Traditions of Health
Systems change through integration, collaboration, strategy, and action

Esther Lucero (Navajo), MPP
Director of Programs and Strategic Development
History and Background

Traditional/Cultural Practices
- Always part of our system of care
- Always treated whole person
- Always considered environment

Impact of Colonization
- Deconstructed traditional systems of care
- Devalued traditional Healing
- Created separation of practices (silos)

Integration
- Reconstruct whole person care
- Value cultural competence
- Consider the environment
The Affordable Care Act

Reauthorized the Indian Health Care Improvement Act
  • Made Urban Indian funding permanent

Named Complimentary/Alternative Medicine

Created a policy window of opportunity
  • Mental Health and Substance Use Services part of the 10 essential benefits
  • State level changes in reimbursements i.e. payment reform and Drug Medi-Cal expansion
  • Movement toward integration
Traditions of Health Project

**Objective 1:** Identify Policies that support for traditional/cultural practices from other states

**Objective 2:** Culturally adapt the SAMHSA’s six levels of integrations tool

**Objective 3:** Test the adapted tool within UIHOS across California

**Objective 4:** Develop a culturally competent integration model

**Objective 5:** Develop a comprehensive policy change and sustainability strategy for Traditional Health

**Objective 6:** Use innovative strategies for dissemination
Who?

Behavioral Health Peer Network

Traditional Health Taskforce

Traditional Healers Advisory Committee
Taskforce Considerations

- **Sovereignty & Self Determination**
  - Respect & maintain integrity of tribal and community sovereignty

- **Traditional Healing**
  - Validation
  - Design
  - Trust building
  - Safeguards from...
  - Not being compromised
  - Paper work
  - About to administer

- **Accessibility**
  - Suitable space
  - Cultural knowledge
  - Traditional healers & natural helpers
  - Protect sacred sites

- **Language**
  - Translation of words into their literal meaning

- **Funding**
  - A community organization not receiving funding from sources

- **Appropriation**
  - Safeguards
Policy Review and Analysis

Oregon Tribal Cultural Best Practices- Response to SB 267

- Identify government departments that contain key supporters and programs that have windows of opportunity for systems changes.
- Oregon’s model set precedence for the validity of Community-defined practices as equal to Evidence-based practices.
- Focus on outcomes and Evidence.
- Create a Community Approval Panel.
- Create an American Indian Research and Evaluation body to be a resource to government systems and Tribal Communities.
- Decide on a classification system for Community-defined practices.

VA Central California Health Care System- 2007 Policy

- Incorporated Traditional Healing into treatment plan if referred by physician.
- Traditional Healers had to register as clergy.
SB 52 (cut in 2009) and Native American Training Associates

- Created the Indian Health Program under the California Department of Health.
- Traditional Healers considered Technical Assistance Providers.
- Recommendations from NATA never came to fruition.

First Nations Health Program at Whitehorse General Hospital Canada

*Still under review

Pilot Billing Models

The California Rural Indian Health Board was funded through SAMHSA to create their CRIHB CAIRS project, which included a pilot, billing model for Traditional and Cultural Practices.

Dr. Carrie Johnson at the United American Indian Involvement was funded through a Los Angeles County Innovations Project to produce a pilot, billing model to be utilized within her Behavioral Health Program.

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

<table>
<thead>
<tr>
<th></th>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KEY ELEMENT</strong></td>
<td>COMMUNICATION</td>
<td>PHYSICAL PROXIMITY</td>
<td>PRACTICE CHANGE</td>
</tr>
<tr>
<td><strong>LEVEL 1</strong></td>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Close Collaboration Onsite with Some System Integration</td>
</tr>
<tr>
<td><strong>LEVEL 2</strong></td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
</tr>
<tr>
<td><strong>LEVEL 3</strong></td>
<td>Basic Collaboration Onsite</td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
</tr>
</tbody>
</table>

**Table 1. Six Levels of Collaboration/Integration (Core Descriptions)**

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**Behavioral health, primary care and other healthcare providers work:**

In separate facilities, where they:

- Have separate systems
- Communicate about cases only rarely and under compelling circumstances
- Communicate, driven by provider need
- May never meet in person
- Have limited understanding of each other’s roles

In separate facilities, where they:

- Have separate systems
- Communicate periodically about shared patients
- Communicate, driven by specific patient issues
- May meet as part of larger community
- Appreciate each other’s roles as resources

In same facility not necessarily same offices, where they:

- Have separate systems
- Communicate regularly about shared patients, by phone or e-mail
- Communicate, driven by need for each other’s services and more reliable referral
- May meet occasionally to discuss cases due to close proximity
- Feel part of a larger yet ill-defined team

In same space within the same facility, where they:

- Share some systems, like scheduling or medical records
- Communicate in person as needed
- Collaborate, driven by need for consultation and coordinated plans for difficult patients
- Have regular face-to-face interactions about some patients
- Have a basic understanding of roles and culture

In same space within the same facility (some shared space), where they:

- Actively seek system solutions together or develop work-arounds
- Communicate frequently in person
- Collaborate, driven by desire to be a member of the care team
- Have regular team meetings to discuss overall patient care and specific patient issues
- Have an in-depth understanding of roles and culture

In same space within the same facility, sharing all practice space, where they:

- Have resolved most or all system issues, functioning as one integrated system
- Communicate consistently at the system, team and individual levels
- Collaborate, driven by shared concept of team care
- Have formal and informal meetings to support integrated model of care
- Have roles and cultures that blur or blend

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# SAMHSA’s Six-levels of Integration Adaptation

## Table 1. Six Levels of Collaboration/Integration (Core Descriptions) Including Cultural Adaptation

<table>
<thead>
<tr>
<th>Level</th>
<th>Coordinated Communication</th>
<th>Co-located Physical Proximity</th>
<th>Integrated Practice Change</th>
</tr>
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<tbody>
<tr>
<td>Level 1</td>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>接近的协作实践，包括一些系统集成</td>
</tr>
<tr>
<td>Level 2</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
<td>面对面的协作实践，包括一些系统集成</td>
</tr>
<tr>
<td>Level 3</td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Close Collaboration Approaching and Integrated Practice</td>
<td>全面的协作实践，在一体化整合的实践</td>
</tr>
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</tr>
</tbody>
</table>

### Behavioral health, primary care, traditional health, and other healthcare providers work:

<table>
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<tr>
<th>In separate facilities where they:</th>
<th>In separate facilities where they:</th>
<th>In same facility not necessarily same offices, where they:</th>
<th>In same space within the same facility, where they:</th>
<th>In same space within the same facility, sharing all practice space, where they:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have separate systems</td>
<td>Have separate systems</td>
<td>Have separate systems,</td>
<td>Share some systems,</td>
<td>Have resolved most or all system issues, functioning as one integrated system</td>
</tr>
<tr>
<td>Communicate about cases only rarely and under compelling circumstances</td>
<td>Communicate, driven by provider need</td>
<td>Communicate regularly about shared patients,</td>
<td>like scheduling or medical records</td>
<td>Communicate frequently in person</td>
</tr>
<tr>
<td>Communicate, driven by patient request</td>
<td>Communicate, driven by community request</td>
<td>by phone or email Collaborate, driven by operational standards</td>
<td>Collaborate, driven by need for consultation and coordinated plans for difficult patients</td>
<td>Collaborate, driven by desire to be a member of the care team</td>
</tr>
<tr>
<td>May never meet in person</td>
<td></td>
<td>Communicate, driven by community request</td>
<td>Have regular face-to-face interactions about some patients</td>
<td>Have regular team meeting to discuss overall patient care and specific patient issues</td>
</tr>
<tr>
<td>Have limited understanding of each other's roles</td>
<td>Have limited understanding of each other's roles as resources</td>
<td>Have a theoretical understanding of each other's practice</td>
<td>Have a basic understanding of roles and culture</td>
<td>Have an in-depth understanding of roles and culture</td>
</tr>
<tr>
<td>Have limited understanding of each other's healing modalities</td>
<td>Have limited understanding of each other's capacity</td>
<td>Appreciate each other's roles as resources</td>
<td>Have respect for each other's practice</td>
<td>Have institutional support and encouragement for collaboration</td>
</tr>
<tr>
<td>Have limited understanding of each other's capacity</td>
<td>Have little-to-no institutional support for collaboration</td>
<td>Have a theoretical understanding of each other's practice</td>
<td>Have some institutional support for collaboration</td>
<td>Have a basic operational structure</td>
</tr>
<tr>
<td>Skeptical about each other's effectiveness in practice</td>
<td>Have no institutional support for collaboration</td>
<td>Lack a basic operational structure</td>
<td>Lack of formal protocol for collaboration</td>
<td>Have general protocol for collaboration, but lack QI structure to ensure collaboration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of formal protocol for collaboration</td>
<td></td>
<td>Have resolved most or all system issues, functioning as one integrated system</td>
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**CCUIH**
Next Steps

Complete Culturally Relevant Integration Model
Finalize Policy Change Strategy
Host Traditional Healers Retreat
Thank you!
Questions, Input, and Feedback