

INTEGRATING HEALTH CARE PARADIGMS:

A WHOLISTIC POLICY PROTOTYPE

By

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the requirements for the degree of**

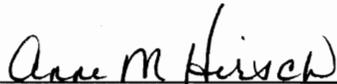
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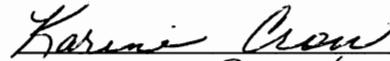
**WASHINGTON STATE UNIVERSITY
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To the Faculty of Washington State University:

The members of the Committee appointed to examine the clinical project of CHARMAINE ALLEN-JOHNSON find it satisfactory and recommend that it be accepted.


Chair





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Abstract

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As health care provider roles evolve, we have become increasingly aware of a need to expand and integrate diverse health paradigms into a facility's organizational culture in order to create wholistic health care delivery systems. A concrete step toward this integration is policy development. The following is a policy prototype which can be used for establishing a desired organizational culture. The format can easily be adapted to the needs and nuances of different facilities. A literature review was conducted to research the subject matter needed for this policy formation. In 1996, the Nez Perce Tribal General Council (a community forum) directed Health and Human Services to develop a clinic policy which integrated traditional Native American, allopathic and alternative healing practices. The policy was developed using a modified Delphi technique with community groups, providers, and an internal policy committee. A final policy critique was conducted by multi-cultural nursing policy leaders in Polson, Montana, 1998.

A policy can be an essential keystone that launches a vision into implementation. However, it is only effective if it is developed and accepted by persons affected by the policy's direction. Accountability and responsibility must be established to ensure implementation. Patient and employee satisfaction surveys provide an objective method for evaluating whether the policy, as a tool, was effective in bringing about the desired changes.

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Integrating Health Care Paradigms: A Wholistic Policy Prototype

Introduction

There is an increasing need for culturally relevant, wholistic, health care systems which address the traditional, current and future health care demands of diverse populations (Chung, 1996; Crow, 1988; Nursing Leadership, 1996; Pew, 1991, 1994, 1995; Tresoloni, 1994; Trujillo, 1995, Appendix A). This need is overtly acknowledged by changes in how the public is acquiring its health care, by recent research studies, legislative actions and by visibility in the media.

Recent studies have indicated that the use of alternative modalities is becoming increasingly important. A survey conducted by Eisenberg et al. (1993) found that 34% of Americans reported using unconventional therapies (described in their survey as medical interventions not taught widely at U.S. medical schools or generally available at U.S. hospitals). In terms of cost, they reported that in 1990, out-of-pocket expenditures associated with use of unconventional therapy amounted to approximately \$10.3 billion, which was comparable to the \$12.8 billion spent out-of-pocket for hospitalizations in the United States in that year. In a follow up survey conducted seven years later, Eisenberg et al. (1998) found that alternative medicine use and expenditures were even greater and were due to an increase in the proportion of the population seeking alternative therapies, rather than increased visits per patient.

Congressional and state legislative measures have been adopted to address the need for alternative medicine. In 1992, Congress mandated that research must be conducted on alternative modalities and established the Office of Alternative Medicine (OAM), presently the National Center for Complementary and Alternative Medicine (NCCAM), as a branch of the National Institute of Health (NIH). Their budget was increased from \$20 million to \$50 million between 1992 and 1996 and is now funding thirteen research centers conducting 50 different research

projects (Marwick, 1998). In Washington State, legislation was enacted which required certain health plans to include alternative providers on their physician panels. The law was challenged and upheld on appeal (Cox, 1998; Washington Physicians Service Association v. Gregoire, 1998).

Increasing attention through professional journals, commonly available media and conferences also highlight the issue. The November 1998 issue of The Journal of American Medical Association (JAMA) was dedicated to alternative medicine, addressing research, policy, financial considerations, ethical, legal and health care trends (Cohen, 1998; Eisenberg et al., 1998; Fontanarosa & Lundberg, 1998). Since the Eisenberg et al. (1993) survey, many different professional health care provider journals have included articles on alternative modalities (Freeman & Landis, 1997; French, 1996a; French, 1996b; Hagland, 1993; Mackey, 1995; Whitehorse, 1996). In 1998, the first PDR For Herbal Medicines was published. Other health care related journal articles provide guidance on the integration, transition and reimbursement for alternatives (Berman et al., 1998; Broida, 1997; Coile, 1998; Coile & Riina, 1998; Pavia, 1998; Pelletier, Marie, Krasner, & Haskell, 1997). Several professional organizations have recently held conferences on the different aspects of integrating health care paradigms, cultural diversity and reimbursement issues (e.g. Indian Health Service, National Managed Health Care Congress and the National Alaska Native American Indian Nurses Association). The internet and the phone book have alternative, complimentary or integrative health care listings and are increasing the number of practitioners listed (Sikorski & Peters, 1998). Mainstream television, radio and magazines (Begley, 1993; Colt, 1996; Langone, 1996) have articles addressing this trend and they are full of advertisements for alternative treatments and products. Products (e.g. Saint John's wort and saw palmetto) and books on the controversies of conventional practices (e.g. herbal and nutritional remedies, alternative modalities and midwifery) were a health food store novelty and

are now found over the counter at grocery stores and on pharmacy shelves (Arms, 1975; Balch & Balch, 1997; Carter, 1993; Dobeles, 1986; Ehrenreich & English, 1974; Gottlieb, 1995; McGee & Chow, 1994).

An important reason for incorporating alternative modalities is the increasing cultural diversity characterizing the American public (Chesanow, 1998; Tresolini, 1994). Kohn (1995) reported that in the 1990 U.S. census, 80.3% of the population were categorized as Caucasian non-Hispanic and that by about 2050, the number will be reduced to 53%. Much of the literature on alternative medicine refers to ethno-cultural health beliefs/paradigms/practices as being principle reasons for integrating traditional modalities which are different from those offered by conventional practices (Arms, 1975; Buhner, 1996; Cahn, 1969; Callahan 1995; Clark, 1995; Crow, 1988; Davis, 1999; Hollow, 1999; Mander, 1991; McGee & Chow, 1994; Ross, 1989; Sams, 1994; Vogel, 1990). In the western U.S., where a large Native American population is serviced by the Indian Health Service (IHS), this duality in cultural paradigms is especially acute. In acknowledgment, Dr. Trujillo, Assistant Surgeon General and Director of IHS, and various individual tribes have stipulated that their services incorporate some component of traditional healing and counseling into their health and wellness programs (Trujillo, 1995, Appendix A; Davis, 1999).

Many facilities or providers who are trying to address this need are being met with challenges to the implementation of policy changes. There is a resistance to incorporating or recognizing alternative modalities because of fear regarding the safety of these practices. Also, employee reluctance can manifest when an organizational change is introduced. However, when the consumers demand that their providers encompass alternative views, a response will be required.

Policies and mission statements are important vehicles for manifesting changes in organizational culture (Lewis, 1996; McGuire & Longo, 1993). They give direction to an organization's services, and provide and govern the actions of its employees. Policies can serve as a means to insure that adequate funding and consideration is given to aspects of the program that the agency wishes to emphasize. They can also be used as an educational document to inform the recipient population and the service providers of the organization's culture, intent and how it will conduct its actions (Shapiro, 1984; Straub, 1992). Policies should be written in general terms for administrative problem solving and need to leave room for unanticipated qualifications and conditions (Barnum, 1995). A policy may serve as a tool to guide a facility during its integration of complementary medicine and facilitate the evolution of its new organizational culture (Bruhn, 1996).

A case in point is the origin of the policy presented in this document. In 1996 the Nez Perce Tribal General Council gave a directive to their Department of Health and Human Services to develop a policy focusing on a wholistic health care perspective. The author was appointed to co-chair a committee of tribal members at large and health care providers to develop the policy. The Tribe decided to take the route of establishing a policy in order to make changes in the organizational culture and delivery system of its existing health care services. The innovative and progressive directive was intended to not only integrate allopathic medicine with traditional Nez Perce healing practices but include alternative modalities as well. In this policy example, the community assessed their own needs. Their Health and Human Services Department already had a culturally relevant health care mission statement and the people wanted the mission statement developed into a working policy for the purpose of ensuring a change in the organizational culture at Indian Health Service (IHS).

The structure of this policy mirrors Hancock's "bottom-down health care system" (as cited in Nursing leadership in the 21st century, 1996) (Figure 1). Hancock's model proposed a redesign of the health system by placing more emphasis on home care, disease prevention, self-care, wellness and health maintenance which is inverse of the current conventional medical model which focuses the greatest amount of attention and resources on tertiary care, hospital care and primary care by specialists. In this model minimal resources are spent on self-care and healthy communities. The current medical paradigm emphasizes those interventions that deal with treatment rather than prevention and wellness.

Hancock's philosophy is consistent with non-conventional, wholistic health care. Hancock's paradigm emphasizes health promotion and allows more responsibility and authority to the consumer/community in reforming their health care services (Nursing leadership in the 21st century, 1996). This is an important aspect of the policy because it reflects a restructuring of the medical model of delivery (Figure 1) and also considers physicians to be of equal value to other health care providers. In this model a physician is expected to be a resource for health and wellness and not just a gate keeper of illness. Most conventional medical practices are focused on the treatment of illness and disease, whereas alternative practices are generally more focused on prevention, wellness, balance, harmony and wholeness (Berman, 1998; Callahan, 1995; Carter, 1993; Chung, 1996; Clark, 1995; Colt, 1996; Eskinazi, 1998; Fifer, 1996; Freeman & Landis, 1997; McGee & Chow, 1994; Mosher, 1978; Pew, 1991, 1994, 1995; Tresolini, 1994)

Research Design

The topic of this Masters project will focus on the use of a prototype policy that can be adopted by health care facilities attempting to provide a wider scope of treatment modalities. After receiving permission from the Nez Perce Tribal Executive Committee to utilize the development of this policy as the origin of my Masters project (see Appendix B), a policy prototype was developed that could be transferred to other health care facilities. Using this prototype, a modified Delphi approach was utilized to have the policy critiqued. The policy was then edited to accommodate the most common themes appearing in the reviewer's comments.

The Delphi technique is a method of soliciting, obtaining, combining and measuring expert opinion (or judgment) on a topic and is used to gain consensus for the purpose of assessing priorities or making forecasts (Powers & Knapp, 1995). The technique uses multiple "rounds or waves" of questionnaires (in this case, critiquing the policy) to compile and summarize feed back. If consensus is not reached, the summarized comments are redistributed for additional rounds. When consensus is reached, the final analysis is completed and the findings are reported (Figure 2). The purpose of redistributing the result summaries is to obtain a group consensus without face-to-face confrontation. Delphi technique provides a method of obtaining diversity and candidness in feedback and does not require a schedule or meeting time (Lindeman, 1975). It also prevents persuasive behavior of individuals from altering other participants opinions, which can occur at a meeting. Delphi can be seen as an intermediate between intensive interviewing and conventional survey research (Burns & Grove, 1997).

The original policy developed for the Nez Perce Tribe, used a modified version of Delphi technique. A committee was formed, at the direction of Tribal Council, to develop the policy. Through a series of meetings, a number of individuals, community groups, and health care

providers gave input regarding the policy. Their comments were incorporated into a policy format, and the results were distributed for critique. Several iterations of review were undertaken, all of which required open-ended (qualitative) responses. While a strict Delphi approach would typically incorporate a questionnaire requiring a close ended (quantitative) response (Burns & Grove, 1997). Using this modified Delphi technique the policy draft was distributed to the developers for their final critiquing.

The policy presented in this Masters' Project, is derived from an edited version of the Nez Perce Tribal policy. This prototype was presented to a number of policy experts, critiqued and finalized using the modified Delphi approach. Names of agencies were edited out for the purpose of making the policy more global and encompassing needs of a non-specific community/facility composition. The draft was distributed to national multi-cultural nursing policy experts attending a conference sponsored by the National Alaska Native American Indian Nurses Association entitled "Expanding the Circle: Enhancing Our Practice and Nursing Roles" held at Polson, MT October 18 - 20, 1998. This was the last review of the modified Delphi approach.

Result

The results of the modified Delphi approach are the solicitation, collection and combination of the experts' opinions and formulation of the policy: Integrating Health Care Paradigms: A Wholistic Policy Prototype. The final policy prototype may be found in Appendix C. It is placed as an appendix because it is intended to be a stand-alone document which can be adopted by interested health care facilities.

Discussion and Implications

Introducing a policy that defines a new organizational culture can be met with different emotions. Change can be perceived as threatening to some, exhilarating and challenging to others (Olson, 1979). The main comments by the policy reviewers reflected their understanding of this effect of change. However, it is important to reiterate that this policy prototype was created with the assumption that the consumers desired a change.

A key comment elicited from the Delphi critique was, “how would an outcome of the policy be measured ?” In response, the policy was revised by adding a section titled Evaluation of Effectiveness. It addressed the effectiveness of the policy at four different levels: patient, staff, community being served, and a follow-up community health needs assessment.

A principle mechanism to evaluate outcome would be through the use of patient surveys. Since a primary assumption is that an integration of health care paradigms is desired by the community being served, the patient/consumer response would be the most appropriate measure of success. According to Scardina (1994), there are at least 21 instruments that measure patient satisfaction. Patient satisfaction surveys can be an important outcome measuring tool for assessing, organizing, and providing health care (Anderson, 1991; Bushy, 1995; Fottler, Ford, & Bach, 1997; Goldfield, 1996; Ryan, Collins, Dowd, & Pierce, 1995). Proponents of patient satisfaction surveys believe that patient outcomes are affected by the perception of care and the process involved in care (Carberry, 1998; Fifer, 1996); both are dependent upon the organizational environment in which the care is received (Abdellah & Levine, 1975; Fottler, Ford, & Bach, 1997). Thus, by evaluating patient satisfaction at a baseline (prior to implementation of the policy) and then as a follow-up, the effectiveness of change can be ascertained. The method of application of the survey (e.g., phone, mail or questionnaire) should be appropriate for the

community (Thomas, 1996). An open ended questionnaire should be developed (asking if the policy is being honored) as it is a more specific, direct way of getting feed back on the policy question. The survey should also represent which aspect of patient satisfaction is being measured (e.g., reception, providers, nursing, modalities or hospital stay).

Linn's (1975) "Patient Satisfaction with Health Care Survey", would be adequate because it addresses each interface of the patient's visit. It asks for a satisfaction rating on their reception, nursing performance, provider performance, and the quality of education they receive. It collects demographic information as well. Each of these interfaces can present barriers to health care, therefore it is important to determine if the policy has been incorporated at every level of interaction. To avoid offensive or non-applicable questions, Linn's survey can be tailored to cultural aspects of the recipient community by using the Delphi technique with community members and providers.

Another key comment from the policy critique was "how would you hold staff accountable for implementing the policy?" Generally, accountability is spelled out in the procedures portion of a manual, not in the policy. However, accountability is addressed in this policy in the Personnel Compliance and Policy Implementation sections. Several items address implementation by making it a criterion in performance evaluation, by recruiting individuals willing to embrace the policy, and by encouraging provider education and mentoring. The proposed patient survey would also serve as an indicator of which departments within the organization are successful at integrating the policy. To determine whether the program has been implemented as desired, the administrators can periodically use the results of the evaluation tools as a performance review for their health care providers and departments. Numerous approaches

are available (e.g., Total Quality Improvement) to guide an organizational culture in working together towards the same goal (McGuire & Longo, 1993).

A section on Continuous Quality Improvement/Total Quality Management was also added to the policy. The section attempts to address comments on the safety of the various modalities to be offered by the facility and also condenses the number of task forces called for in the policy draft. A task force made up of practitioners of the different modalities would be most knowledgeable about the quality of services available and licensing issues within the state. This diverse group could then serve as internal consultants for the practices to be provided at the facility.

Community resources need to be reflected in the adaptation of this policy in two places. Under the section titled Who's Needs Are Served by the Policy, the language should clarify for which population the facility provides services. In the Glossary, under *Health Care Community*, the community resources/health agencies available should be added to this sentence "...and any other related health programs or individuals...". This section was generalized because resources are different in each community (e.g., churches, WIC, Alcohol Programs and cultural groups). One caution regarding this section is that the structure should remain unchanged as it reflects the essence of a wholistic/community/wellness focus (versus a provider/illness focus). For this policy to be effective, the providers should be equal status.

Limitations

There are four principle limitations to implementation of this policy: community resources, financial resources, and reimbursement, licensure of providers and internal resistance. Suggestions and resources for resolving these issues are discussed below.

Financial resources may have a significant effect on adopting this policy because the existing financial arrangements (e.g., insurance, HMO, Public Health, Indian Health, Veterans) may not cover alternatives. The section on Budgeting for Policy Implementation must be designed within the financial arrangements of each facility. To include alternative modalities will require research and commitment. Most facilities rely on a provider's *fee for service* ability as the financial resource, and alternative practitioners are not consistently reimbursed in the 50 states, therefore creativity and innovation will be necessary (Pelletier, Marie, Krasner, & Haskell, 1997).

Some suggestions to overcome barriers to funding alternative practitioners are:

1. Employ providers that already incorporate alternative modalities into their practices.
2. Have a cash pay status for the non-reimbursed services/items.
3. Do not employ alternative practitioners, but lease a room in the facility so that they may provide on site services, yet legally remain outside of the auspices, policies, procedures, employment and insurance obligations of the facility.
4. For long term solutions, lobby the financial resources to reimburse alternative providers.

State licensure for alternative providers varies and can significantly limit the availability of non-conventional practitioners (Pelletier et al., 1997). Each facility that wishes to integrate non-conventional modalities will need to research state laws and resources. Three suggestions for providing alternative services in states that do not license the practitioners are to:

1. Solicit conventional practitioners that already integrate alternatives into their practice modalities.
2. Develop a reference list of alternative practitioners for referral.
3. For long term solutions, participate in lobbying legislation to license alternative practitioners in your state.

Internal resistance can severely hamper implementation of a policy. Imposed change in an organizational structure will prompt resistance (Barnum, 1995). According to Lewin's change theory, as cited in Olson (1979) (Figure 3), there are three phases to change: unfreezing, moving and refreezing. In this theory, current circumstances represent the status quo and equilibrium. During Phase I, unfreezing occurs when driving forces push on the status quo and create disequilibrium. Phase II, moving, is when most changes occur during a state of disequilibrium. Finally, in Phase III, refreezing occurs which is the solidification of a new status quo and equilibrium. During these three phases varying degrees of resistance can be anticipated. These resisting forces try to maintain the previous status quo by resisting the intended change (Olson 1979). In the case of an externally imposed policy, (e.g., if the community being served was asking for a change) resistance can be expected (Barnum 1995; Haiman, 1989). This externally imposed policy would be interpreted as a driving force to change by a facility which provided solely conventional services, and would probably be met with a restraining force in order to maintain its equilibrium, conventional health care.

Another reason for resistance is that this policy inverts the current paradigm of the medical delivery system (Figure 1). Providers have become accustomed to a delivery system that focuses a greater amount of resources and attention on specialty and hospital services, and the least amount on prevention and wellness. This policy reverses that focus and attention and attempts to

incorporate a wholistic care perspective. Some conventional providers may not feel equipped to deal with the additional education which would be required to practice wholistic complementary medicine. In fact, some may not agree with the concept of alternatives at all (Cirigliano & Sun, 1998).

A policy (or system) will be effective only if it is adhered to and implemented. Because most policies come from upper level management, the entities most capable of sabotaging a organizational culture change are the top level administrators and providers. Administrators that do not require implementation of the policy and do not hold persons accountable can make the policy irrelevant. Providers can effect the collegial relationships with the health care community by resisting their input and by undermining different modalities or one another's practices. Personnel management resources should be consulted regarding these behaviors and how to curb them. Respect is an important aspect of this policy and is not reflected in these behaviors.

Conclusions

This policy is an example of how consumers can guide and develop an organizational health care culture and thereby promote a health care delivery system that provides the type of care they want. Recent consumer demands have resulted in encouraging at least 14 hospitals to integrate alternatives (Pelletier et al., 1997). The publicly funded Kent Community Health Center of Seattle, WA, opened in fall of 1996 as the nation's first public health clinic overtly providing natural medicine (Foster, 1996). Meanwhile the number of private clinics providing alternatives (e.g., Medicine Tree, Polson, MT, Healing Arts Center, Colville, WA, and Wholistic Family Medicine Center for Healing, Spokane, WA) are rapidly increasing. In locations with diverse cultural demographics, the need for understanding alternative modalities is acute and in Native American communities served by the Indian Health Service, tribal members are demanding recognition and respect of traditional healing methods. The conventional method of providing health care is being challenged to incorporate alternatives and this policy offers a tool to facilitate this change.

A policy change in a local clinic can have a significant effect in how health care is delivered. Pew research (1994, 1995) predicts that health care delivery will change focus from specialists to generalists and increase primary care and community care. Thus a community clinic delivery system may be the most important interface that individuals will have (versus directions from a specialist). A community based health care system can be tailored to the culture of the clients by development of an organizational policy and thus become a lot more innovative and responsive to needs of the community.

The nursing profession will certainly play a significant role in developing health care policy in the future. At a 1996 conference, Sigma Theta Tau, the Honor Society of Nursing,

recommended that the nursing profession should take a greater role in creation of new health care delivery systems. They found that the nursing profession, through its existing roots in community advocacy, has engendered the respect of the service community and thus is well positioned for leadership roles in shaping and implementing health care reform (Nursing leadership in the 21st century, 1996).

A policy can be a very strong and binding mechanism to implement changes in an organization. It gives direction to an organization's services, and provides and governs the actions of its employees. It can serve as a means to ensure that adequate funding and consideration are given to aspects of the program that the agency wishes to emphasize. It can also be used as an educational document to inform the recipient population and the service providers of the organization's intent and how it will conduct its actions. The policy presented in this paper, if adopted, could launch the vision of an integrated wholistic health care service into reality.

Figure 1. Adapted models contrasting Hancock’s 1993 proposed redesign of the “Bottom down health system” (in *Nursing Leadership*, 1996, pp. 29) and the Orientation of the U.S. Health Care System and Medical Model: Resource Distribution 1995’s “Trickle down health system” (in *Pew Health Professions Commission*, 1994 pp.9).

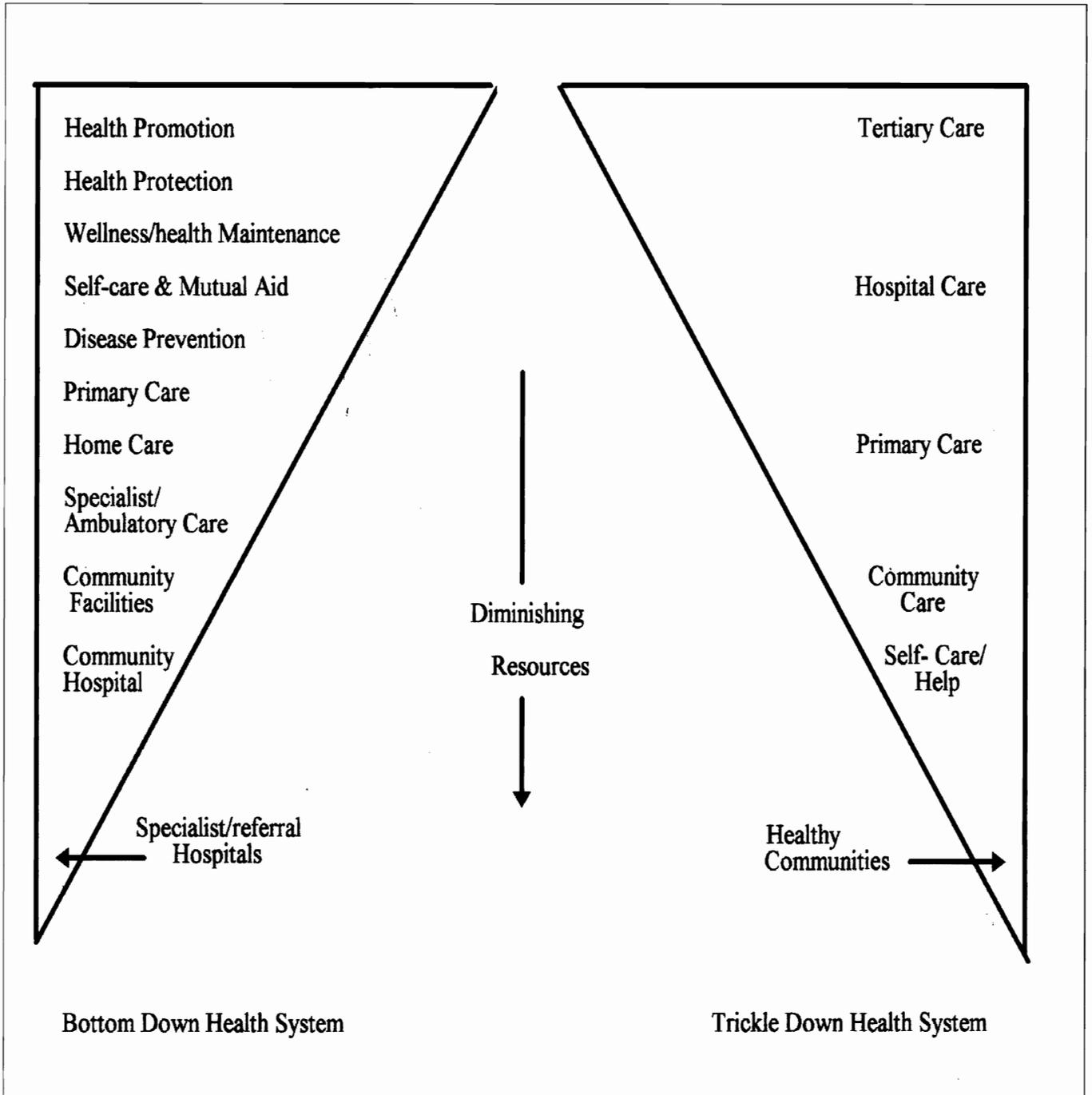


Figure 2. Adapted Delphi Technique Sequence Model (from Burns & Grove, 1997).

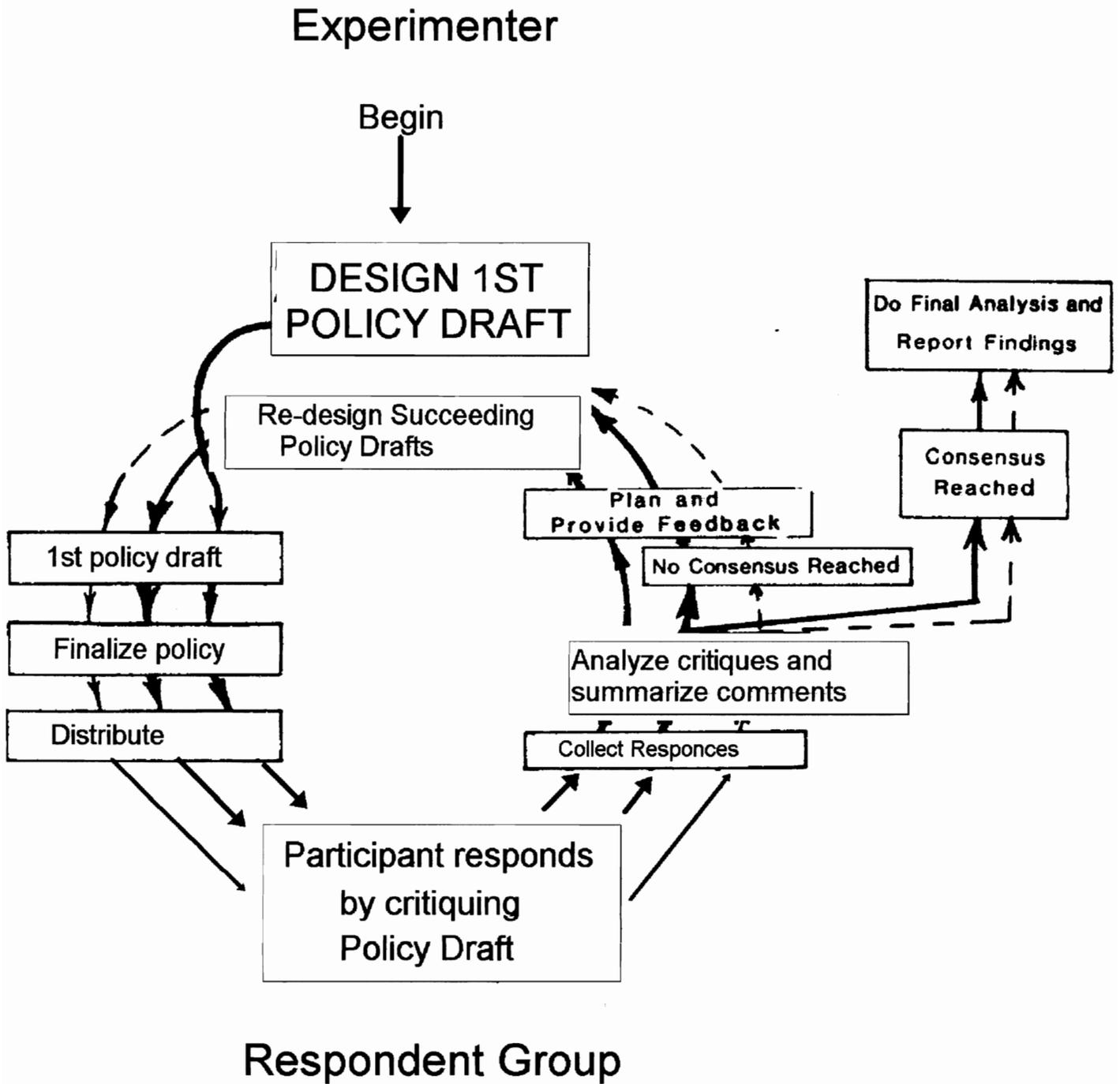
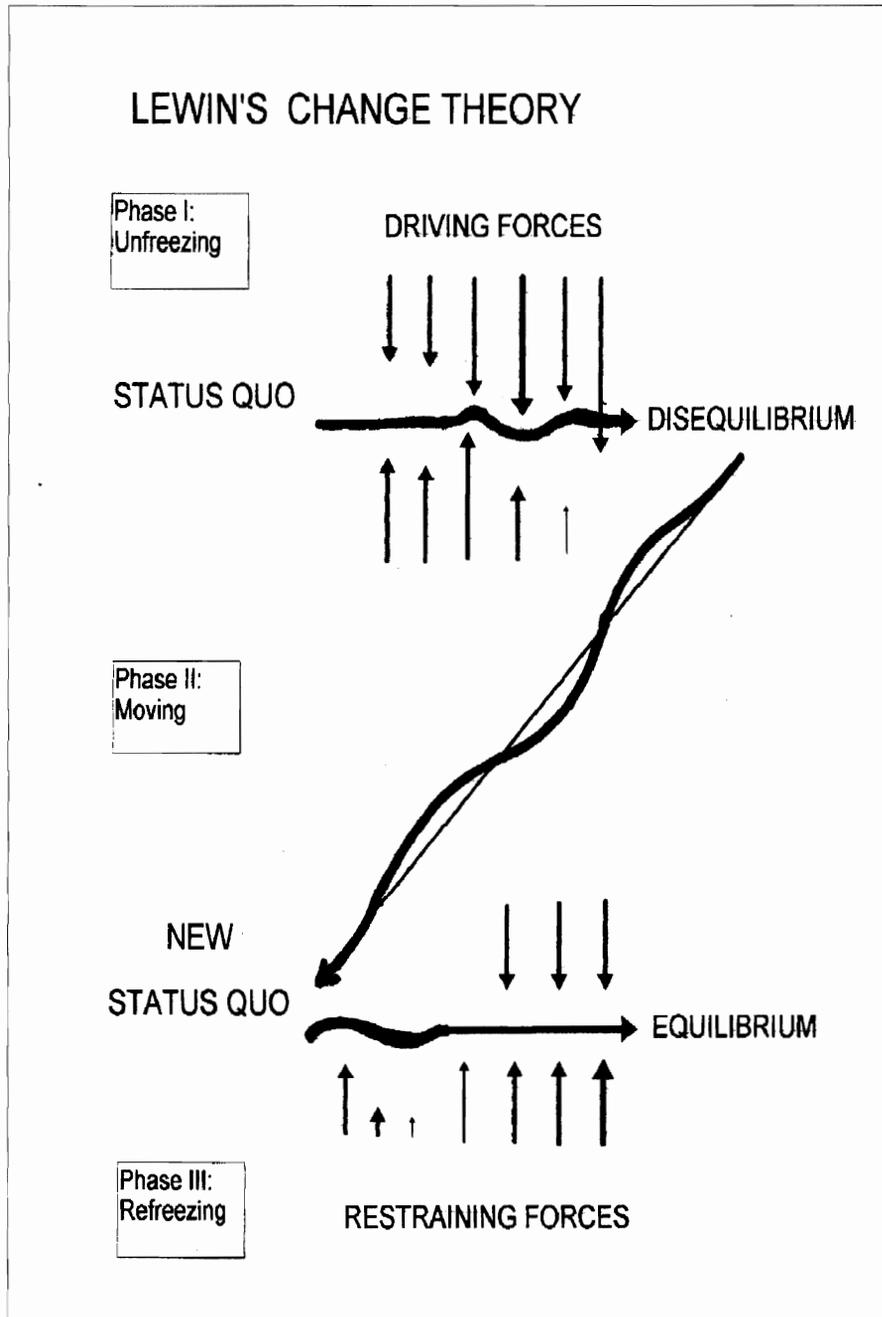


Figure 3. Adapted model of Lewin's Change Theory: Phases and forces in the change process (from Olson, 1979).



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Appendix A

Letter from Trujillo



DEPARTMENT OF HEALTH & HUMAN SERVICES

9/27/95 JH

Public Health Service

SEP 1 1995

Indian Health Service
Rockville MD 20857

Dear Health Care Leader:

During this first year of my leadership of the Indian Health Service (IHS), I have directed several initiatives to help the Agency become more efficient, accountable, compassionate, and responsive to local and national Indian health care needs. One special project that I have directed is a review of the IHS policy and protocols for traditional healing, including the reorganization of the Agency's program for traditional medicine, the Traditional Cultural Advocacy Program.

I am very aware of the need to allow this project the time and flexibility required to ensure that multi-tribal cultural considerations are addressed. I also realize the controversy and challenges that will be faced when building the bridge between allopathic medicine and traditional healing practices. We take on this responsibility because the priority of the IHS is the total health and well-being of every American Indian and Alaska Native patient that we serve.

As part of this project, two meetings have been held to solicit the advice of traditional healers on how the Agency should address traditional medicine. The first meeting was held in Missoula, Montana, and the second was in Sisseton, South Dakota. Enclosed are copies of reports from both meetings. A common theme emerging from the meetings is that traditional healing ways need to be respected, recognized, and supported by local IHS facilities. We will continue to meet with traditional healers from across the country to ensure multi-tribal participation in this process.

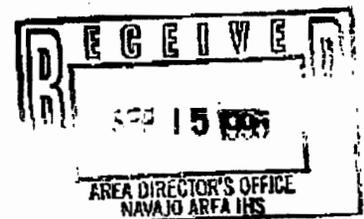
I am also considering the establishment of a national advisory board composed of multi-tribal traditional medicine people to guide us on this issue. It is the goal of the IHS to establish formal relationships that can be fostered and supported by the local Service Units and the traditional healers, through advocacy from the Office of the Director. We hope to develop stronger ties between the Senior Clinicians, Chief Medical Officers, and locally recognized healers. We anticipate discussing this topic in an open forum at the National Indian Health Board conference in November in Tampa, Florida.

Thank you for your interest and support of Indian health care. Your comments, advice, and input should be directed to Ms. Cynthia A. Smith, M.P.A., Senior Advisor to the Director, on (301) 443-1083.

Sincerely yours,

Michael H. Fujita, M.D., M.P.H.
Assistant Surgeon General
Director

Enclosures



Appendix B

Permission Granted

**NEZ PERCE TRIBAL EXECUTIVE COMMITTEE MEETING
REGULAR MEETING
November 12, 13, 1996**

The meeting was called to order 8:00 a.m. by Chairman Samuel N. Penney with the opening prayer by Chaplain Mrs. HighEagle in the Richard A. Halfmoon Council Chambers, Lapwai, Idaho.

ROLL CALL: Samuel N. Penney, Chairman - present
Wilfred A. Scott, Vice-Chairman - present
Tonia Garcia, Secretary - present
Jaime Pinkham, Treasurer - present
Arthur Taylor, Asst. Secretary/Treasurer - present
Carla HighEagle, Chaplain - present
Del T. White, Member - present
Julia A. Davis, Member - present
Della Cree, Member - present

Announcements

November 6th Mainstem Passage Issue, Portland
November 7th PSC Advisory Board, Portland
November 15th Elder Circle Meeting for Nez Perce Language, Kamiah
November 18th Inter-Tribal Timber Council Board meeting, Lewiston
November 20th CRITFC Subcommittee meetings, Portland
November 21th CRITFC Commissioners meeting, Portland

1. Agenda Motion/Mrs. HighEagle, second/Mr. Pinkham to approve the agenda, motion carried.
2. Minutes Motion/Ms. Davis, second/Mrs. Cree to approve the minutes of October 29-30, 1996, with corrections, motion carried.
3. Treasurer's Report Motion/Mr. Taylor, second/Ms. Davis to accept the treasurer's report, motion carried.
4. Office of Legal Counsel Motion/Mrs. Cree, second/Ms. Garcia to go into executive session at 8:36 a.m., motion carried. Motion/Mrs. HighEagle, second/Ms. Davis to come out of executive session at 9:44 a.m., motion carried.

HEALTH & HUMAN SERVICES SUBCOMMITTEE - November 4, 1996

Roll Call: Julia A. Davis, Chairperson - present
Carla HighEagle, Vice-Chairperson - present
Tonia Garcia - present
Jaime Pinkham - present
Del White -
Wilfred Scott - present
Della L. Cree - present

Administrative Actions

5. Western & Traditional Medicine Policy Motion/Ms. Davis, second/Mrs. HighEagle to authorize Charmaine Allen the use of Western & Traditional Medicine Policy information for her masters project, with publication rights subject to NPTEC approval, motion carried.

Appendix C
Policy Statement

POLICY STATEMENT

It is a *¹policy of [-Name of Health Care Facility -] that their *Health Care Providers incorporate a *Wholistic approach to healing and wellness by recognizing, encouraging and integrating the use and practices of *allopathic, (* Indigenous where applicable) and *non-conventional *modalities.

Purpose of the Policy²

To improve health care by expanding available health care practices, therefore, giving consumers choices in health care delivery modalities.

Whose Needs are Served by the Policy

The policy is designed to serve [-Your target population/community-]. The policy will be beneficial and welcoming to people who use, trust and prefer to integrate the modalities represented by allopathic medicine, (indigenous healing where applicable), and non-conventional health care practices. In general, the policy and philosophy is designed to serve any human being that chooses [-Name of facility-] to provide their health care services.

Goals of the Policy

To achieve:

1. A measurable, long-term, improvement in health outcomes for the mental, physical, spiritual and emotional health of the people served.
2. Maintenance of a wholistic approach to wellness, preventing the onset of illnesses, decreasing the severity of unavoidable illnesses and promoting a therapeutic environment for healing.
3. An “open door” philosophy manifested as a health care delivery system which is more respectful and responsive to the individual, family and community’s needs and promotes easier access to health care.
4. Consumer responsibility and pride in the creation and development of an organizational culture which reflects a personal, family and community centered health service.
5. An improvement in overall collegial relationships among all *health care community providers.

¹ The * indicates that a definition is provided in the glossary.

² Policy outline from Rothwell & Kazanas (1993).

Adoption of the Policy

The policy will be presented and authorized by the [-Name of facility-] Board according to the facilities philosophy and mission statement by:

1. Submission of the policy to the group requesting the policy for approval (if applicable).
2. Concurrence for approval by [-Name of facility-] governing board or board of directors.
3. [-Name of facility-] governing board or board of directors will establish a time frame for adoption and implementation of the policy and determine a methodology for enforcement.
4. Describing the policy in the local newspaper, posting it and providing pamphlets in the community public areas and offices of the health care community, and presenting it at informational public forums.

Policy Implementation

1. Internal group training:
*Health Care Community personnel will be oriented to each other's services so that clients can be directed to the available programs. All members of the Health Care Community will be invited and encouraged to attend general health care staff meetings and educational workshops.
2. External education:
*Health Care Providers will participate in annual training/education that introduces them to or enhances their existing knowledge of allopathic, indigenous and non-conventional modalities. Health Care Providers will maintain a network and collegiality with other practitioners of allopathic, indigenous and non-conventional modalities for the purposes of referring clients to the best resources for treatment and coordinating care.
3. On-the-job training:
Sharing of technical, educational and philosophical knowledge among members of the Health Care Community will be encouraged.
4. Mentoring:
In an effort to promote enthusiasm for multi-cultural, wholistic health care, members of the health care community are encouraged to mentor interested health care students. The mentor's role is to encourage and empower students to act as health care change agents, to provide them with additional education and, where applicable, to encourage their return to their communities as providers of health care.

Responsibilities for Policy Implementation

1. Health Care Community:
The responsibilities of the members of the Health Care Community are to inform the people they serve of the adoption of the policy and to reflect the implementation of the policy in their actions.

2. **Health Care Providers:**
The responsibilities of the Health Care Providers are to be knowledgeable enough in the different modalities to facilitate a wholistic health care perspective and to work with the health care community and board on implementation and adherence.
3. **Board of Directors:**
Will oversee the policy implementation, guide orientation issues, safeguard against any biases or interferences in the integration, and safeguard provider dominance of one *paradigm over the other. Their role is to maintain the policy essence, which is “consumer choice”.

Personnel Compliance

1. **Orientation:**
The employees of [-Name of facility-] will be oriented to this policy in the same manner as other policies and *procedures.
2. **Performance appraisals for the Health Care Providers:**
The employees of [-Name of facility-] will be evaluated on adherence and compliance to this policy in the same manner as other policies and procedures of [-Name of facility-].
3. **Recruitment for the Health Care Providers:**
Prospective health care providers for the [-Name of facility-] will be informed of this policy in the solicitation for employment.

Budgeting for Policy Implementation

The policy will be funded and budgeted for in the same manner and with the same resources that currently provide health care for the [-Name of facility -]. Monetary compensation for health care practices stipulated by this policy will be incorporated to the fullest extent possible within the current financial program. The business department will revise their policies and procedures on compensation to accommodate implementation of this policy. (This section may need revision specifically for your state and facility. One viable alternative in states that do not license alternative practitioners is to employ conventional practitioners who integrate alternatives into their practices or refer).

Evaluation of Effectiveness

1. **Develop a baseline patient satisfaction survey, with a section specifically related to alternative modalities offered, and repeat it periodically. Use the results as an outcome measurement evaluation to indicate the effectiveness of the policy. Provide survey results to the directors for evaluation.**

2. In order to garner internal feedback from staff, provide opportunities for candid, confidential responses. In addition to utilizing comment boxes, objective interviews should be obtained periodically to evaluate staff perception of the policy.
3. In order to gather community feedback, periodically evaluate whether the changes made are those that were intended. Task forces and community forums can be used to solicit responses.
4. A Community Health Needs Assessment Survey should be repeated periodically to gather important information about the changing demographics and attitudes of the consumers' community.

Continuous Quality Improvement/Total Quality Management

Establish a task force(s) that represents the different modalities and departments. They will be responsible for researching and developing protocols regarding:

- Safety and efficacy of conventional, non-conventional and indigenous medicine.
- Triage of patients for effective and cost efficient care.
- Compensation, credentialing, licensing, malpractice insurance coverage and reimbursement resources.

GLOSSARY

<i>Allopathic medicine</i>	Conventional, cosmopolitan, Euro-Anglo, science based, western medical paradigm which governs the providers practice and modalities (e.g. MD.'s. Psychiatrists, Dentists, Pharmacists and RN's using radiology, surgery and pharmaceuticals as modalities).
<i>Alternative</i>	A “choice” between two or more things. Employing non-traditional or non-conventional ideas and methods. In health care it is generically referred to as any non-allopathic practices /modalities used for healing.
<i>Non-conventional providers</i>	A wide variety of practitioners/people that use “...a broad set of health care practices (i.e. already available to the public) that are not readily integrated into the dominant health care model, because they pose challenges to diverse societal beliefs and practices (cultural, economic, scientific, medical and educational)...”(Eskinazi, 1998). They utilize non-conventional, multi cultural, wholistic paradigms, therefore allopathic care can be included but is not exclusive (e.g. Osteopaths, Advanced Nursing Practitioners, Chiropractors, Physical Therapists, Midwives, Acupuncturists, Naturopaths, Homeopaths, Dietitians, Nutritionists, Herbalists, etc).
<i>Health Care Community</i>	Persons who provide, manage and administer the different aspects of wholistic health care to diverse populations including: Health Care Providers and their staffs, Public Health Department, Health and Human Services, Women Infants and Children, Maternal Child Health, Youth programs, Head Start, Food Services (Commodities), Home Health Agencies, family and any other community related health programs or individuals.
<i>Health Care Providers</i>	Persons who practice allopathic, non-conventional modalities and indigenous healing.
<i>Modality</i>	The type of application in a therapeutic method.

<i>Paradigm</i>	An example serving as a model or pattern, a way of perceiving the world, a point of view.
<i>Policy</i>	A long range statement of objectives formalized by administrative authority that reflect a philosophy and requires specific actions and delegates accountability.
<i>Procedures</i>	A written description intended to coordinate actions and fix responsibilities.
<i>[Indigenous healing]</i>	Health or medicinal practices of an Indigenous/ traditional culture.
<i>Wholistic</i>	Meaning “whole”. A wholistic approach encompasses all aspects of a person's, family, community and environmental life forces in the maintenance of wellness, prevention or healing of an illness or disease (Nez Perce Tribe Policy Development Committee, 1996). “Not a body part or just a person but the family, community, country and even the universe” (Alta Guzman, personal communication, spring 1997). Holistic - Entities function as complete organisms that cannot be reduced to a sum of their parts.

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