and communities (Huhndorf, 2017). Respect for TH is also a matter of human rights. The United Nations Declaration on the Rights of Indigenous Peoples of 2007 reads, “Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination to all social and health services” (Article 24, United Nations, General Assembly, 2007).

Traditional Healing at Urban Indian Organizations

Either explicitly or implicitly, most UIOs incorporate the “Culture is Prevention” model into their services, where culturally based experiences and activities are offered to improve the physical, spiritual, emotional, and/or mental health of a patient as well as that patient’s community (National Council of Urban Indian Health, 2022b). The “Culture is Prevention” model allows UIOs the flexibility to tailor TH to the multi-tribal urban AI/AN population in their service areas (Masotti et al., 2020; National Council of Urban Indian Health, 2022b). This model allows for UIOs to offer culturally tailored care to their patients without excluding AI/AN patients due to tribal cultural differences.

The “Culture is Prevention” model utilized by many UIOs was developed by a community advisory workgroup of multiple UIO communities through a Substance Abuse and Mental Health Services Administration (SAMSHA)-funded project to develop an indigenized approach to preventing substance use and improving mental health in Indian Country (Masotti et al., 2020). The model focuses on the prevention of illness, rather than how to react to an already present illness as typified by Western medicine (Sloboda & David, 2021). Through this model, UIOs provide AI/AN cultural activities and practices the community identified as





having positive health and behavioral outcomes in their communities (Masotti et al., 2020). Culturally based experiences restore and maintain the balance between all four aspects—physical, mental, emotional, and spiritual—of a person’s being and their overall community. “Culture is Prevention” models have been implemented by Tribal Nations and UIOs, endorsed by the National Indian Health Board, and serves as the foundation of the Native Connections grant program administered by SAMSHA (Masotti et al., 2020; National Council of Urban Indian Health, 2022b; National Indian Health Board, 2017; SAMSHA Native Connections, 2018).

Our Study’s Definition of Traditional Healing

Definitions and practices of TH vary across Tribes. For example, in some cultures drumming is a sacred ritual done only by men of the nation, but in other cultures there is no custom for gender differences in who can drum and participate in associated ceremonies (Dickerson et al., 2021). This project applies the “Culture is Prevention” model to the literature around AI/AN healing practices, employing a multi-tribal definition that recognizes commonalities across traditions while acknowledging that these traditions will vary among Tribes and locations. Using this definition, this study focuses on sweat lodge ceremonies, talking circles, smudging, traditional food programs, and indigenized substance use treatment programs as these are some of the most common TH practices offered by UIOs. Additionally, there is a nascent research literature supporting the benefits of these specific ceremonies and practices.

According to a survey of UIOs administered by NCUIH in 2022, almost all (90%, n=37) of UIOs offer TH services (Figure 2). Among the 37 UIOs offering TH services, talking/healing circles, arts, and Indigenous foods are the most common (Figure 3).





Figure 2. Urban Indian Organizations (UIOs) that Offer Traditional Healing in 2022. (National Council of Urban Indian Health, 2022b).

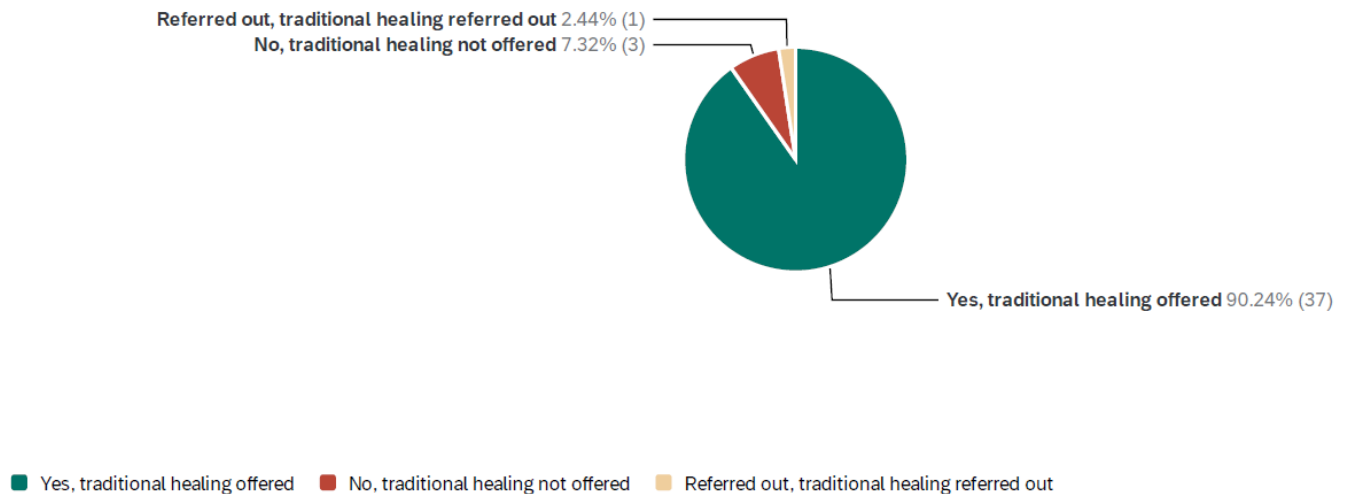
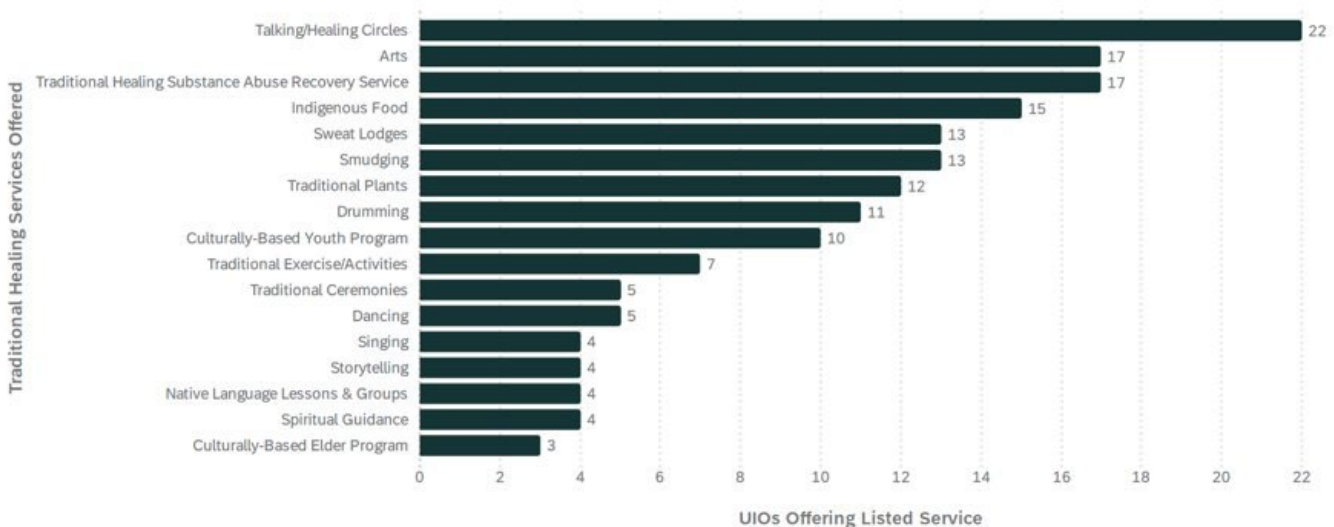


Figure 3. Types of Traditional Healing Offered at Urban Indian Organizations (UIOs) in 2022 (not referred out). (National Council of Urban Indian Health, 2022b).

Commonality of Different Traditional Healing Offerings at UIOs





Interventions

In this section, we describe common traditional healing services among UIOs—talking circles, sweat lodges, smudging, traditional diets and foods, and indigenized substance use treatment programs.

Talking Circles

Talking circles are a form of group communication, where several people gather in a circle to share their thoughts with each other on a particular subject. One person in the group is allowed to speak to their peers at a time. This time is designated by that individual holding a sacred object. Other members in the talking circle are to listen and reflect on what the person who is speaking is saying. The goal is to foster shared knowledge in the group, address commonalities, and understand how other's personal journeys and successes may help those with shared experiences. In talking circles, everybody's contribution is relevant and impactful, enhancing the overall knowledge of not only the group, but the community at large (Mehl-Madrona & Mainguy, 2014; National American Indian and Alaska Native ATTC Navigation, 2023).

Talking circles have been researched for their effectiveness in improving health outcomes. In a study of Cherokee youth that used substances the effectiveness of Cherokee talking circles was compared to a baseline of substance use education. Participants in the Cherokee talking circles experienced significantly lower levels of substance use symptom severity, compared to the group that only received substance use education (Lowe et al., 2012). The difference between the two groups persisted three months after the intervention ended (Lowe et al., 2012). Similarly, the group that attended talking circles had significantly higher Cherokee self-reliance scores three months after the intervention compared to the group that received only substance use education (Lowe et al., 2012). In another study, adults who reported problems with drugs, alcohol, and mental health who attended four talking circles reported a significant improvement in symptom severity and an increase in quality of life from before attending talking circles (Mehl-Madrona & Mainguy, 2014).

Sweat Lodges

Sweat lodge ceremonies are ceremonial steam sessions created with intense heat and are typically held in a traditional domed structure. These ceremonies are guided and monitored by trained traditional healers for the purposes of physical and/or spiritual purification and/or cleansing. This ceremonial sweat is usually done in groups, and depending on the culture, some sweats are exclusive to certain groups of people (i.e., men can only sweat with other men) (Garrett et al., 2011).

Sweat lodge ceremonies have been used for centuries to improve mental health, fight off diseases, improve spirituality, and enhance quality of life. Sweat lodge ceremonies have been used as a successful intervention for substance use recovery in AI/AN populations (Rowan et al., 2014). For example, Navajo patients that attended multiple sweat lodge ceremonies reported a





significant decrease in number of alcoholic drinks consumed compared to before attending the observed ceremonies (Gossage et al., 2003).

AI/AN sweat lodge ceremonies include the spiritual component of guided ceremonies and a physical component of passive heat therapy. Passive heat therapy is a wellness practice with variations across the world, including the Finnish Sauna, the Turkish Hammam, the Russian Banya, and the Japanese Sento. A recent literature review compiled evidence of the benefits of passive heat therapy from a cross-national selection of studies (Hussain & Cohen, 2018). Passive heat therapy was associated with improvements in joint pain, chronic fatigue, skin conditions, stress management, immune functioning, cardiovascular health, immune functioning, and detoxification (Hussain & Cohen, 2018). One study from Finland found that adults that attended more saunas were significantly less likely to have a fatal cardiovascular disease event, compared to those who did not, during a 15-year follow-up (Laukkanen et al., 2018). Another study from the Netherlands found that regular passive heat therapy improved insulin sensitivity (Hesketh et al., 2019). Although the mentioned literature does not include AI/AN sweat lodge ceremonies, the similarities in practice for other cultures' passive heat therapy traditions may share similar benefits as well. More research in collaboration with Tribes and Traditional Healers on the different AI/AN sweat lodge ceremony practices are needed to demonstrate the explicit benefits of the ceremony for Western ideals of evidence.

Smudging

Smudging is the ceremony of burning sacred medicinal plants (i.e., sage, tobacco, sweetgrass, cedar) and using the smoke to bless and/or purify people, places, or things—the practice varies based on the Tribe. Indigenous university students in Canada identified smudging as a method they used to manage depression and anxiety (Beshai et al., 2023). One study of American Indian women cancer survivors indicated smudging was a spiritual practice that gave them comfort and lessened the burden of their ailments (McKinley et al., 2020).

Traditional Diets and Foods

Traditional diets are foods and meals based on indigenous practices that limit or exclude Westernized foods. Colonization, destruction of indigenous food sources, forced assimilation, relocation, governmental food assistance programs, poverty, food deserts, and other factors have supported a diet that is high in highly processed calories, instead of the traditional foods of AI/AN culture and land (Cowell, 2018; Frank, 2021; “Indigenous Foods,” n.d.; National Indian Health Board, 2017; Warne & Wescott, 2019).

Numerous studies have concluded that increasing traditional food intake in indigenous populations is associated with an improvement in diet quality (Bersamin et al., 2008; Blanchet et al., 2020, 2021; Johnson-Down et al., 2019; Receveur et al., 1997;





Walch & Bersamin, 2020). For example, in one study with urban Alaskan Native women, higher traditional food intake was associated with better diet quality and health. (Bersamin et al., 2008). Another study found that Alaska Native students that attended a traditional food system school program (*Neqa Elicarvigmun*) showed an improvement in diet quality 4.57 times greater than their peers who did not. . Overall, increasing the traditional food intake of AI/AN people has shown to alleviate nutrition-based diseases, such as cardiovascular disease and type 2 diabetes, and allow for a healthier lifestyle (DeBruyn et al., 2020; Warne & Wescott, 2019).

Red Road Recovery, Wellbriety, and Indigenized Substance Use Recovery Programs

Ceremonies and activities rooted in AI/AN culture have been well studied as viable interventions for improving the four cardinal aspects of AI/AN health, and specifically substance use disorder (Rowan et al., 2014). Wellbriety and other Red Road recovery programs are indigenized substance use recovery programs. These programs incorporate the Medicine Wheel into the program's core curriculum as a foundation for maintaining balance and sobriety in one's life (Gone, 2011; Red Road Recovery, n.d.; Wellbriety Training Institute, White Bison, 2013a, 2013b). While there are many similarities to the twelve-step programs of Narcotics Anonymous and Alcoholics Anonymous, these indigenized approaches address the historical trauma unique to AI/AN people which has a significant influence on substance use (Coyhis & Simonelli, 2008; Gameon & Skewes, 2021; Gone, 2011; Wellbriety Training Institute, White Bison, 2013a, 2013b).

Marsha Linehan, Ph.D. the creator of dialectal behavioral therapy (DBT), an evidenced-based treatment for comorbid disorders, including substance use disorders, reviewed TH practices of AI/AN populations and stated that smudging, sweat lodge ceremonies, and talking circles all met the manualized goals of the “mindfulness” aspect of DBT. Because of this, Dr. Linehand determined it would be appropriate for providers to incorporate those TH components into their DBT interventions (Beckstead et al., 2015). Additionally, a 2015 study supported the combined use of DBT and TH practices to treat substance abuse disorder in AI/AN adolescents (Beckstead et al., 2015).

III. TRADITIONAL HEALING LAW & POLICY

Part I: Medicaid and Reimbursement for Traditional Healing Services

Medicaid is a joint state and federal program providing health care coverage to millions of eligible Americans, including low-income adults, children, pregnant women, elderly adults, and people with disabilities (Centers for Medicare & Medicaid Services, n.d.-c). The federal government sets guidelines for how the programs must operate, but each state administers their own Medicaid program (Centers for Medicare & Medicaid Services, n.d.-c). These federal requirements are broad, which allows states





flexibility in designing and administering their programs (Center on Budget and Policy Priorities, 2020). Medicaid is jointly funded through states and the federal government (Centers for Medicare & Medicaid Services, n.d.-c). The federal government guarantees Medicaid matching funds for the costs of covered services (Center on Budget and Policy Priorities, 2020). The fixed percentage of payment from the federal government, referred to as the Federal Medical Assistance Percentage (FMAP), differs by state, with economically disadvantaged states receiving higher amounts for each dollar they invest compared to more affluent states.

Under federal rules, state Medicaid programs are required to cover “mandatory” services including hospital and physician care (Center on Budget and Policy Priorities, 2020). While not required by law, each state can also cover additional “optional” services, such as dental care, vision services, hearing aids, and personal care services for seniors and people with disabilities. (Center on Budget and Policy Priorities, 2020). For those not served by managed care plans, state Medicaid and CHIP programs will pay hospitals, doctors, and other providers directly for covered services (Center on Budget and Policy Priorities, 2020). However, it is important to note that health care providers are not required to participate in Medicaid and CHIP, so some do not opt in (Center on Budget and Policy Priorities, 2020). Many UIOs participate in Medicaid and CHIP and thus American Indian and Alaska Native Medicaid and CHIP beneficiaries can get culturally competent care at these locations.

Processes to Make Changes to State Medicaid and CHIP Programs

Several provisions of the Social Security Act (SSA) provide states with flexibility in designing their Medicaid and CHIP programs including: Section 1932(a) State Plan Amendments (SPAs), Section 1915(b) waivers, Section 1915(c) waivers or a Section 1115(a) demonstration (Centers for Medicare & Medicaid Services, n.d.-d; Medicaid and CHIP Payment and Access Commission (MACPAC), n.d.-d). States using these authorities to make changes to their Medicaid and CHIP programs must do so in a way that is consistent with the statutory authorities and implementing regulations (*Managed Care Authorities | Medicaid*, n.d.). However, before states can make changes, they must apply for and receive approval from the Centers for Medicare and Medicaid Services (CMS)(Medicaid and CHIP Payment and Access Commission (MACPAC), n.d.-c). Federal approval is a legal requirement and is necessary as the federal government plays a role in funding at least half of the Medicaid costs in every state (Families USA, 2012).

For purposes of this report, particular attention will be given to Medicaid Section 1115(a) demonstrations because several states are currently seeking approval of Section 1115(a) demonstrations to expand reimbursement for TH services provided to American Indians and Alaska Natives receiving care in the Indian health care system (often referred to as the Indian Health Service(IHS)/Tribal/UIO or I/T/U system).





a. State Plan Amendment (SPA)

A state plan is a formal written agreement between the state and the federal government, as specified in 42 CFR § 430.10, and outlines the manner in which a state administers its Medicaid program (42 U.S.C. § 1396(a), 2022). States have the option to submit SPAs to make changes to their Medicaid and CHIP programs, such as updating “groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state” (Centers for Medicare & Medicaid Services, n.d.-e).

SPAs are filed through the states’ CMS Regional Office and can be filed at any time. The SPA process is used when states want to make changes to administrative aspects of their Medicaid program (42 CFR § 430.12, 2016). Once a SPA is submitted, CMS has 90 days to approve, deny, or request additional information about the SPA, otherwise the proposed change will automatically go into effect (42 CFR § 430.16, 2005). Once approved, changes can take place retroactively “to the first day of the quarter in which the state submitted the amendment.” SPAs do not expire, and changing a program contained in the State Plan or subsequent SPA can only be changed through a succeeding SPA (Families USA, 2012). There are no budgetary requirements, but changes must comply with federal Medicaid regulations and any exceptions are those stated in the federal Medicaid statute (42 CFR § 430.32, 2011).

If a state makes changes to its Medicaid program using a SPA submitted pursuant to the authority in Section 1932(a) of the Social Security Act, AI/AN beneficiaries have unique protections which differ from those of the general beneficiary population. Section 1932(a) plan amendments “may not require . . . the enrollment in a managed care entity of an individual who is an Indian (as defined in section 4(c) [1] of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)) unless the entity is participating in the plan and is the Indian Health Service (IHS), an Indian health program operated by a Tribe or Tribal organization pursuant to an Indian Self-Determination Act contract, or a UIO operating pursuant to an Indian Health Care Improvement Act contract with IHS (42 U.S.C. § 1396u-2(a)(2)(C)).”

b. Section 1115(a) Demonstration

The Public Welfare Amendments of 1962 (P.L. 87-543), which added Section 1115(a) of the Social Security Act, granted the federal government the authority to waive compliance with numerous requirements of the SSA (Medicaid and CHIP Payment and Access Commission (MACPAC), 2011; Public Law 87-543, Sec. 122, 1962). PL 89-97 amended Section 1115(a) to broaden this authority to include the requirements for state plans for medical assistance (42 U.S.C. § 1315, 2010; 42 U.S.C. § 1396(a), 2010;





Public Law 87-543, Sec. 122, 1962; Public Law 89-97, Sec. 1109, 1965).² Section 1115(a) therefore permits states to make broad, structural changes to their Medicaid program, on a demonstration basis, if the Secretary of Health and Human Services determines that the demonstration project is likely to assist in promoting the objectives of the Medicaid program (42 U.S.C. § 1315, 2010; Centers for Medicare & Medicaid Services, n.d.-a). CMS has issued comprehensive regulations governing the submission and approval (or denial) of Section 1115(a) demonstrations, commonly referred to as “Transparency” requirements (42 CFR § 431.400-428, 2010). Required contents in a Section 1115(a) demonstration application include:

- (i) A comprehensive program description of the demonstration, including the goals and objectives to be implemented under the demonstration project.
- (ii) A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration to the extent such provisions would vary from the State's current program features and the requirements of the Act.
- (iii) An estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable.
- (iv) Current enrollment data, if applicable, and enrollment projections expected over the term of the demonstration for each category of beneficiary whose health care coverage is impacted by the demonstration.
- (v) Other program features that the demonstration would modify in the State's Medicaid and CHIP programs.
- (vi) The specific waiver and expenditure authorities that the State believes to be necessary to authorize the demonstration.
- (vii) The research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, a plan for testing the hypotheses in the context of an evaluation, and, if a quantitative evaluation design is feasible, the identification of appropriate evaluation indicators.
- (viii) Written documentation of the State's compliance with the public notice requirement (CFR § 431.412(a)(1)(i)-(Viii), n.d.).

² See 42 U.S.C. § 1315 (current authority for Section 1115 demonstration projects, including changes to the law following its enactment in 1962)





In addition to confirming compliance with the regulatory and statutory requirements for proposal design and submission, CMS reviews each Section 1115(a) demonstration proposal to determine whether the objectives of the demonstration are aligned with those of the Medicaid program, whether the proposed waiver authorities are appropriate, and whether the demonstration is budget neutral (Centers for Medicare & Medicaid Services, n.d.-a). Because Section 1115(a) demonstrations can vary in scope and complexity, states often must engage in a lengthy negotiation process with CMS to receive approval (Medicaid and CHIP Payment and Access Commission (MACPAC), n.d.-b).

CMS approves Section 1115(a) demonstrations for an initial five-year period (Centers for Medicare & Medicaid Services, n.d.-a; Medicaid and CHIP Payment and Access Commission (MACPAC), n.d.-b). Approval generally can be renewed for an additional three years, though it may sometimes be granted for an additional five years, depending on the impacted beneficiary population (Centers for Medicare & Medicaid Services, n.d.-f).

Part II: Culture as Healing: A Look at Medicaid and CHIP Reimbursement for Traditional Healing Services

Traditional healing services are currently not a Medicaid and CHIP covered service (MACPAC, 2021). However, there is growing support for the expansion of Medicaid coverage for TH, especially because TH is already incorporated into the I/T/U healthcare delivery system and both IHS and Congress have expressed their support for these services (25 U.S.C. § 1680u, 2010; Indian Health Service, n.d.-b). States have worked with Tribes to take steps to apply for authority to cover TH services provided by Indian health providers (MACPAC, 2021, NIHB 2020a).

Opportunities for States to Change Medicaid and CHIP Programs

There is growing interest by states in exploring the potential benefits of TH practices (Bargfeld & Cronkite News, 2022). Despite the Indian Health Care Improvement Act (IHCIA) and Indian Health Service (IHS) authorizing TH practices for AI/AN patients, TH practices have not been covered as separate services by state Medicaid programs. (25 U.S.C. § 1680u, 2010; Indian Health Service, n.d.-a). Funding for TH has been minimal and has mainly come from tribal funds, pilot programs, grants, and personal resources from staff within the IHS/Tribal/UIO (I/T/U) system (National Council of Urban Indian Health, 2022a). The AI/AN community recognizes the valuable contributions of their healers and practitioners and have long aimed to offer TH services in, at, or through I/T/U facilities in a complementary manner often alongside Western-based delivery models to benefit AI/AN patients who request these services (National Council of Urban Indian Health, 2022a).

i. Addressing Social Determinants of Health through 1115(a) Demonstration Waivers





States are utilizing Section 1115(a) demonstration waivers to implement innovative and tailored solutions and approaches to address social determinants of health (SDOH). Social determinants of health (SDOH) “consider the non-clinical factors that can profoundly impact an individual’s well-being” (Nova & Clements, 2023). These factors can include housing instability, food insecurity, and the ability to afford or obtain medications (Nova & Clements, 2023; Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services, n.d.). To address these social determinants, providers can rely on non-clinical services or provide medical services in alternative settings (Nova & Clements, 2023). Pursuant to certain statutory and regulatory authorities, states can add non-clinical services to their Medicaid programs, by using funds to pay costs of services such as housing and food (Hinton & Ortega, 2021). These non-clinical services may include case management, housing support, employment support, and peer support services (Hinton & Ortega, 2021).

CMS allows states the flexibility to design their Medicaid programs, including shifting from volume-based payments to value-based payments (Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services & Costello, 2021). The interest in addressing SDOH through Medicaid has grown as more states move toward alternative payment models and value-based care (Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services & Costello, 2021).³

There is also recent precedent for non-conventional or non-medical practices to be included and covered under Medicaid through a Section 1115(a) demonstration. One such example is produce prescriptions. Massachusetts, Oregon, North Carolina, and Arkansas are using 1115(a) demonstrations to fund “food-as-medicine interventions” (Held, 2023). These demonstrations are being used to address categories of “health-related social needs” (HRSN)⁴ (Held, 2023). This program differs from existing federal programs, such as the Supplemental Nutrition Assistance Program (SNAP) or the Women, Infants, and Children Nutrition Program (WIC), in that there must be a medical need established to qualify (Held, 2023).

Because states can use Section 1115(a) demonstrations to make changes to their Medicaid programs on a demonstration basis, with the goal of promoting the objectives of the Medicaid program, (42 U.S.C. § 1315, 2010; Centers for Medicare & Medicaid

³ For example, North Carolina’s “Medicaid Reform Demonstration” is piloting interventions for housing, transportation, and food (Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services & Costello, 2021). Through this 1115(a) demonstration, North Carolina developed an incentive payment fund to provide value-based payments for health and socioeconomic outcomes. (Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services & Costello, 2021).

⁴ Health-related social needs are an individual’s unmet, adverse social conditions like housing instability, homelessness, or nutrition insecurity. These conditions significantly impact one’s health and arise from the underlying social determinants of health, which encompass the circumstances in which people are born, develop, work, and age. See generally CMS, SMD #: 23-001 RE: Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care, (Jan. 4, 2023), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf>.





Services, n.d.-a) a state could develop a demonstration project that integrates TH practices into its Medicaid program, with the goal of improving health outcomes and reducing healthcare costs (Families USA, 2012; Waddill, 2022). Thus, Medicaid programs aiming to promote health equity should consider the potential impact of a 1115(a) demonstration and explore all available options to achieve their goals.

1115(a) Demonstrations and Traditional Healing: State Case Studies

Several states have submitted Section 1115(a) demonstration project waivers to expand access to traditional healing services through their state Medicaid program.

Arizona

In Arizona, IHS, Tribal facilities, and UIOs have integrated TH practices into healthcare delivery services for AI/ANs (Arizona Health Care Cost Containment System, 2016). In 2015, the Arizona Health Care Cost Containment System (AHCCCS) established its Traditional Healing Workgroup with the intended purpose of providing culturally appropriate options for AI/AN AHCCCS beneficiaries. The goal was to maintain and sustain health and wellness through TH services made available at, in or through a facility that provides or arranges TH services (Arizona Health Care Cost Containment System, 2020). In 2016, the AHCCCS submitted their initial TH Section 1115(a) demonstration proposal developed, in part, by the Traditional Healing Workgroup to CMS (Arizona Health Care Cost Containment System, 2016).

AHCCCS continues to negotiate coverage for TH services with CMS (Arizona Health Care Cost Containment System, 2020; Ducey, 2020). As of 2022, the request for reimbursement includes TH services provided by IHS, Tribal facilities, and UIOs (Arizona Health Care Cost Containment System, 2022). CMS noted in their October 14, 2022, letter approving most of Arizona's Section 1115(a) demonstration proposal that while the agency did not approve the TH portion of the demonstration proposal, it "recognizes the state's goals of addressing disparities in the American Indian and Alaska Native community and will continue to work with the state on this traditional healing request" (Tsai, 2022).

California

Starting in 2017, the California Department of Health Care Services (DHCS) submitted a Section 1115(a) demonstration to CMS which included a request to cover traditional healer and natural helper services under the Drug Medi-Cal Organized Delivery System (DMC-ODS) (Department of Health Care Services, 2022). The stated purpose of this request was "to provide culturally appropriate options and improve access to SUD treatment for American Indians and Alaska Natives receiving SUD treatment services through Indian health care providers" (Department of Health Care Services, 2022). When this was unsuccessful, DHCS





submitted a second request in 2020, and CMS neither approved nor disapproved of this request (Cooper, 2020; Department of Health Care Services, 2022). With no definitive response, DHCS submitted a third request to CMS in 2021, which remains pending with CMS (Cooper, 2022). In an effort to reform and improve outcomes for the millions of people in California enrolled in Medi-Cal, the DHCS launched the California Advancing and Innovating Medi-Cal (CalAIM) in December 2021, including efforts to amend the state's 1115(a) demonstration to authorize CMS reimbursement for TH services (Department of Health Care Services, n.d.).

DHCS continues to seek federal reimbursement for all substance use disorder (SUD) services provided by traditional healers and natural helpers as part of CalAIM's focus on advancing health equity (Cooper, 2020). CalAIM recognizes TH practices are a fundamental element of Indian health care that help patients achieve wellness and healing, restore emotional balance, and improve their relationship with the environment (Cooper, 2020). Medi-Cal has stated that they recognize the critical need to reimburse for these services in a manner that respects and maintains the sanctity of these ancient practices, particularly in addressing SUD (Department of Health Care Services, 2022).

Despite the pending CMS approval, DHCS has been working with community partners and remains committed to securing CMS approval for coverage of TH services. DHCS developed the Tribal Medication Assisted Treatment (Tribal MAT) program, to promote and improve the availability of medication assisted treatment while also incorporating Tribal and Urban Indian values, culture, and treatments (California MAT Expansion Project, California Department of Health Care Services, 2023). The goal of the Tribal MAT is to "...support the local integration of cultural and traditional healing and recovery practices into developing or existing Tribal and Urban Indian health programs for SUD services" (California MAT Expansion Project, California Department of Health Care Services, 2023). This program is funded from the California State Opioid Response (SOR) grant through the Substance Abuse and Mental Health Administration (SAMHSA).

Oregon

In 1994, Oregon's initial 1115(a) demonstration waiver established the Oregon Health Plan (OHP), which is Oregon's Medicaid and CHIP program (Oregon Health Authority, n.d.-b). Oregon has been working to use its Section 1115(a) demonstration waiver to provide coverage for TH services for AI/ANs and the state has taken steps to improve access to culturally appropriate healthcare services for AI/ANs through other initiatives that focus on substance use disorders and mental health care (Brown, 2020).

In 2016, the OHA created the Behavioral Health Collaborative (BHC) aimed at enhancing the care systems for behavioral health to better serve Oregonians (Oregon Health Authority, n.d.-a). The BHC is made up of approximately 50 Oregonians from various stakeholder groups including peer support services, advocates, counties, behavioral health providers, courts, CCOs, as





well as a representative from an Oregon Tribe and a representative from a UIO (Oregon Health Authority, n.d.-a). In response to this effort, Oregon's nine Tribes, the UIO Native American Rehabilitation Association (NARA), and the Northwest Portland Area Indian Health Board (NPAIHB) articulated a need to work together to address behavioral health care in AI/AN communities within the state (Oregon Health Authority, n.d.-c). Representatives from the nine tribal organizations, NARA, and the NPAIHB formed the Oregon Native American Behavioral Health Collaborative (Oregon NABHC), which works to create unique behavioral health systems that are appropriate for the communities they serve (Oregon Health Authority, n.d.-c).

In March of 2019, the Oregon NABHC convened to address the behavioral health concerns of AI/AN people in Oregon by developing a strategic plan (Oregon Health Authority, n.d.-c, p. 2). While the 2019 to 2024 Strategic Plan does not include any specific language on TH services, Strategic Pillar 5 "Governance and Finance" has a strategic outcome of "maintain[ing] the existing tribal billing structure, including encounter rates and the fee-for-service system, *and expand reimbursement codes* [emphasis added]" (Oregon Health Authority, n.d.-c). Action steps for this pillar include "expanding billing codes for peer support specialists, family support specialists, and recovery mentors" as well as "include billing codes for tribal-based practices" (Oregon Health Authority, n.d.-c, p.15).

In 2019, Oregon's Senate Bill 134 was passed into law and authorizes the Oregon Health Authority to "[d]evelop uniform contracting standards for the purchase of health care including . . . [s]tandards that accept and consider tribal-based practices for mental health and substance abuse prevention, counseling and treatment for persons who are Native American or Alaska Native as equivalent to evidence-based practices." (Oregon State Senate Bill 134, 2019). This bill also mandated that:

[A] medical assistance program shall consider tribal-based practices for mental health and substance abuse prevention, counseling, and treatment services for members who are Native American or Alaska Native as equivalent to evidence-based practice for purposes of meeting standards of care and shall reimburse for those tribal-based practices. (Oregon State Senate Bill 134, 2019)

According to the OHA, examples of tribal-based practices include talking circles, sweat lodges, and horse programs (Johnson et al., 2022).

In 2017, Oregon's 1115(a) demonstration renewal expanded investment in social determinants of health (SDOH) through the use of health-related services (HRS), which allowed CCOs a specific funding mechanisms in their budgets to address the SDOHs, including health-related social needs (HRSNs) of their members (Wachino & Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, 2017). On February 8, 2022, Oregon submitted a 1115(a) Demonstration Waiver renewal application to CMS, which included a request for reimbursement for tribal-based practices as well as extended coverage of new





health-related social need (HRSN) services to tribal members not enrolled in a CCO in an effort to strengthen and improve coverage for American Indians and Alaska Natives in Oregon. On September 28, 2022, CMS addressed this request but ultimately, did not approve these proposals and stated that they will “continue to explore these proposals with the state” (Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services & Brooks-LaSure, 2022).

New Mexico

New Mexico's Medicaid program, known as Centennial Care, is primarily managed under a Section 1115(a) demonstration waiver (Grisham, 2022). Approximately 92 percent of New Mexico's Medicaid and CHIP beneficiaries are enrolled in one of three managed care organizations (MCOs) (Kaiser Family Foundation, 2022). MCOs are compensated by the state on a per member, per month basis, also called a capitation rate (Centers for Medicare & Medicaid Services, n.d.-b; Medicaid and CHIP Payment and Access Commission (MACPAC), n.d.-a). MCOs take responsibility for overseeing patient care and managing reimbursement to providers (Vestal, 2011). MCOs provide medical services to Medicaid beneficiaries through their own networks of doctors and hospitals, and Medicaid beneficiaries must seek care through their MCO's network (Vestal, 2011).

In 2018, CMS approved a five-year extension of the New Mexico 1115(a) demonstration, which included TH services for certain Native Americans, and the state changed the demonstration name to Centennial Care 2.0 (Smith-Leslie, 2018). Under Centennial Care 2.0, a Native American beneficiary who is eligible for community benefit services and enrolled in the Self-Directed Community Benefit Program may include services from Native American healers as a specialized therapy in their care plan. (Smith-Leslie, 2018). The approved 1115(a) demonstration limits overall expenditure for specialized therapies to \$2,000 annually. To make this member-directed benefit possible, each MCO collaborates with a financial management agency (Grisham, 2022).

In December 2022, New Mexico submitted its renewal application to CMS and introduced the program under a new name, Turquoise Care, with an effective date of January 1, 2024 (Grisham, 2022). Under the proposed Turquoise Care plan, New Mexico seeks to expand access to TH to all AI/AN beneficiaries enrolled in managed care. (Grisham, 2022, p. 46). AI/AN beneficiaries would be provided with a \$500 per year budget for TH services provided by traditional healers. Beneficiaries enrolled in the Self-Directed Community Benefit Program⁵ would continue to have the option to include services from Native American healers as a specialized therapy in their care plan but would not receive an additional \$500 per year. Services provided as a community benefit service which would also be eligible for reimbursement under the expanded proposal include: “prayer, dance, ceremony and song, plant

⁵ The New Mexico Medicaid Community Benefit Program provides long-term services and supports to members who need assistance to live at home or in a community setting rather than in a long-term care facility.





medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing” like the medicine wheel. (Grisham, 2022).

IV. UIO INTERVIEWS

To better understand how UIOs administer and fund TH services, NCUIH contacted UIOs to participate in remote video interviews. UIOs were randomly selected from a stratified sample based on services offered. NCUIH also tried to recruit UIOs from the four states who have submitted a Section 1115(a) demonstration waiver with proposals expanding Medicaid reimbursement for TH. NCUIH began recruiting UIOs in December 2022 and contacted 17 UIOs. Eight UIOs were interviewed between February 23, 2023 and April 19, 2023.

The following categories were represented in the interviews:

- UIOs Offering Smudging: 1 UIO was randomly selected from among the 13 UIOs who reported offering smudging on a 2022 NCUIH survey of UIO services. All 8 UIOs that were interviewed offered some form of smudging at their site.
- UIOs Offering Sweat Lodges: 1 UIO was randomly selected from among the 11 UIOs who reported offering sweat lodges based on a 2022 NCUIH survey of UIO services. 5 of the 8 UIOs interviewed offered sweat lodge ceremonies.
- UIOs Offering Talking Circles: 1 UIO was randomly selected from among the 18 UIOs who reported offering talking circles on a 2022 NCUIH survey of UIO services.
- UIOs in States with 1115a waivers: 3 UIOs were selected from among the 18 UIOs across 4 states based on their state having a Section 1115a waiver.

Two additional UIOs were selected at random. The sampling resulted in the following representation based on NCUIH’s assigned regions: two UIOs from the Southwest region, one UIO from the Eastern US, one UIO from the Great Plains, and one UIO from Great Lakes. In NCUIH’s regional assignment, California is treated as its own region because it contains 10 UIOs, the largest concentration of UIOs in a single state. One UIO from California participated in an interview. Montana is treated as its own region because it contains 5 UIOs, the second largest concentration of UIOs in a single state. Two UIOs from Montana participated in interviews.

V. THEMATIC ANALYSIS OF INTERVIEW RESPONSES

As previously stated, UIOs are not a homogenous group and do not serve a homogenous Native population. Traditional healers in the UIOs go by different names, such as cultural specialists, cultural brokers, cultural nurses, medicine persons (i.e. men





or women, sometimes gender specific). However, for this report, they will be referred to as traditional healers or healers. The following sections contain summaries and thematic analysis of the information NCUIH received during its eight interviews with UIO staff regarding TH.

A. The Role of Traditional Healing at UIOs

TH is not required but is available to all patients at UIOs offering TH. Traditional healers in the UIO setting frequently communicate with medical providers to best coordinate care for the patient. UIO providers and staff are educated on the benefits and the history of TH practices to help best inform patients of TH options. They encourage providers to sit with patients and inform them of traditional approaches to supplement their care.

[W]e do have Peer Support Recovery workers as well as Case Managers where they are, they have kind of a dual affiliation with our behavioral health program, as well as traditional healing and so they do a lot of linkages around that. And the other thing I should add is our Traditional Wellness Program does a lot of hands-on case management services that are also integrated with the Cultural Wellness. (Southwestern UIO)

TH staff frequently work in other departments such as behavioral health, health promotion, community wellness, medical, and case management, so incorporating TH into their work is natural. For example, smudging can occur before individual therapy sessions, talking circles, medical visits, case management appointments, and surgery. Talking circles are used for support services for intimate partner violence, trauma, housing insecurity, and substance use recovery curriculums. Diabetes programs have community gardens that grow indigenous foods and healthy cooking classes use traditional recipes as a foundation. Pregnancy and postpartum programs have lactation classes led by trained traditional healer lactation consultants. Substance use recovery programs have patients build sweat lodges, attend sweat lodge ceremonies (SLCs), and participate in drumming groups. The Arizona UIO described recovery programs that incorporate the patient's family to maintain the "traditional value of family."

UIOs work to find the balance between TH and Western medicine. UIO staff emphasized that TH practices are distinct from Western practices, even when a UIO weaves them together for patient care. At the Great Lakes UIO, the staff emphasized that TH is "self-care" and "preventative care," it is an indigenized approach that is often dismissed by Western approaches to health. Maintaining balance in all aspects of your life, whether emotionally, physically, spiritually, mentally, and even culturally, is essential for staying healthy—which UIOs work to do with both TH and Western medicine.

B. Staff Providing and Leading Traditional Healing Ceremonies and Activities





UIOs have established personnel that provide TH for their communities. In Western medical settings, providers have certain education and training requirements and are licensed by the state to practice a certain scope of services. While the credentialing process for traditional healers at each UIO varies from Western licensure and credentialing for health care providers, nearly all TH is done by a vetted individual educated in the traditional ways.

We created our own internal credentialing process. We have a form for traditional healers, we ask about how they trained to offer a ceremony, who they studied with, how they received tribal permission to offer that ceremony, and our cultural services team reviews that application. (Arizona UIO)

UIOs do not hire traditional healers solely based on Western educational credentials. However, many healers do have degrees (e.g., doctorates, masters) in a specific field, but an educational background in Western medicine is not sufficient to host TH ceremonies or activities.

Several UIOs look for either formal or informal recognition from the traditional healer's Tribe to ensure the integrity of their services. UIOs stressed the importance of trust and credibility for their TH personnel. Earning formal recognition from a Tribe is a rigorous process which often requires serving in apprenticeships for many years and the assent of tribal elders. One UIO has a mentorship program for new TH staff to demonstrate their existing knowledge in TH and then teach them the UIO's approach to TH for their multiracial patients. The Arizona UIO mentioned third-party Native organizations, outside of Tribal government, that provide credentials to the traditional healers (i.e., Navajo Nation's consortium of traditional healers where a person can formally graduate to be a traditional healer). The TH vetting process is complicated, and even a vetted background in TH is not sufficient to lead all ceremonies offered at a UIOs. UIOs stressed the importance of the traditional healer being the appropriate person for specific TH ceremonies and activities. For instance, the Great Plains UIO interviewed for this project holds talking circles for substance use recovery, but these talking circles are held by peer recovery specialists and not to be held by TH staff who are not sober and in recovery themselves. This also applies to SLCs, sweats specifically for two-spirit and non-binary people are not to be conducted by a healer who is not two-spirit or non-binary themselves. "[A cultural service provider] just provide[s] smudging and talking circle but not ready for sweat lodge" (Arizona UIO).

It was common among UIOs interviewed for traditional healers specializing in talking circles to also be licensed and trained as substance use counselors, peer support recovery specialists, and therapists. Additionally, many traditional food programs are held by licensed nutritionists that are educated in Indigenous nutrition.

We do it in terms of our system to ensure that the individual receives the most appropriate Cultural Care, as well, as takes part of a very safe practice so that the individual benefits for the wellbeing. (California UIO)





Due to limitations for budgets, physical space, staff, and traditional medicines, some UIOs refer their patients to outside traditional healers. UIOs that must refer out to Tribes or other sources for TH ceremonies or activities still maintain high standards for TH qualifications and follow up with these third parties to ensure the credibility and appropriateness of the traditional healer and their processes. UIOs stated the safety of their patients during any TH practice is the priority.

Smudging is the only TH practice that is not always conducted by established traditional healers. It is commonplace for UIOs to give traditional medicines and smudge kits to the community for their own use and provide training to their staff and demonstrations to their patients on smudging rituals. For example, the Great Lakes UIO provides smudge kits as a convenient “drive-thru” service. Traditional healers at the UIO site will educate the community in smudging so the community is aware of the importance and benefits. For example, the Great Lakes UIO provides smudge kits as a convenient “drive-thru” service. Smudging kits shared with the community are often paired with informational cards detailing these facts. However, smudging that is a part of a ceremony or specifically requested for an individual, including at offsite care facilities, are most often provided by traditional healers.

C. How UIOs Provide Culturally Tailored Healing Efforts to a Multi-Tribal Population

UIOs serve a Native patient community that has origins “from Alaska, North Dakota, to Texas” (Arizona UIO), and thus are faced with providing culturally tailored TH to a multiracial and multicultural population. UIOs take patient and community feedback on what cultural aspects should be represented during TH. The California UIO uses “community to find practice, as much as possible.” A few UIOs have boards of elders and cultural consultants to act as advisory committees to ensure that different traditions are accurately represented and respected. At a Montana UIO, the committee also “teach[es] the staff...this is the world view of that began in the [Tribe] people, of the [another Tribe] people...so that [the staff] can create those connections with those community member.” UIOs view different cultural TH practices as learning opportunities for both staff and their patients and remain “transparent in terms of what they can provide” (Arizona UIO).

The consensus at UIOs is if a patient asks for a specific tradition represented, then the UIO staff will try to serve that request as best they can, given their resources. Having multiple TH personnel with different TH backgrounds is crucial for these programs to work in the urban AI/AN context.





Talking Circles

UIO talking circles were not guided by a specific Tribe's practice. However, some UIOs mentioned that the talking circle traditional practices would defer to whatever traditions the traditional healer guiding the talking circles practiced. UIOs found that talking circles were easily applied to a multitribal community.

Talking circles are kind of universal...but people in our, again, the core group of people in [city], they very much appreciate it when folks from other Tribes come to share their knowledge and that again, because they are feeling such great disconnection, and often, difficulty connecting with what might have been their traditional teachings. (Eastern Region UIO)

Sweat Lodge Ceremonies

Sweat Lodge Ceremonies (SLCs) were the most difficult ceremony to make appropriate for all patients, even by UIOs with TH staff from diverse traditional backgrounds. To accommodate diverse traditions, several UIOs offer different traditional healers to perform their SLC to tailor to all participant's traditions. Noted obstacles for SLCs were: having SLCs separated by gender, the type of prayer to happen, elder-specific SLCs, and who can drum during the ceremony.

While smudging and talking circles are generally not tailored to a specific cultural tradition, numerous UIOs in different regions of the United States followed the Lakota tradition for SLCs. The Arizona UIO expressed that the healer needs to be aware, respectful, and open to sharing their own traditions and the community's traditions when conducting a SLC, but also "deferring to the, to the...nations which land we're, our properties are sitting on." The Arizona UIO was the only UIO to specifically mention the SLC traditions of their local area.

UIOs that must refer out their SLCs to local Tribes and universities also deferred to the land's nation for SLC practices. In these instances, the third party holds the SLC themselves instead of the UIO personnel. UIOs that referred out SLCs expressed discontent that they could not offer SLCs tailored to an urban AI/AN audience.

Smudging

Most UIOs did not report difficulty in providing smudging or other traditional medicines to their multicultural community. The Great Lakes UIO noted their smudging services are popular among AI/AN patients from many Tribes, including the First Nations of Canada. The smudging was also popular with patients with of indigenous backgrounds from Latin America.

On the other hand, a Montana UIO indicated that "not every Tribe practices smudging and so we are really culturally sensitive to who would like to smudge and who that just doesn't fit in with their culture." These differences are seen as a learning





opportunity by UIOs to share the “different kinds of relationship with medicine and how medicine can vary across Tribes” (Eastern Region UIO).

Recovery Programs

UIOs commented that their patients who are in recovery or incarcerated feel so disconnected from their culture that their “identity is kind of stripped from them” (Montana UIO). Any connection to Native culture is appreciated by these patients, even if not specific to their Tribe.

UIOs provide TH to a multiracial population by demonstrating a strong emphasis on community engagement and cultural education, with the knowledge that not all cultures can be represented to the same extent as others.

D. Uses of Traditional Healing Ceremonies and Services

TH is used to increase cultural connection, enhance preventive care, combat loneliness and isolation, and specifically address historical trauma. UIOs noted benefits range from the spiritual, to the emotional, to the mental, and physical. TH at UIOs offers AI/AN patients cultural connection and community while also treating their other physical health issues. At UIOs, health is viewed from a holistic approach and traditional healers ensure that all four aspects of a person’s being are in balance.

But in the research that I did in this community, our community members told us that they felt that they weren't able to achieve and sustain wellness because they were disconnected from culture and ceremony. (Eastern Region UIO)

Traditional Foods

Nutritional programs, diabetes programs, and traditional foods are all interconnected at UIOs. Many nutritional programs at UIOs are indigenized to support the promotion of not only a healthy diet, but a healthy diet based in the culture and tradition from various Tribes. These programs sometime include maintaining a community garden for patients to help tend to and bring home indigenous produce. Educational cooking classes and community gardens improve mood, increase community connectedness, promote physical activity, and aid in the prevention and management of diabetes along with other nutrition-based illnesses.

Talking Circles

Talking circles build bonds and community resiliency of alike individuals, using storytelling to establish trust and respect in the circle and find community support to source answers for members. Talking circles are frequently integrated into substance use recovery, including Wellbriety and Red Road recovery programs, to help maintain sobriety and establish cultural





connectedness which “brings purpose” (California UIO). UIOs also offer talking circles addressing trauma, Post Traumatic Stress Disorder, victimization, grief, intimate partner violence, and suicidality, as well as more general circles for women, men, youth, elders, and two-spirit and non-binary individuals. Overall talking circles help combat the alone mentality and allow individuals to create community with individuals that share their experiences. Talking circles differ from Western group therapy as it focuses on the individual members as a community and the stories and experiences each person can share from their own journeys, providing a less clinical approach under the instruction of an unfamiliar mental health provider.

It's YOU the elements and, and your relatives that are sitting on each side of you. (Arizona UIO)

It is so important, and it's not sometimes there's a lot to say about talking to a third party or talking to a stranger about your problems. But then that's not really common for Native Americans, you know, it may not be your mother or your father or your sister or brother, but it's common to go to one of your peers that you trust. (Great Lakes UIO)

But if you look at the person as a whole, they are maintaining sobriety by attending these you know, these talking circle groups. (Montana UIO)

Smudging

Smudging “complements the health care that we’re offering here,” minimizes anxiety, and cleanses the mind and spirit (Great Plains UIO). Smudging allows individuals to set the tone and mentally prepare themselves for tough appointments and ceremonies. It also acts as a coping and grounding mechanism, with the Arizona UIO attributing it to the “mindfulness” aspect of “DBT” (dialectical behavioral therapy).

Sweat Lodge Ceremonies

SLCs benefit people in varying stages of substance use treatment, and people experiencing arthritis, sex addiction, sleep problems, grief, mental fog, depression, anxiety, and trauma. SLCs are especially impactful for the AI/AN veteran and homeless populations. The ceremony paired with the associated properties of sweating and short controlled intense exposure to heat, alleviates joint pain, mental fatigue, chronic fatigue, and loneliness, and also promotes weight loss, cultural connection, spirituality, and greater connection with all the senses in one’s body. Overall, SLCs address and balance the four parts of an individual’s being.

You got the start of a bad knee or arthritis or sore soreness. So let me go ahead a couple of sweat lodges and see what I can do before I need to go get an X-ray or need to go get put on a prescription naproxen or whatever, you know what I mean? So it's like you say one thing, Western medicine and then you preach the other. So if we're talking about





preventative care, and self-care, then that's exactly what it needs to be like it doesn't shouldn't be tagged to a certain behavioral health diagnosis. (Great Lakes UIO)

We've seen [SLCs] play a really helpful part in folks' wellness, especially in like recovery from alcohol, drug abuse, we really seen that be a powerful component in someone's path to recovery. And we'll have people who come to counseling or go to any of our Red Road support groups also come to sweat lodge and like that's one of the most important parts of their recoveries, all those things together. (Great Plains UIO)

Other Traditional Healing

Recovery programs use many different TH practices, but UIOs also note the importance and benefits of involving the whole family in recovery programs as substance use disorder affects the whole unit and healing must happen together for the whole family to recover. Additionally, Red Road Recovery and Wellbriety programs address the historical trauma that AI/AN communities need to address to create true and total balance in their lives.

Other uses of traditional healing include providing: traditional medicines and herbal teas to patients for respiratory illnesses; equine therapy to youth to support mindfulness, breathing, connection to nature and culture, physical activity, for youth and; calling the spirit back, or spiritual counseling, to help with deep trauma. Additionally, one UIO uses cultural wellness classes to promote traditional activities like regalia making while screening for intimate partner violence and taking A1C levels.

E. Tracking Health Outcomes for Traditional Healing Ceremonies and Activities

Currently, UIOs are working to track health outcomes for TH through electronic health records (EHRs), partnerships with outside researchers, patient surveys, and storytelling. UIOs would like to have some record to indicate progress and benefits of their TH programs, but tracking those outcomes consistently and appropriately is difficult. Anonymous patient feedback through satisfaction surveys or discharge surveys is a popular method of gaining insight into TH. Some UIOs can see if a provider referred a patient to TH through their EHR, but to monitor health outcomes of TH would require EHR and data analytics support that most UIOs do not have. Additionally, some staff with differing backgrounds in TH see monitoring individual outcomes for smudging, SLCs, and talking circles as inappropriate and there is a desire to “keep that information sacred and private” (California UIO). Despite concerns about data privacy, all UIOs interviewed expressed that they want to demonstrate that TH is beneficial for their patients and want to share their successes with other organizations to support implementation in other communities. UIOs reported that they were encouraged to develop best practices in tracking TH outcomes, as there was anecdotal evidence from their community on the benefits of TH at their UIOs. UIOs emphasized that tracking of any TH among their patients’ needs to be





developed in a “way to document the outcomes...from a positive point of view” (California UIO) while “respecting [the patients’] privacy” and “autonomy” (Great Plains UIO).

F. Availability and Accessibility of Services

While providers at UIOs often direct their patients to TH options, members of the UIO’s community may also have the option to directly request participation in TH services. Talking circles at recovery programs are often done on a reoccurring weekly schedule. Smudging is usually done at the beginning of the day and upon patient request. At some UIOs, the community can even request smudging to occur at a local hospital, home, or other location if the traditional healer finds it appropriate. SLCs are done on a schedule of multiple times a week or month. UIOs able to offer SLC onsite can offer more regular ceremonies for their patients. One Southwestern UIO provides cultural services for youth through the local public school system:

[We] have fairly strong connections with the [city] Public School system, because we want to bring that service into the youth and, you know, educate them about traditional values and provide that piece because that that's not readily available in an urban setting. (Southwestern UIO)

UIOs try to make their TH services as available as possible and facilitate requests from their community for TH even if they currently cannot provide the requested TH. For example, during the COVID-19 pandemic several UIOs hosted virtual talking circles and drive-thru traditional medicine handouts. Other UIOs provide smudge kits for patients to take home, provide traditional foods, conduct house calls for TH, transport patients to offsite SLCs, provide childcare for TH patients during visits, and share comprehensive lists of recommended traditional healers and their TH offerings for TH that needs to be referred outside of the UIO.

Several UIOs partner with community organizations to refer AI/AN people to their UIO for TH. Mentioned partners include hospitals, Child Protective Services (CPS), court systems, non-profits, outreach programs, schools and universities, juvenile justice systems, government agencies, and prison programs. These partnerships allow the greater AI/AN community who may not have existing knowledge of the UIO to learn of the opportunities for TH in their area. The benefits extend to the health of the whole community as those patients return to the UIO for high-quality, culturally competent care. For example, the UIO with the popular drive-thru traditional medicine program during the COVID-19 Pandemic attributed their holistic approach to COVID outreach to a subsequent surge in patients. The UIO now has more patients than were seen pre-COVID. UIOs did share that they often had waitlists and must limit the number of regular TH opportunities for their services due to high demand in the community paired with limited staffing and resources.





All patients and we are seeing a large number of patients really resonating with that holistic approach and being more in sync with it. And that really started I think with COVID, I will say. Just us being able to classes," outreach from our drive-through COVID clinic and that really bring forth awareness of "Hey, there's a health clinic over there [neighborhood] that's doing COVID classes, and it's like, "Well, what else are you guys doing in it?" You know, we took that opportunity to outreach and we put packets together with, you know, flyers and pamphlets of our services and what we do and we now see more clients now than we did pre-COVID. (Great Lakes UIO)

Oh, yeah. [metro area] Health Network, we have a contract with them, so if they identify Native American clients, they will refer them to us. We actually have a huge referral of 100 right now, a huge referral booklet with all the referrals that we will refer to or that they refer to us. Another one is [state] Department of Health and Human Services. (Great Lakes UIO)

We actually also did Talking Circles over at a, the [city] Healthcare for the Homeless, weekly, we were doing that for their homeless community members because they wanted to have an opportunity to you know, to sit with someone to, to basically engage in this kind of ceremony. And that was actually quite successful. (Arizona UIO)

Because this is what my community tells me but lack of access to traditional health services really is a deficit for them and it's something people want so badly and just don't have access to. (Eastern Region UIO)

G. Involvement and Engagement of Patients and Community in Traditional Healing Efforts, specifically for an Urban AI/AN Population

The community is central to TH at UIOs, and staff constantly engage with their patients to better tailor TH to their stated needs. At many UIOs, this starts with patient intake, where staff will discuss TH options with them. Multiple UIOs conduct regular community health assessments to gauge community attitudes toward TH. The California UIO reported their patients indicated a lack of integration for smudging practices in medical care, so now that site does smudging in everything they do. Policies and procedures around TH are developed based on community input. UIOs view engagement with their patients as fundamental to TH. They recognize the need to ensure everyone's safety as well as maintain the trust and respect of their community for these TH to demonstrate a positive effect.

Talking circles demonstrate how TH is guided by patients. The topic is guided by the whole circle and not just restricted to what the staff decides. Unlike in Western group therapy, talking circles allow the healer to be vulnerable with the group. The honesty of the traditional healer facilitates mutual respect and builds lasting relationships with their circle.





Patients across numerous UIOs conveyed to staff that there was a cultural disconnect and cultural/social isolation which develops from being AI/AN and living in a city. UIOs try to bridge that cultural gap for their urban AI/AN patients by addressing their historical trauma and isolation. Offering TH connects their patients with the greater urban AI/AN community, strengthening the whole population.

But in the research that I did in this community, our community members told us that they felt that they weren't able to achieve and sustain wellness because they were disconnected from culture and ceremony. (Eastern Region UIO)

H. Noted Barriers to Offering Traditional Healing Ceremonies and Services

UIOs reported being confronted by several barriers in offering TH to their community. A consistent issue across all UIOs of varying sizes was the lack of TH staff. Many expressed the need to expand services to meet the TH demand from their community, but were unable to due to a lack of appropriate full-time staff. For instance, a Montana UIO only has one traditional healer on staff running SLCs. The traditional healer is male and primarily runs male sweat lodges. The UIO indicated that they would need “three to five people” to meet the community need for female sweat lodges and mixed gender sweat lodges. Staffing issues were attributed to a lack of funding and a lack of certifiable traditional healers in the area.

Gathering materials for TH also can prove difficult. For example, some UIOs had to acquire permits to be able to cut down wood for SLCs. Many UIO staff are responsible for picking up their own stones, medicines, and wood when they go back to their Tribal lands or else these ceremonies would not be able to occur. UIOs that do have community gardens and the ability to grow some traditional medicines, stated that their gardens could not meet the demand of TH supplies for their community, due to needing more land or having inadequate environments to support the growth of certain medicines. This leads to UIOs having to find alternative sources.

With our sources, they don't have 100 braids,⁶ but that's how many braids we needed to get together for our [Question, Persuade, Refer] suicide prevention training for middle and high school students... think of something else because of the demand and it can't fit the demand. (Montana UIO)

Even if funding and supplies are available, local ordinances and regulations can present further barriers in carrying out a TH practice. For example, many UIOs have their sweat lodges within city limits and are restricted from holding these ceremonies due to local fire safety codes. Some UIOs expressed that once they explained to the city the cultural benefits of SLC, especially for substance use recovery and the homeless population, the city agreed to a cultural waiver. However, the Arizona UIO stated that,

⁶ Sweet grass braids. Sweet grass is often braided together and then used to smudge.





“sometimes we’ve had to permit our sweat lodges with the fire department under a refuge, a trash refuge, a fire burn permit, and it’s insulting, you know, discouraging.” Other UIOs indicated that they had to alter some of the ceremonial materials to minimize smoke from the lodge.

UIOs that must refer out their SLCs, or hold them offsite, reported that a lack of transportation to the site is a hinderance to care for some people, particularly people with disabilities and those that did not have access to their own car who could not attend ceremonies due to distance.

Challenges for people participating in the sweat is the bus system doesn't run out there. It only runs to the hospital. And then the client has to walk an extra mile to get to the sweat because it's next to the river... if they have a disability or a walker, there's really no support. (Montana UIO)

Some UIOs reported that requiring a diagnosis to participate in talking circles would further increase hesitancy for patients as it would make the talking circle more clinical and put a label on people that prefer to refrain from being labeled. While not necessary for many of the talking circles discussed with UIO staff for this project, in seeking to expand reimbursement for TH, diagnosis may be required in order to generate a billing code.

You know, for billing where then that person thinks, ‘Okay, why does this have to be mental health?’ You know what I mean? And then how do you know that in EHR, is that going to be part of my health record forever, you know, that I had to go to because you know, there's still that stigma, that taboo, with behavioral health for some people, for a lot of institutions. I don't I don't think [talking circles] could be tied to a diagnosis. Because again, the stigma because sometimes it got so associated with group therapy work that people aren't just coming to you know, talk about their home life or the struggles that they have...And that and that's why it's because they didn't want to be labeled. (Great Lakes UIO)

VI. THEMATIC ANALYSIS OF INTERVIEW RESPONSES RELATED TO BILLING

UIOs support TH services with a mix of funding sources, including Medicaid, federal grants, state grants, and private donations.

A. Medicaid Funding

Out of the eight UIOs interviewed, six reported no use of Medicaid funding for TH. Two UIOs reported a limited ability to be reimbursed for providing TH to Medicaid beneficiaries.





One Southwestern UIO reports partial success in billing for providing TH to Medicaid beneficiaries in their state. The state contracts with three Managed Care Organizations (MCO) to manage the care of beneficiaries. Out of three MCOs, only one MCO provides reimbursement for smudging, sweat lodges, and talking circles. This MCO offers TH as a “value-added service,” which means the MCO pays for the service to be provided to Medicaid beneficiaries even though the service is not covered by the State (Southwestern UIO). The UIO is unable to get reimbursed for providing TH to patients enrolled in the other two MCOs. The UIO has asked these two MCOs to consider expanding their contract to include TH. The MCOs, “said they were very interested in doing that,” but the UIO “hasn’t heard back from them as of yet” (Southwestern UIO).

The Arizona UIO reported limited success in billing Medicaid for TH with significant restrictions on billing. Talking Circles can only be reimbursed if they are coded as “group therapy,” and smudging can only be reimbursed if it is integrated into a Talking Circle.

It’s discouraging to have to bill it as group. Why do you have to use a basic group code to be able to bill things that have been traditionally used to heal native people for centuries? Billing under a group is a really cheap code. We’re really not getting compensated for bringing in outside community people that are considered healers and compensating them. It’d be nice to have traditional healing codes that are more respectful code, honoring it as equal to a clinician offering group therapy. This is a credentialed, traditional provider offering a traditional healing service that might be even more effective than some of our other groups. (Arizona UIO)

The Arizona UIO also receives Medicaid funding for clients in residential treatment under a “bed day code,” a set daily reimbursement rate for each client. These funds partially support sweat lodge treatments for residents, but they are inadequate to cover “the rebuilding of the lodges, and the built the gathering of the willows, and the stones, and the medicine, and everything that’s included” (Southwestern UIO). Medicaid funds are not currently available to fund sweat lodge ceremonies for outpatient clients.

B. Grants

Most UIOs reported directing grant funds toward supporting TH. Health and Human Service (HHS) grants are a common source of funds. Two UIOs fund TH with the Native Connections grant awarded by SAMHSA. One UIO reported only one funding source which they believe allows coverage of smudging services, SAMHSA’s Tribal Opioid Response (TOR) program. Another UIO uses funds from the Special Diabetes Prevention Initiative (SDPI) to fund a community garden and traditional food demonstrations.





UIOs also seek out state-level grants to fund TH. The California UIO receives funding for TH through California's Affordable Housing and Sustainable Communities (AHSC) Program. A Montana UIO funds smudging by writing the service "into almost every local and state grant that we can." The Great Lakes UIO receives a state-level grant, as a sub-awardee through a local urban hospital system.

C. In-Kind Donations

Many UIOs rely on community donations and relationships with nearby Tribes to obtain the supplies necessary to administer TH. In some cases, UIOs prefer to rely on donations as opposed to cash purchases due to necessity or cultural factors. For instance, according to the Eastern Region UIO, "I feel very strongly about not purchasing medicine. Medicine doesn't belong to the person accepting money for it, it belongs to creator, it belongs to the earth. I don't know the intentions of a person selling medicine."

The Great Plains UIO receives donations of smudging supplies (cedar, sage, and sweetgrass) from community members in the summer, when the plants are growing locally. In the winter, the UIO used general funds to purchase from a small local shop near their clinic.

The California UIO maintains relationships with tribal communities through "Cultural Brokers" from Tribes in California, Arizona, and New Mexico.

[The Cultural Brokers] live up in the higher regions of the mountains and so this sage comes from there. So there's many different sages, that are used in this practice, but most of it is donated and we have an abundance of it. We have been donated live sage and we've incorporated as part of our garden. So, now that the garden in the back has a dedicated area near the sacred space to grow our own and offer it to our patients. (California UIO)

D. Support for Medicaid Reimbursement of Traditional Healing Services

UIOs expressed universal support for expanding Medicaid reimbursement of TH services, but several UIOs voiced concerns about the administrative burden associated with Medicaid billing. The Great Lakes UIO is concerned that a billing program for TH would incorporate the need for diagnosis codes. However, they did express openness to Medicaid billing for TH in an SDOH and preventative health context.

If we are talking about preventative care, and self-care, then that is exactly what it needs to be. It should not be tied to a certain behavioral health diagnosis code. There's still that stigma with behavioral health. (Great Lakes UIO)





At least one UIO expressed concerns regarding onerous credentialing processes associated with the Medicaid program. The Eastern Region UIO is wary of any possible credentialing process for provider eligibility. This UIO stopped participating in Medicaid billing after 2019, because the re-credentialing process was “just such a nightmare,” and a “bureaucratic headache” (Eastern Region UIO). They emphasized that smaller UIOs do not have the capacity to undergo an onerous credentialing process in order to receive reimbursement.

UIOs listed a variety of intended uses for additional Medicaid reimbursement funds. UIOs currently referring out their SLCs to local Tribes would use the funds to expand facilities to build their own multi-tribal Sweat Lodge Programs. The Southwestern Treatment Center UIO would expand their outpatient Sweat Lodge services for patients who are discharged from residential treatment into an outpatient program. The Eastern Region UIO would like the flexibility to address the health and social needs of the homeless population. The Montana UIO would use funds to create permanent, stable positions for full-time traditional healers.





VII. TRADITIONAL HEALING META-ANALYSIS

To better understand the efficacy of TH practices, NCUIH performed a systematic review of research articles about TH.

The scope of the systematic review was defined as the TH practices of indigenous persons whose place of origin is the Continental United States, Alaska, or Canada. Although the primary purpose of this report is to inform health policy in the United States, there are several ethnographically defined indigenous cultural regions shared by the United States and Canada such as the Northwest Coast, the Plains, and the Arctic (Ubelaker, 2006). This review excluded research on practices of indigenous persons in Hawaii, the Pacific Islands, and the Caribbean, because these populations are culturally distinct from the North American Indigenous population. Articles about TH practices from the Indigenous regions of Mesoamerica, the Isthmo-Columbian Area, the Andes, and the Amazon Basin were excluded because these populations have distinct and separate cultural identities from the Indigenous population in the Continental United States, Canada, and Alaska.

The systematic review also excluded articles written in languages other than English, due to a lack of team capacity to review non-English articles with enough fluency to extract statistical outcomes. It is possible there were relevant Spanish-Language articles on culturally continuous groups extending from the United States into Northern Mexico (such as the Tohono O'odham) that we were unable to review.

The following keywords were used to search article abstracts for the relevant population, services, and outcomes:

- Keyword(s) 1, Population: “American Indian/Alaska Native” OR “AI/AN” OR “American Indian” OR “Alaska Native” OR “Native Alaska” OR “Native American” OR “North American Indigenous” OR “United States Indigenous” OR “First Nations” OR “Tribe”
- Keyword(s) 2, Services: “Traditional Healing” OR “traditional medicines” OR “traditional healers” OR “indigenous food” OR “traditional food” OR “smudging” OR “purification ceremony” OR “inipis” OR “sage burning” OR “talking circles” OR “healing circles” OR “traditional beading” OR “cultural connectedness” OR “traditional arts” OR “traditional health” OR “Tribe-based practices” OR “shamanism” OR “traditional drumming” OR “dancing circles” OR “spirituality” OR “spiritual healing” OR “traditional diets” OR “sweats” OR “Red Road” OR “Wellbriety”

To keep the size of the project feasible, only articles published after 1/1/2000 were included in the search. We searched the following databases: PubMed, ScienceDirect, and Scopus (accessed through the University of Chicago). Abstracts generated from the keyword search were downloaded as .ris files and then uploaded into the Covidence systematic review management software (Covidence, 2022).

The search terms and perimeters yielded 26,792 articles. Since multiple databases were used, we ran a check for duplicate articles listed in multiple databases. The check revealed that 12,001 articles were duplicates, reducing the unique article



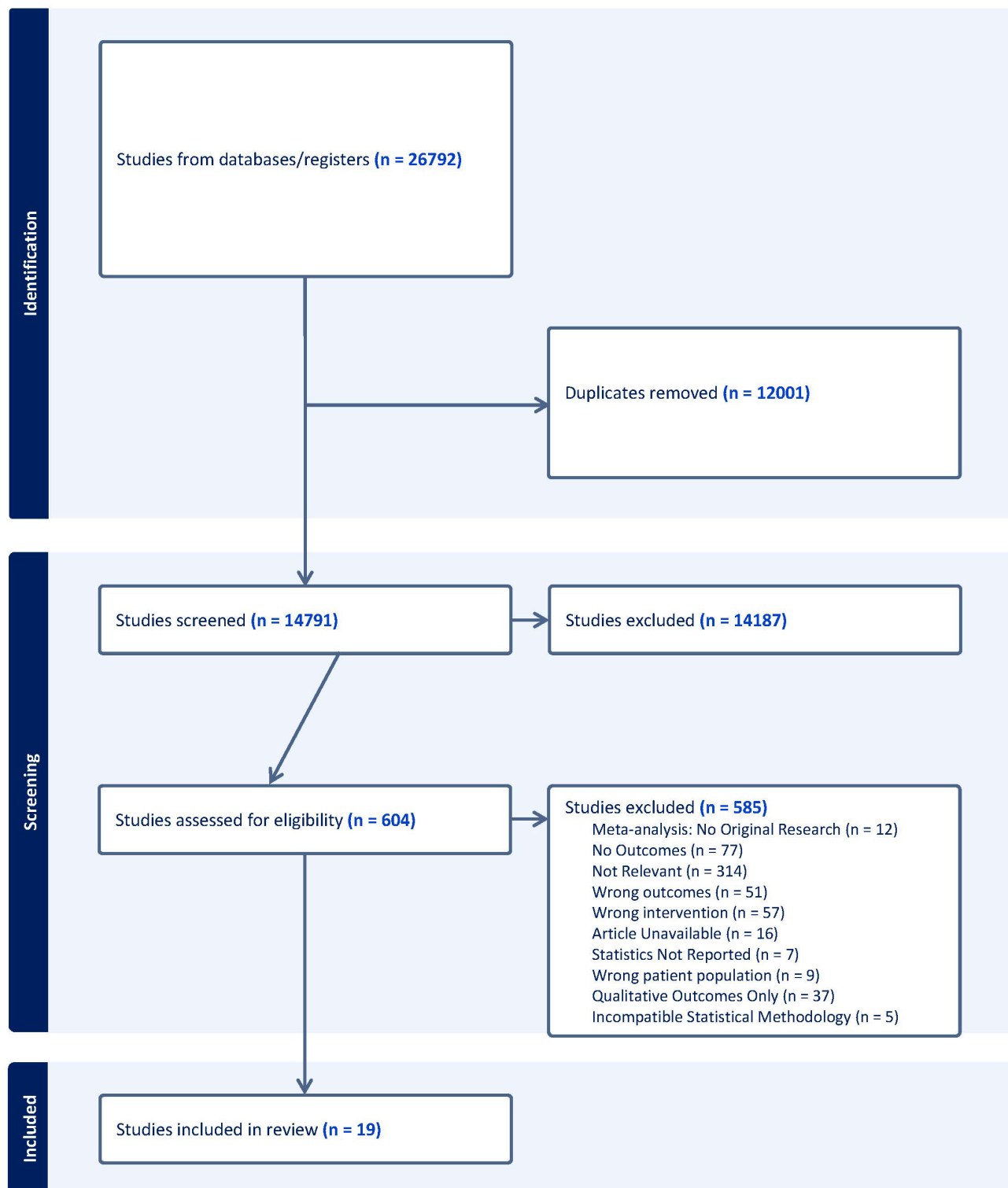


count to 14,791. Abstracts were extracted and screened for eligibility based on information on language, population, services, and methodology. Articles were also excluded if the abstract indicated that an article used purely qualitative methodology, or if it was a review article with no original research. Based on the abstract screening, 604 articles were screened as eligible and then the full text was abstracted. The review of the full text yielded 19 articles for inclusion in the meta-analysis. This low yield of relevant articles is consistent with other similar studies. A 2021 meta-analysis of culturally adapted interventions on substance use outcomes for minority-race patients retrieved 7,184 articles and used 22 articles in their metanalysis (Hai et al, 2021).





Traditional Healing Systematic Review





We conducted the analysis using R 4.1 using the *meta* statistical package (Schwarzer et al., 2015). Although there were 19 unique articles included in our meta-analysis, Wright 2011 included two study groups (an inpatient and an outpatient sample) bringing the count of study groups up to 20.

All articles were divided into their outcome types (Mental Health, Physical Health, and Substance Use). There were seven articles measuring multiple outcome types for a single intervention. For example, Hewson (2012) measured the effect of Sweat Lodges on Mental Health and Physical Health. Outcomes were also grouped by the nature of their measure (continuous or binary).

A continuous variable is a variable that can take on any value within a range. Most of the continuous outcomes used in this metanalysis are scales constructed using patient questionnaire responses. For example, Freeman (2016) measures mental health outcomes with the Behavioral and Emotional Rating Scale (BERS), which is calculated from a 52-item questionnaire and produces scale scores ranging from 0 to 156. Other continuous variables are direct measurements of health indicators, such as Body Mass Index (BMI). Binary outcomes are variables that can only take two values. For example, Hodge (2016) studies the effect of talking circles on cancer pain management outcomes, and measures the outcomes as two values: “improved” or “worsened”.

Unfortunately, there were too few articles to generate estimates for any of the specific TH services (Smudging, Sweat Lodges, Talking Circles, or Traditional Food) so all analyses were conducted on the efficacy of TH in general.





Figure 1.

Article	Treatment	Outcome Type	Outcome Measurement
Batal 2020	Traditional Food	Physical Health	Binary
Beckstead 2015	Talking Circles	Mental Health	Continuous
Bersamin 2008	Traditional Food	Physical Health	Continuous
Blanchet 2021	Traditional Food	Mental Health	Binary
Boyer 2021	Traditional Food	Physical Health	Continuous
Freeman 2016	Sweat Lodges	Mental Health	Continuous
Greenfield 2018	Sweat Lodges	Substance Use	Binary
Harder 2016	Traditional Food	Mental Health	Continuous
Hewson 2012	Sweat Lodges	Mental Health	Continuous
Hewson 2012	Sweat Lodges	Physical Health	Continuous
Hodge 2016	Talking Circles	Physical Health	Binary
Jones 2020	Traditional Food	Physical Health	Continuous
Kelley 2018	Sweat Lodges	Substance Use	Continuous
Kelley 2018	Sweat Lodges	Mental Health	Continuous
Lowe 2016	Talking Circles	Substance Use	Continuous
Lowe 2016	Talking Circles	Mental Health	Continuous
Lowe 2022	Talking Circles	Mental Health	Continuous
Marsh 2016	Sweat Lodges	Mental Health	Continuous
Mehl-Madrona 2014	Talking Circles	Physical Health	Continuous
Patchell 2015	Talking Circles	Mental Health	Continuous
Patchell 2015	Talking Circles	Substance Use	Continuous
Tanner 2022	Traditional Healing Unspecified	Physical Health	Binary
Tanner 2022	Traditional Healing Unspecified	Mental Health	Binary
Wright 2011 Inpatient	Talking Circles	Substance Use	Binary
Wright 2011 Inpatient	Talking Circles	Mental Health	Binary
Wright 2011 Outpatient	Talking Circles	Substance Use	Binary
Wright 2011 Outpatient	Talking Circles	Mental Health	Binary





The statistical package *esc* was used to estimate standardized mean distances with standard errors and odd ratios (Wilson, DB, 2016). The primary meta-analysis separates the articles by continuous and categorical variables, in order to estimate an interpretable effect. This package also allows for a standardized mean distance to be estimated for binary outcomes. This d is included in the general effects analysis as possible additional evidence, which may indicate size and direction, but will lose interpretability. For continuous outcomes, articles marked with an asterisk are single sample pre-post comparisons while those without asterisks are two sample comparisons. For categorical outcomes, studies without asterisks are odds ratios from a two-by-two contingency table while those studies labeled with an asterisk are odds ratios from a logistic regression. Articles marked with a “B” at the end indicate the article studied more than one outcome.

Random-effects models were used to “incorporate an assumption that the different studies are estimating different, yet related, intervention effects” (Deeks JJ et al., 2022).





Analysis 1: Effect of Traditional Healing Interventions on Continuous Mental Health Outcomes.

All analyses of continuous outcomes used the function *metacont*, using Hedge's *g* to determine Standardized Mean Difference (Hedges LV, 1981).

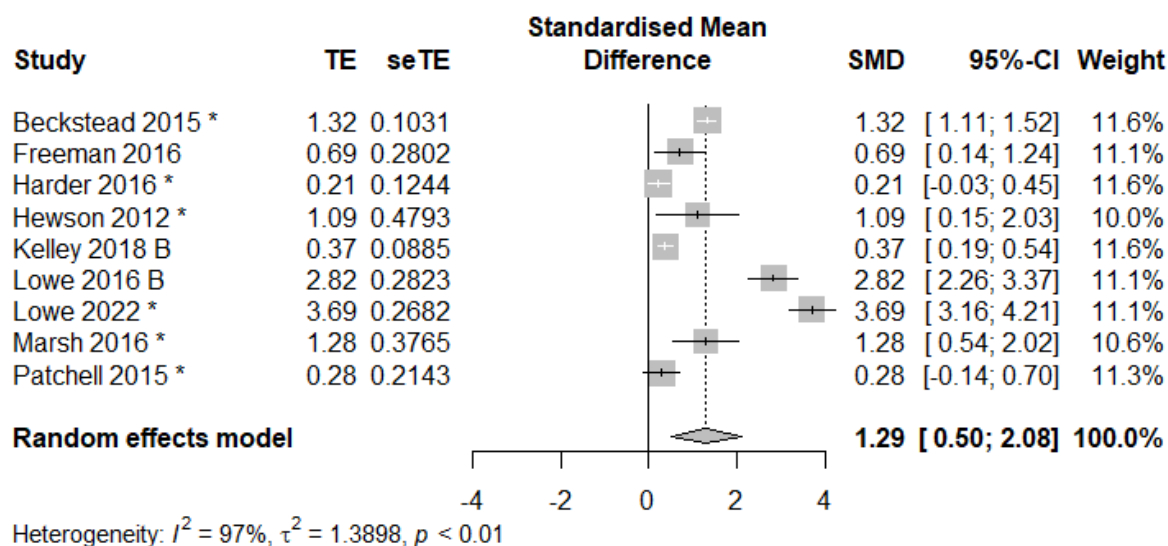
To interpret the Hedge's *g* effect size, the following rule of thumb is recommended by the National Institutes of Standards and Technology(2017):

0.2	=>	small effect
0.5	=>	medium effect
0.8	=>	large effect

In the analysis of effects of all TH interventions on mental health, there was evidence that TH improves mental health outcomes.

Meta-analysis of the continuous measures estimated a pooled effect size of 1.29, indicating a large positive effect ($p = 0.001$). This analysis included four talking circle interventions, four sweat lodges, and one traditional food intervention.

Figure 1. Random Effects Model of Traditional Healing on Continuous Mental Health Outcomes



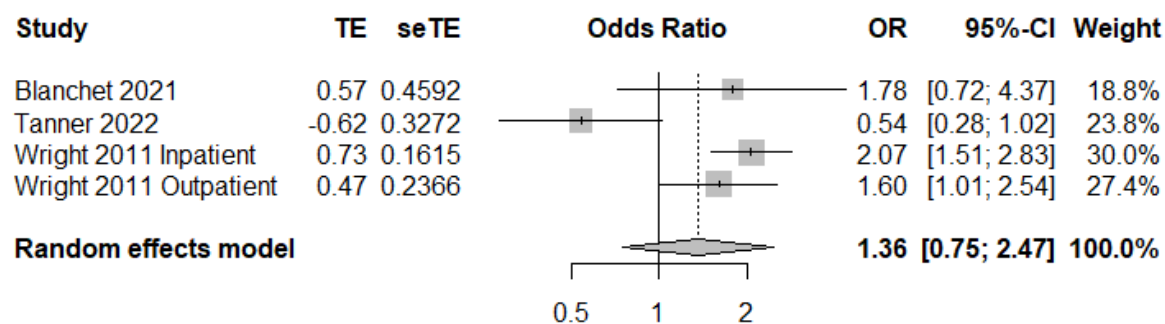


Analysis 2: Effect of Traditional Healing Interventions on Binary Mental Health Outcomes

The categorical and the mixed analyses used the *metagen*, which uses a generalized inverse variance matrix to generate pooled effects of binary outcomes can be measured as an odds ratio (Higgins et al., 2009). The odds ratio represents the odds that an outcome will occur given a particular intervention, compared to the odds of the outcome occurring in the absence of that intervention (Szumilas, 2010).

Meta analysis of the binary mental health outcomes did not find a statistically significant pooled Odds Ratio estimate (p = 0.316).

Figure 2. Random Effects Model of Traditional Healing on Binary Mental Health Outcomes



Heterogeneity: $I^2 = 78\%$, $\tau^2 = 0.2842$, $p < 0.01$

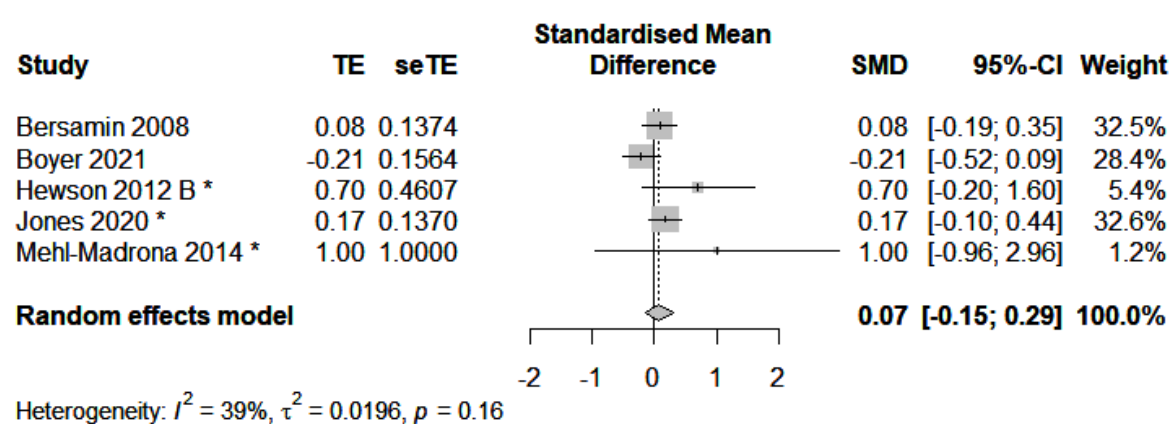




Analysis 3: Effect of Traditional Healing Interventions on Continuous Physical Health Outcomes.

Meta-analysis of the continuous physical health outcomes did not find any statistically significant pooled effect estimate ($p = 0.532$).

Figure 3. Random Effects Model of Traditional Healing on Continuous Physical Health Outcomes

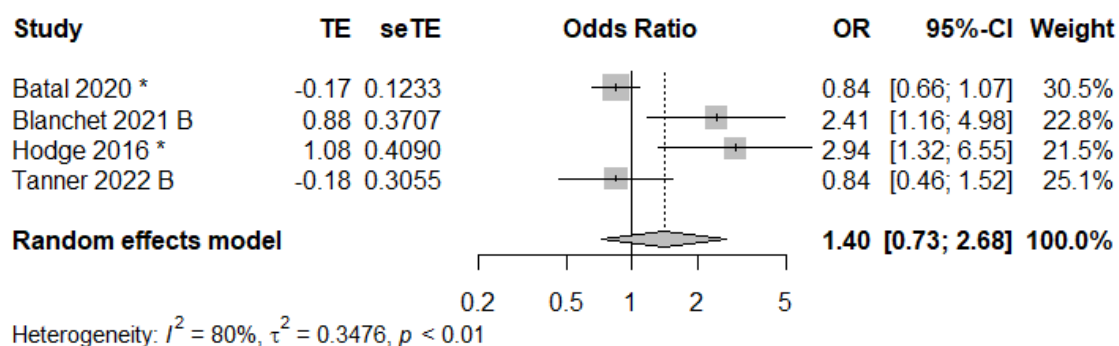




Analysis 4: Effect of Traditional Healing Interventions on Binary Physical Health Outcomes.

Meta-analysis of the binary physical health outcomes did not show as statistically significant pooled Odds Ratio ($p = 0.315$).

Figure 4. Random Effects Model of Traditional Healing on Binary Physical Health Outcomes

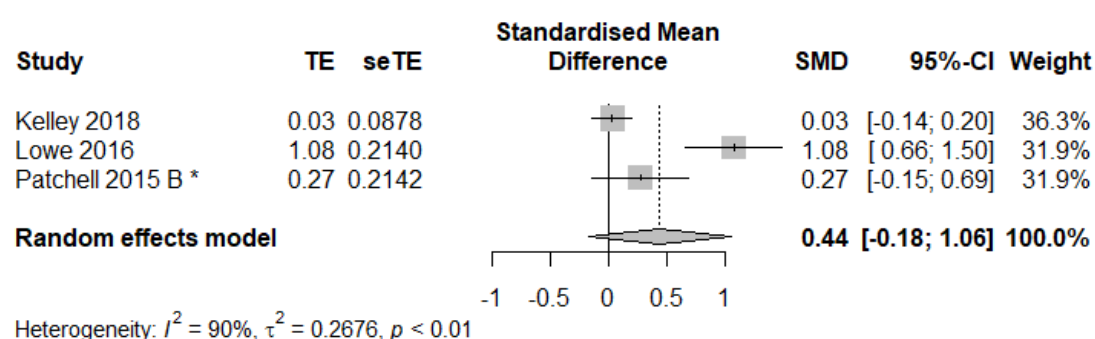




Analysis 5: Effect of Traditional Healing Interventions on Continuous Substance Use Improvement Outcomes.

Meta analysis estimated there was no statistically significant pooled effect for substance Use improvement as measured by continuous measures ($p = 0.163$).

Figure 5. Random Effects Model of Traditional Healing on Continuous Substance Use Improvement Outcomes

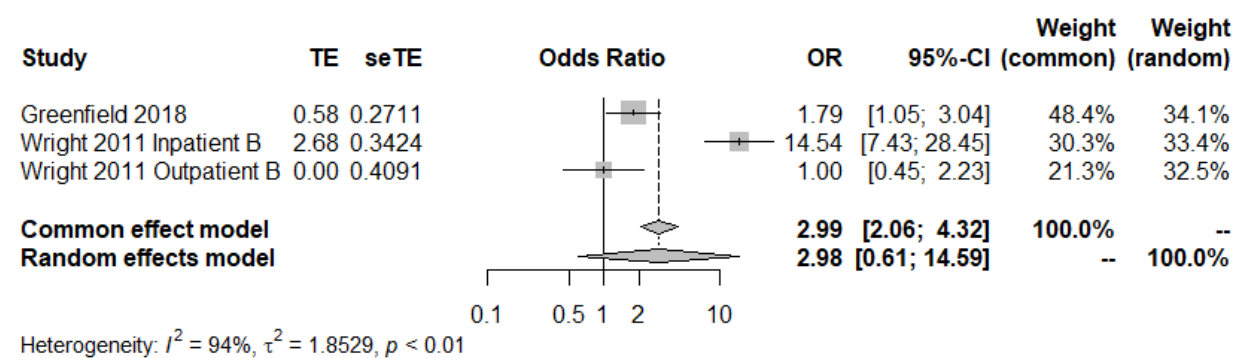




Analysis 6: Effect of Traditional Healing Interventions on Binary Substance Use Improvement Outcomes.

Three articles reporting substance use cessation used the binary measure of whether a patient used any drugs or alcohol use in the past month. All three articles measured the effect of Sweat Lodge Ceremonies. Because they measure the same outcome, the results of a fixed effect model may be considered. **Meta analysis estimated as very large effect size, an Odds Ratio of 2.99 to improvement in substance use cessation. Fixed effect model indicates statistical significance ($p < 0.001$), while random effect model does not (0.178).**

Figure 6. Fixed and Random Effects Models of Traditional Healing on Binary Substance Use Improvement Outcomes





Analysis 7: Upper Estimate of Traditional Healing Interventions on All Outcomes:

This meta-analysis combines continuous and categorical effects on all outcomes: physical, mental, and substance use. This analysis represents a trade-off in specificity. This report is uniquely focused because it generates effect estimates that are specific to North American Indigenous Traditional Healing Practices. As a trade-off, it is necessary to combine a wider spectrum of physical, mental, and substance use outcomes than would be typical in most systematic reviews in order to estimate a generalized effect. The method of combining outcomes also aligns with the medicine wheel concept of interconnected aspects of holistic health.

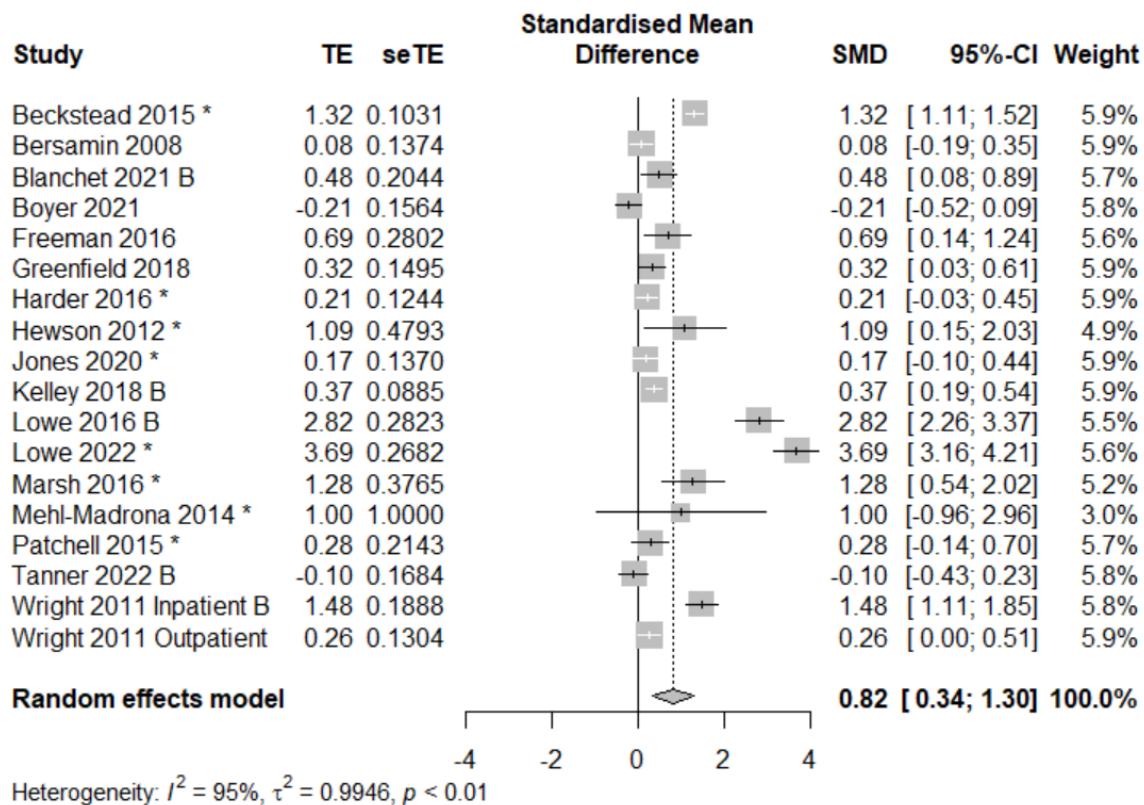
There were seven articles where multiple outcome types were measured. However, only one outcome can be included from each intervention, because it is unrealistic to assume that mental health, physical health, and substance use are independent from each other. Including multiple outcomes from a single intervention would give that intervention too much weight in the pooled analysis. To address this problem, we generated an upper and lower estimate of effect size.

To generate an upper estimate of effect size, Analysis 7 uses the larger outcome estimate from each article. Analysis 7 shows a statistically significant pooled and substantively large effect ($g = 0.82$).





Figure 7. Upper Estimate Random Effects Models of Traditional Healing on All Outcomes

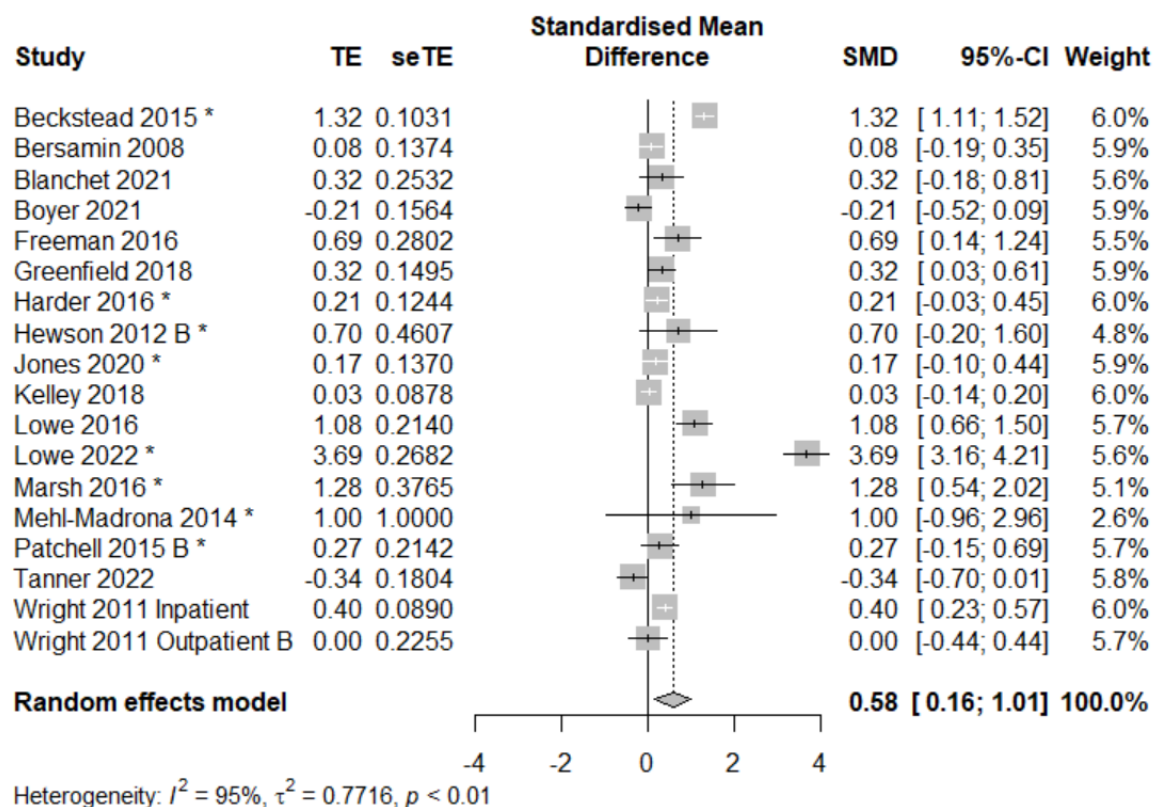




Analysis 8: Lower Estimate of Traditional Healing Interventions on ALL Outcomes:

To generate a lower bound, this meta-analysis was re-estimated where the smaller effect estimate was used for these seven articles. The second analysis estimates a medium effect ($g = 0.58$). Therefore, these analyses suggest that TH has a medium to large positive effect.

Figure 8. Lower Estimate Random Effects Models of Traditional Healing on All Outcomes





Meta-Analysis Conclusions

Among the six analyses focused on an outcome type, a large effect size was estimated for the effect of TH services on continuous mental health outcomes. This analysis had the largest grouping of articles (9), making it easier to detect any possible effects.

A large effect was also estimated for TH on binary substance use outcomes. Even with only three interventions, the large pooled effect was most likely a result of success of the inpatient intervention at the Native American Health Center as reported by Wright et al. (2011). The Native American Health Center (NAHC) is a UIO in Oakland, California. Inpatient treatments at NAHC ranged from 90 days to 1 year, and included smudging, talking circles, and sweat lodges. After treatment, patients were 90% less likely to have used Alcohol or Drugs in the previous 30 days.

The small number of articles made it difficult to detect effects in physical health which illustrates that more research is needed on TH efficacy with larger populations measuring longer time scales, especially at UIOs and other locations with the cultural competency to provide TH services.

As with any meta-analysis, results must be interpreted with caution due to publication bias. In general, studies with significant results are more likely to be published by journals, and as a result, investigators are more likely to submit significant results for publication (Easterbrook et al., 1991)

The lower bound effect of TH on all outcomes was medium ($g = 0.58$) and the higher bound effect was large ($g = .82$). Therefore, using the quantitative benchmarks set by Western medicine, TH should be considered generally effective for health outcomes, and especially effective for mental health outcomes.





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