CCUIH **California** Consortium **for** Urban **Indian** Health

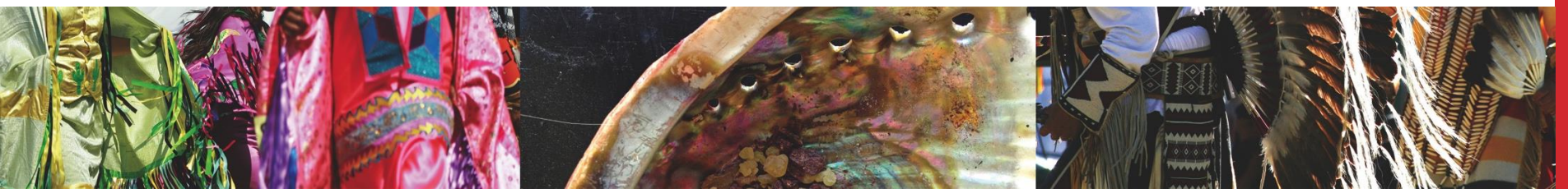
Strengthening The **Organizations** That **Strengthen** Our **Communities**

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

CCUIH

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

CCUIH

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

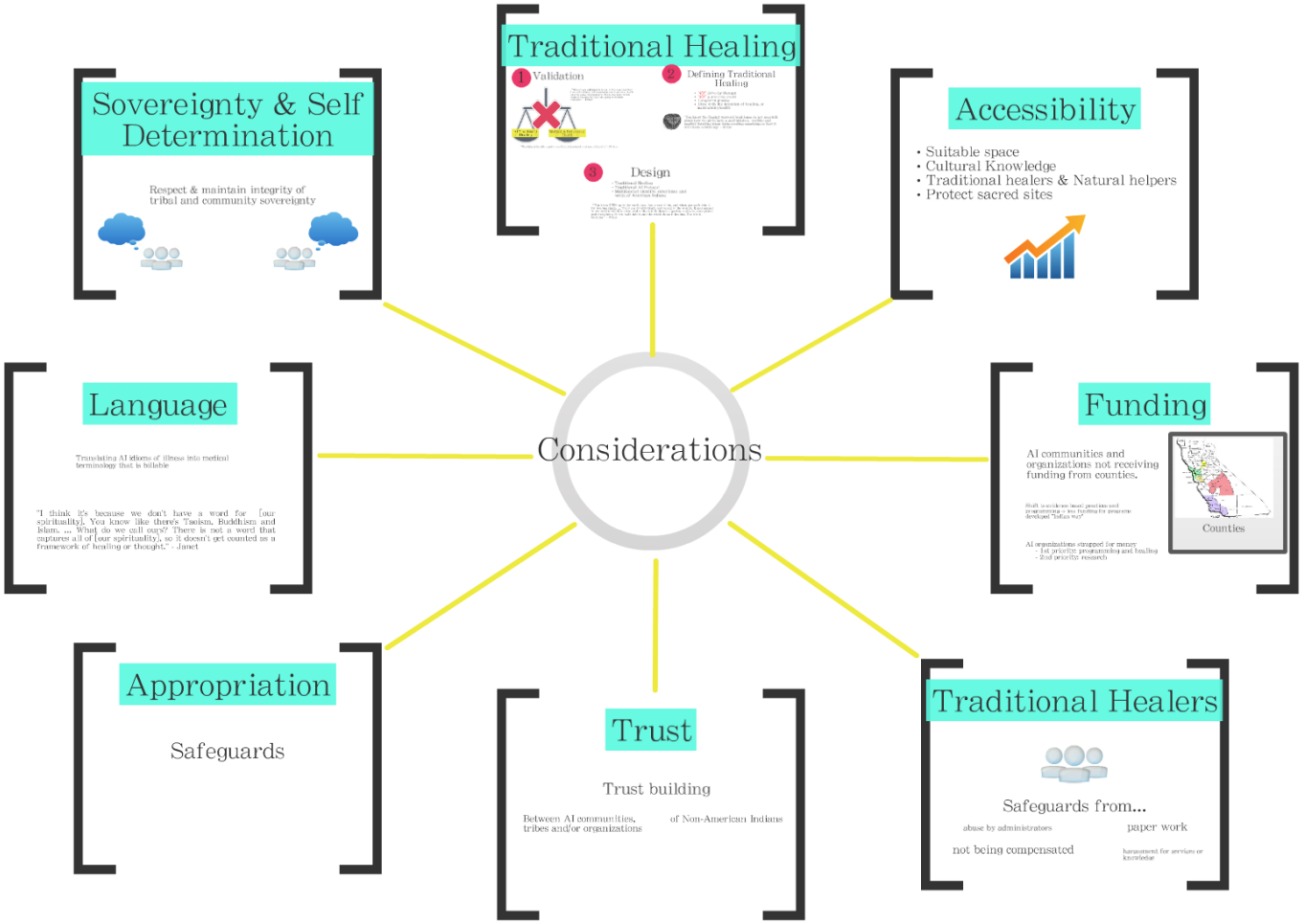
Who?

Behavioral Health Peer Network

Traditional Health Taskforce

Traditional Healers Advisory Committee

Taskforce Considerations



CCUIH

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.

CCUIH

Policy Review and Analysis Cont'

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.

CCUIH

SAMHSA's Six-levels of Integration

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

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, 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	▸▸ 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	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ 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	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ 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	▸▸ 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

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

CCUIH

SAMHSA's Six-levels of Integration Adaptation

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

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSCIAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching and Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/Merged Integrated Practice
Behavioral health, primary care, traditional health, and other healthcare providers work:					
In separate facilities where they:	**In separate facilities where they:**	**In same facility not necessarily same offices, where they:**	**In same space within the same facility, where they:**	**In same space within the same facility (some shared space), where they:**	**In same space within the same facility, sharing all practice space, where they:**
Have separate systems Communicate about cases only rarely and under compelling circumstances Communicate, driven by provider need Communicate, driven by patient request Communicate, driven by community request May never meet in person Have limited understanding of each other's roles Have limited understanding of each other's healing modalities Have limited understanding of each other's capacity Skeptical about each other's effectiveness in practice Have no institutional	Have separate systems Communicate periodically about shared patients Communicate, driven by specific patient issues Communicate, driven by client request Communicate, driven by community request May meet as part of larger community Have a theoretical understanding of each other's practice Appreciate each other's roles as resources Have little-to-no institutional support for collaboration	Have separate systems Communicate regularly about shared patients, by phone or email Collaborate, driven by operational standards Collaborate, driven by need for each other's services and more reliable referral Meet occasionally to discuss cases due to close proximity Feel part of a larger yet non-formal team Have basic understanding of each other's practice Have respect for each other's practice Have some support for collaboration Lack operational structure Lack of formal protocol for collaboration	Share some systems, like scheduling or medical records Communicate in person as needed Collaboration, 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 Have respect for each other's practice Have some institutional support for collaboration Lack a basic operational structure Lack of formal protocol for collaboration	Actively seek system solutions together or develop work-a-rounds Communicate frequently in person Collaborate, driven by desire to be a member of the care team Have regular team meeting to discuss overall patient care and specific patient issues Have an in-depth understanding of roles and culture Have institutional support and encouragement for collaboration Have a basic operational structure Have general protocol for collaboration, but lack QI structure to ensure collaboration	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 and blend Have institutional support and expectation of collaboration Have a comprehensive operation structure Have a comprehensive QI structure to ensure continued quality improvement

CCUIH

Next Steps

Complete Culturally Relevant Integration Model

Finalize Policy Change Strategy

Host Traditional Healers Retreat

Thank you!
Questions, Input, and Feedback

CCUIH

esther@ccuih.org
www.ccuih.org
415.638.6154