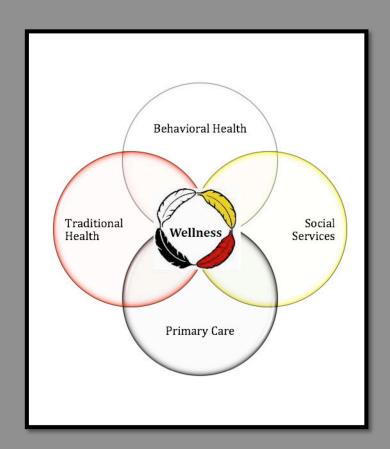# Traditions of Health:
The Culturally Relevant Integration Model

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INTRODUCTION

The California Consortium for Urban Indian Health's (CCUIH) **Traditions of Health** project aims to improve the integration of behavioral health and primary care for Urban Indians by advancing the cultural revitalization efforts of Urban Indian Health Organizations (UIHO) in California. This project convened key stakeholders to advance policy reform and sustainability planning, and worked to develop culturally specific, integrated systems of wellness for Urban Indians. CCUIH developed the **Culturally Relevant Integration Model** to empower UIHOs to return to integrated wellness practices. This model is the result of one year of planning, informed by our Traditional Health Taskforce, Behavioral Health Peer Network, and Traditional Healers Advisory Committee along with key stakeholder interviews.

The Culturally Relevant Integration Model is a tool that UIHOs can use to implement integration approaches that move beyond shared information through electronic health records (EHR), to address the organizational changes required to meet the holistic needs of the people they serve. This model is designed to strengthen the use of American Indian cultural practices within systems of care to increase access to traditional knowledge and to ensure that wellness practices remain community-centered and culturally relevant through this time of healthcare reform and for generations to come.

The primary audience intended for this model is CCUIH's member UIHOs who will gain the opportunity to pilot these recommendations to support their integration efforts. Additionally, this model can also assist tribal organizations and other American Indian serving agencies in the assessment of their services and strategies for meeting population-specific holistic care needs. Similarly, other health and social service organizations that serve culturally-specific marginalized communities can also benefit from this model and adapt it to meet the needs of their populations.

The passage of the Affordable Care Act and implementation of Healthcare Reform requires the integration of healthcare systems, outlines specific provisions for behavioral health, and acknowledges the value of complementary medicine. This landmark legislation presents an opportunity for UIHOs to establish sustainable models that integrate primary care with behavioral health while maintaining the cultural integrity valued by Urban American Indians.

BACKGROUND

Prior to European arrival, American Indians had holistic, community-centered wellness systems in place.[1] These traditional systems of health were dismantled through various aspects of colonization including genocide, forced assimilation, the criminalization of spiritual and cultural practices, and the introduction of western models of healthcare. This dismantling separated physical health from behavioral and spiritual health.

Many indigenous communities have names to describe a traditional way of life. For example, the Diné (Navajo), walk in Hózhó or The Beauty Way, which is a state of order grounded in

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[1] Vogel, V. J., & NetLibrary, I. (1970). *American Indian Medicine* ([1st ed.].). Norman: University of Oklahoma Press.

harmony and balance within individuals and their alignment with the world. It encompasses physical, mental, spiritual, community, and environmental wellness. An imbalance of these elements can manifest in illness. All cultural mechanisms pre-birth through death, and even into the spirit world, are focused on fostering and maintaining this balance. Moreover, all members of the community are considered valuable; that is not to say that there are not differences among people, but that differences can offer contributions that are important.

One example of this valuing of difference comes from CCUIH's Traditional Health Task Force member, Martha Martinez, a Lakota woman living in Oakland, California. She tells a story of a young man who struggled for most of his life with what western models would diagnose as depression and suicidal ideation. Instead of responding to his condition through medical protocol and admitting him into a psychiatric facility, where he would be isolated from his family and community, the community took him into ceremony. His entry into ceremony was designed to transcend illness by restoring balance. Led by a traditional healer, the family and community became responsible for this young man's healing. In ceremony, prayer strengthens healing and love instills hope. The ceremony reinstated balance and supported this young man in strengthening his will and well-being. The components of ceremony, the traditional healer, family, and community collectively healed him through a healing transformation that recognized him as a valuable community member.

The systematic dismantling of indigenous systems of wellness has occurred over many generations and contains the following components:

> 1. **Cultural Genocide:** Assimilation policies, such as boarding schools, the criminalization of American Indian religious and cultural practices, urban relocation, and tribal termination, has had a tremendous impact on traditional wellness systems. All of these policies aimed to strip American Indians of their cultural identities and forced them to become part of dominant American culture. Traditional healers were pushed underground and traditional knowledge was sentenced to secrecy out of fear of punishment.

> 2. **Relocation:** The forced removal of tribes from their traditional homelands to reservations distanced them from their land bases that held connections to their creation stories, ceremonial grounds and traditional medicines. It became more difficult to conduct important ceremonies that served as preventative mechanisms throughout the cycle of life including naming ceremonies, coming of age ceremonies, and healing ceremonies because wellness and the practices that foster wellness are intrinsically linked to the land of their origin. Relocation disconnected American Indians from their ways of life and disrupted their ability to maintain wellness.

> The Bureau of Indian Affairs (BIA) federal Urban Relocation Program of the 1950s exacerbated American Indians' disconnection from their land. Through this program, American Indians from various tribes began migrating in large numbers from reservations to selected California cities with the promise of access to education, jobs, housing and a better life. Ultimately, the BIA did not deliver its promises, which created a chronically disenfranchised Urban American Indian population with unique issues including isolation from traditional and cultural wellness practices, statistical invisibility, and well-documented health disparities that are vastly disproportionate to the general population.

3. **Western Structures:** Through the federal implementation of western government models in reservation governments, including tribal constitutions, government structures, and the development of health and social service facilities, tribes moved away from their traditional systems. Tribal systems of wellness began to transform into healthcare systems, which were focused on identifying and addressing illnesses through a distinctly compartmentalized service delivery model. Primary care and behavioral health practices became separate entities, each with different sustainability mechanisms. Traditional healing became a community responsibility because it did not fit within these funding structures. Unfortunately, a community responsibility model is not sustainable. The American Indian community structure now resembles the structure of dominant American culture, rather than upholding the traditional model of balance.

4. **Focus on Illness:** The creation of diagnostic tools such as the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), as well as contemporary healthcare systems' dependence on these tools to dictate billable services and activities, limits treatments to western medical modalities. This prevents American Indian people from receiving holistic treatment through beliefs in balance and harmony.

The destruction of indigenous systems of wellness also played a role in the development of Historical Trauma (HT). HT has been identified as an underlying factor in American Indian health disparities. HT, as defined by Dr. Maria Yellow Horse Brave Heart, is the "collective emotional and psychological injury both over the lifespan and across generations, resulting from a cataclysmic history of genocide."[2] Historical Trauma Response is the way HT manifests into visible ailments often seen in the vast health disparities suffered by American Indians. Figure 1 below gives some examples of these ailments.

Figure 1: Historical Trauma Response

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[2] Brave Heart, M. Y. H. (1998). The return to the sacred path: Healing the historical trauma and historical unresolved grief response among the Lakota through a psychoeducational group intervention. *Smith College Studies in Social Work*, 68 (3), 287-305.

INFORMANT WORKGROUPS

The **Traditions of Health** project and the **Culturally Relevant Integration Model** were informed by CCUIH's Traditional Health Taskforce, Traditional Healers Advisory Committee, and Behavioral Health Peer Network.

CCUIH developed and facilitated the Traditional Health Taskforce to access diverse perspectives on the integration of traditional healing, and to assess the need for policy and systems change to support the integration and sustainability of traditional healing into holistic systems of care. The Taskforce is comprised of primary care and behavioral health providers, traditional healers, tribal council members, organizational leaders, policy advocates and other systems partners. Information from this group was collected through in-person meetings, and additional key informant interviews were conducted on an as needed basis. Meetings were recorded, transcribed, analyzed, and reported through a living document. This analysis was also summarized in a narrated presentation. (See link in Appendix A.)

The Traditional Healers Advisory Committee was developed to intentionally include contributions from traditional healers. CCUIH accessed the Traditional Healers Advisory Committee to develop the integration model and policy change/sustainability strategy. Information was collected from this group through an in-person meeting and key informant interviews.

The Behavioral Health Peer Network (BHPN) was comprised of all behavioral health directors from each of our member UIHOs. The BHPN contributed to the development of the model by providing clinical perspectives, completing CCUIH's integration readiness assessment (see Appendix C) and presenting organizational success and challenges in their efforts toward integration. Information from this group was collected through survey format, key informant interviews, and verbal or written feedback on project outcomes.

ANALYSIS

Literature Review

To begin the process of data collection and analysis for the Culturally Relevant Integration Model, CCUIH conducted a literature review to examine the scope and success of traditional health in contemporary healthcare systems. Appendix B is an annotated bibliography of scholarly publications. This is a living document that CCUIH will add to as related literature emerges.

Workgroup Outcomes

CCUIH understood that the subject of the integration of traditional healing is complex and dynamic, so we treated the workgroup meetings not only as venues for collecting perspectives of diverse stakeholders, but as opportunities to collect data that we could thoroughly analyze using qualitative research methods. We recorded the Traditional Health Taskforce meetings,

Traditional Healers Advisory Committee meetings, and key informant interviews, and then coded and analyzed the transcripts, using qualitative data analysis software. CCUIH then compiled a research report focused on three key questions: (1) What should CCUIH consider when creating a culturally responsive integration model? (2) How can CCUIH respond strategically to address those considerations? and (3) What does it look like to integrate traditional healing? This report was used to guide the Cultural Relevant Integration Model and the accompanying Policy Change and Sustainability Plan.

One of the major themes from the workgroup data is the validation of traditional healing. Taskforce and Committee members want traditional healing to be treated as a valid part of the healthcare system, equal to primary care and behavioral health. In order for system-wide validation, the workgroup recognized a need not only for research and innovative evaluation methods, but also a need for building trust among organizations, traditional healers and non-Indian government stakeholders. Currently, many traditional healing and cultural services are funded through grants that may or may not be integrated into an organization's sustainability plan. System-wide validation can lead to traditional healing practices becoming billable, making these practices financially sustainable for both Indian health programs and traditional healers.

The workgroups considered the ways that traditional healing practices would need to be defined, and how traditional healers may need certification in order to make traditional healing practices billable. Defining practices and certifying practitioners should not be solely regulated by the state. The voices of diverse American Indian stakeholders, particularly traditional healers, must be at the forefront of the movement for traditional healing sustainability in order to maintain the integrity of the practices. Members of the workgroups also discussed their concerns about misappropriation of traditional healing practices by non-Indians, the limitations of diagnostic and healthcare language, and the challenges of navigating tribal self-determination while fostering a sense of urban self-determination.

From the workgroup meetings, CCUIH was also able to draw strategies for incorporating traditional health. These strategies include identifying so-called low hanging fruit, a point that arose in the Taskforce meetings, referring to types of traditional healing and cultural practices that already take place at organizations, usually funded through grants. The identification of low hanging fruit can be leveraged to begin the process of validating traditional healing practices and cultural activities in ways that can make them billable and therefore sustainable.

Practices should meet the following criteria to be considered low hanging fruit: (a) Easily translatable into a billable practice, (b) Intertribal and applicable to both Urban and Tribal communities, and (c) Maintains integrity with respect to tribal sovereignty and the self-determination of intertribal communities. The workgroups identified the following practices as low hanging fruit: gatherings of Native Americans, sweat lodges, talking circles; cultural prevention and intervention strategies related to diabetes and obesity, such as traditional food programs; strengthening cultural connection activities including, for example, drumming, beading circles, basket making; and culture-based substance use treatment methods like Red Road, White Bison, and prayer circles.

The workgroups also stressed the importance of supporting traditional healers, building collaborations, and creating and enhancing education and outreach regarding American Indian issues. These strategies and others are included in the recommendations section of the

Culturally Relevant Integration Model and the accompanying Policy Change and Sustainability Plan.

American Indian Integration Assessment Tool & Survey

CCUIH has adapted SAMHSA's Six Levels of Integration Tool to incorporate cultural perspectives and to integrate traditional healing into primary care and behavioral health. Appendix C contains this adapted tool, starting with the Core Descriptions of the Six Levels of Collaboration/Integration. The second table details the Key Differentiators of the Six Levels of Collaboration/Integration: Clinical Delivery, Patient Experience, Organization, Traditional healing, Business Model, and Traditional Health Sustainability. These characteristics help differentiate the levels, and incorporate some functional categories that are important to consumer and staff experiential perspectives regarding the levels of integration. The last table describes the Advantages and Weaknesses at Each Level of Collaboration/Integration, so that these can be built upon or addressed.

Based on this adapted SAMHSA tool, CCUIH has also devised a survey to assess the integration of primary care, behavioral health, and traditional healing for our member UIHOs. The results of this survey influenced the Culturally Relevant Integration Model and will be used by CCUIH to provide our member UIHOs with the technical assistance to implement this model.

AMERICAN INDIAN TRAUMA INFORMED SYSTEMS OF CARE

American Indian Trauma Informed System of Care (AI-TISC) is a fundamental organizational philosophy and core cultural shift that must be in place at American Indian organizations prior to implementing CCUIH's Culturally Relevant Integration Model. A trauma informed approach must be considered in a culturally relevant integration because of historical trauma's tremendous impact on American Indians. Trauma informed systems help to deconstruct the dogma of diagnosis, and provide tools to reconstruct traditional systems of wellness that respect the unique experiences of American Indian people.

In general terms, a trauma informed system of care require all parties involved to recognize and respond to the impact of trauma on those who have contact with the organization including clients/patients, caregivers, families, communities, service providers, and staff.

> A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. (SAMHSA, 2014)

The AI-TISC requires that organizations respond to the needs of the individual, and understand the role of unique cultural experiences within their ailments and care. Trauma informed care incorporates a responsibility to mitigate the potential of re-traumatizing that is commonly experienced in American Indians by public institutions and service settings.

Utilizing SAMHSA's Trauma-Informed approach[3] and Maria Yellow Horse Brave Heart's Historical Trauma Theory,[2] the AI-TISC outlines key assumptions and guiding principles with specific reference to American Indian considerations. The AI-TISC provides an important context in which to understand the recommendations associated with the **Culturally Relevant Integration Model**.

AI-TISC Key Assumptions

The key assumptions in the AI-TISC are outlined in Four R's: (1) Realization, (2) Recognize, (3) Respond, and (4) Resist:

> **1. Realization** assumes that individuals at all levels of the organization have a *realization* about trauma and how it can affect individuals, families, communities, and systems. *Realization* occurs regardless of whether the trauma occurred in the past, is manifesting in the present, or is experienced indirectly through hearing a firsthand account of trauma from others. There is also a clear understanding that trauma is not limited to behavioral health, but is integral to all other systems (e.g., primary care, domestic violence services, and criminal justice).
>
> For American Indians, culturally specific *realization* assumes that individuals at all levels of the organization have a comprehensive understanding of Historical Trauma, and Historical Trauma Response (See Figure 1, pg. 6), and microaggressions (See Table 1, pg. 13).
>
> **2. Recognize** assumes that individuals at all organizational levels are able to *recognize* the signs of trauma. These signs can be found in both clients/patients as well as in service providers and individuals at all levels of the organization. Trauma screening and assessments can be used to recognize trauma in clients/patients, and can also be used in workforce development, employee assistance and supervision.
>
> For American Indian organizations, the insertion of ethnocultural assessment allows organizations to *recognize* how the experience of trauma is culturally specific. The expectation of an ethnocultural assessment is to gain an understanding of not only the connection between culture and trauma, but also to identify strengths and social supports particularly associated with cultural activities, traditional healing, and spiritual practices. An ethnocultural assessment can help compensate for skills, biases, and lack of knowledge by service providers.[4]
>
> **3. Respond** assumes that the organization is equipped to *respond* by applying the principles of a trauma informed approach to all areas of functioning. This requires that

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[3] Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

[4] Korn, L. E. (2012). *Rhythms of Recovery: Trauma, Nature, and the Body*. Routledge.

all organizational policies, procedures, trainings and manuals promote a culture focused on resilience, recovery, and healing from trauma.

For American Indian organizations, this culturally-specific *response* must implement a strengths-based response to healing and should include both respect for and access to cultural approaches to healing. American Indian organizations should also include traditional health policies and protocols. Further, it is helpful to have all service providers experience aspects of traditional healing.

4. Resist assumes that individuals at all organizational levels are committed to *resist* the re-traumatization of clients/patients and staff. Individuals who work in trauma informed environments are taught how organizational practices may trigger painful memories of trauma histories for clients/patients and/or staff and re-traumatize them.

For American Indian organizations, it is imperative to have a comprehensive understanding of microaggressions in order to *resist* re-traumatization. Microaggressions are everyday insults and dismissals that appear as verbal, nonverbal and environmental offences, sending demeaning messages to members of marginalized groups. Microaggressions have a negative impact regardless of whether the insults are intentional or unintentional. Often, microaggressions are thought to occur only through individual interactions, and are therefore ameliorated by cultural competency trainings. However, it is important to look at how organizational policies and practices are just as capable of generating negative impacts by systematizing microaggressions. In fact, a recent study, "Unconscious Biases: Racial Microaggressions in American Indian Health Care," concluded that one out of three study participants reported having experienced microaggressions from health providers. Further, the study documented statistically significant cross-sectional associations between microaggressions in healthcare settings and worsened mental health and physical health outcomes.[5]

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[5] Walls, Gonzalez, Gladney, and Onello. Unconscious Biases: Racial Microaggressions in American Indian Health Care. *J Am Board Fam Med.* 2015; 28(2): 231-239. Doi:10.3122/jabfm.2015.02.140194

Table 1: Forms of Microaggressions and Examples Related to American Indian Individuals and Organizations

Microaggression	Individual Example	Organization Example
Microinsult: Communications that convey rudeness or insensitivity and demean a person's racial heritage or identity.	A service provider asks an American Indian (AI) patient if they smoke tobacco. Their response is that they only smoke tobacco as part of ceremony. The service provider suggests that they should move toward smoking cessation.	A health care organization has aligned their service provisions around the assumption that AI have some of the highest rates of alcoholism, but negates the fact the AI also have the highest rates of abstinence.
Microinvalidation: Communications that exclude, negate or nullify the psychological thoughts, feelings, or experiential reality of a person of color.	A service provider avoids discussing or addressing cultural issues for a patient/client, or a service provider proclaims that they do not see color, which invalidates all cultural and racial experiences of the patient/client.	Traditional healers are often the point of entry for a patient/client to address a health issue through a community event or ceremony, and they offer traditional healing support. Organizations also recognize the importance of bringing in perspectives of other service providers, but when they offer a warm handoff, they are then not included in the panel management of the patient/client.
Microassault: An explicit racial derogation characterized by a verbal or non-verbal attack meant to hurt the intended victim.	An individual may be impacted in dehumanized depictions of AI in the media. Either through derogatory mascots, images of "drunk Indians", hate speech, or simply lack of representation in mainstream media.	Systems often try to lump AI into categories that include other marginalized racial groups. This dismisses AI as the original people of this land and thus, and their unique political status, which was established as a result of land cessation in exchange for government provisions. It is a calculated effort to ignore government obligations to AI people and obstructs their rights.

[Note: microaggressions are not limited to race, and can also include marginalized groups associated with gender, sexuality, and low socio-economic status.]

AI-TISC Guiding Principles

AI-TISC guiding principles provide core organizational concepts that are the foundation of culturally relevant integration implementation. The guiding principles in the AI-TISC are: (1) Safety, (2) Trustworthiness and Transparency, (3) Peer Support, (4) Collaboration and Mutuality, (5) Empowerment, Voice and Choice, (6) Cultural, Historical, and Gender Issues. Each principle is explained below with specific reference to American Indian considerations.

1. Safety is defined by those being served, and ensures the physical and psychological safety for all. This includes organizational, environmental, and personal interactions.

For American Indian organizations adhering to AI-TISC, *safety* uniquely includes their political right to American Indian preference in workforce development. It is widely accepted that clients/patients are most responsive when served by providers who reflect their communities. In addition, individuals drawn to service professions are often those who have had experiences of trauma that are connected to the disparities service organizations are dedicated to addressing.[6] These points also suggest a greater need for *safety* to prevent the potential re-traumatization that can occur through operational systems.

Open door policies and strong listening skills will encourage individuals at every level to express themselves openly. Physical environments as well as interpersonal relations are important to create *safety.* Removing barriers to personal interactions such as sitting without a desk or a table between individuals during a discussion, scheduling meetings in a comfortable space, engaging in active listening practices, and respecting confidentiality are all best practices that foster safe, nurturing, inviting environments.

2. Trustworthiness and Transparency are focused on the service provider's relationship with the client/patient, as well as on organizational operations and decisions. The goal is to maintain and build trust between clients/patients, family members, community members, staff and all others involved in the organization.

For American Indian organizations adhering to AI-TISC, understanding the impact of colonization and the continued impacts of settler colonialism is critical in establishing *trustworthiness and transparency.* Individual voice has been removed from system implementation. Because colonialism is the dominant position, it is often difficult to adequately address the ways that it manifests in organizations. For example, it is not always sufficient to survey clients/patients and staff solely using quantitative methods of data collection. A focus on quantitative data alone can possibly traumatize participants by not allowing them a voice. An important American Indian consideration involves creating a forum to include narrative input in surveys and assessments.

To generate *trust and transparency*, individuals need to feel as though they have been part of the decision making process. Community town hall meetings, staff retreats, and consistent messaging from organizational leadership are imperative to the success of operating with *trust and transparency*. This can be challenging when working within a

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[6] Korn, L. E. (2012). *Rhythms of Recovery: Trauma, Nature, and the Body*. Routledge.

public health system that takes a top-down approach to new protocol implementation and delivery transformation. It is important to offer consistent communication related to mandated systems changes, and to invite leadership, staff, clients/patients, and community input to better understand how to best meet these demands. American Indian communities and other marginalized groups want to know that organizations are capable of listening to their needs and are willing support them through advocacy if necessary.

Further, it is important for organizations to encourage innovative approaches to ensure that the mandates do not interfere with the trauma informed approach to healing. This, however, requires organizational leadership to have the knowledge and skills to identify mandates that threaten American Indian rights to self-determination as opposed to a need to comply as instructed. This distinction can be challenging for leadership. CCUIH, the California Rural Indian Health Board, Tribal governments, regional health consortia, and the state Tribal Liaison are viable avenues for this support.

3. Peer Support and mutual self-help are key to establishing safety and hope, building trust, enhancing collaboration, and utilizing stories and lived experiences to promote recovery and healing. The term "peers" refers to individuals with lived experiences of trauma.

For American Indian organizations adhering to AI-TISC, comprehensive *peer supported* systems requires individual, collaborative, and organizational efforts toward understanding. Staff should have avenues to explore and process their own trauma experiences and their connections to cultural histories. Organizations must also encourage cross-disciplinary collaboration, complete with the opportunity to share individual relationships to trauma and how these experiences affect their service or practice. Finally, this process must include individuals at every level of the organization in order to remove hierarchical systems and to affirm value for every individual and their role in creating a supportive healing environment.

4. Collaboration and Mutuality are highly valued, and the organization recognizes that everyone has a role to play in healing. Partnering and leveling power differences between all staff levels, and with clients/patients is a priority. Methods of *collaboration and mutuality* demonstrate that healing happens in relationships and in the meaningful sharing of power and decision-making.

For American Indian organizations adhering to AI-TISC, *collaboration* can be very challenging to implement because healthcare systems are functioning within structures that promote hierarchy. For example, some organizational roles require extensive schooling and credentialing to perform services. Other organizational roles such as traditional healers, peer support/community health workers, and facilities maintenance do not require academic degrees but rather lived experience to perform their services. Commonly, salary allocations are adjusted according to standardized payment systems, which hold some professions as superior to others. Because most payment structures cannot be challenged in competitive healthcare, it is very important for American Indian organizations to make adaptive/cultural changes in order to mitigate inequity. American Indian organizations must promote an environment that acknowledges that every role within the organization is equally necessary to promote healing. Following the tradition

of tribal communities, every community member has a role, typically based on their skillset that can support the continued existence of the community.

5. Empowerment, Voice, and Choice by fostering a belief in resilience and promoting recovery from trauma. Organizations understand the importance of power differentials and ways that clients/patients and staff have historically been diminished in *voice and choice*. Operations, workforce development and services are organized to strengthen *empowerment*.

For American Indian organizations adhering to AI-TISC, this involves client/patient participation in decision-making, choice, and goal setting regarding their treatment and healing. This also includes training staff to cultivate self-advocacy skills for clients/patients. Once this sense of self-determination is in place, staff can begin to understand the role of traditional medicine in the client/patient's healing experience and they can become advocates for their care and wellness.

6. Cultural, Historical, and Gender Issues move past stereotypes and biases, and actively address historical trauma and access to gender responsive services. The organization incorporates policies, protocols, and processes that respond to the racial, ethnic and cultural needs of individuals served.

For American Indian organizations adhering to AI-TISC, the intersectionality of *cultural, historical, and gender* trauma is important to consider. Tribal communities are diverse and unique in culture, language, and traditional practices. Further, Urban Indian communities can consist of members and descendants from over 200 different tribes. It is also important to consider that the fluidity of gender identity and expression, and the fluidity of sexuality, as American Indian *gender issues* can be complex. Concepts of feminism can also appear very different for American Indian women. An American Indian woman's "right to choose" may not be as focused on the right to an abortion but rather on the right to birth, feed, and house their children. Or "choice" might be based on the right to have an intrauterine device (IUD) removed despite the fact that Indian Health Service only pays for the insertion and not for the removal. These perspectives highlight the intersectionality of trauma resulting from the forced sterilizations inflicted on American Indian women as recently as the 1970s.

RECOMMENDATIONS

The following recommendations can help UIHOs implement culturally relevant integration. These recommendations are organized in the same format as the American Indian Integration Assessment Tool. They are geared toward UIHOs that know their level of integration readiness, based upon their participation in CCUIH's Integration Assessment Survey. Descriptions of characteristics of each integration level are provided for those that did not take the survey. For more detailed descriptions of each level, see Appendix C: American Indian Integration Assessment Tool. It is important to note that regardless of where your organization falls in the levels of integration, there are aspects to all levels that may be beneficial. CCUIH suggests reading the recommendations in their entirety.

Recommendations for UIHOs at Coordinated Levels 1 & 2

> **Characteristics of Clinical Delivery at Levels 1 &2:** Practices held in separate spaces, with completely separate systems from assessment through care. Service providers know little about each other's roles. Collaboration is only initiated through few providers, and information sharing only occurs through these collaborations.

To enhance integration through clinical delivery, begin with an assessment of clinician time currently spent to coordinate care and to negotiate collaborations. In partnership with organizational leadership, clinical leadership should schedule training/technical assistance (TA) to introduce and plan for the implementation of trauma informed systems of care. Consider using ethnocultural assessment tools across disciplines to develop a more comprehensive understanding of client/patient needs, strengths, cultural and community support. Begin coordination of consistent cross-cultural medicine meetings to allow providers to learn about one another's practice and to begin building relationships. Be sure to include primary care, behavioral health providers, traditional healers and any other relevant service providers. Leadership should recommend provider attendance at CRIHB's Traditional Indian Health Gathering to acquire continuing education credits and to have first-hand experiences with traditional healing.

In order to ensure the sustainability of an integrated practice, clinicians should be included in building an integrated funding strategy. This strategy should focus on supporting a cross-disciplinary approach to clinical service delivery. Be sure to include providers from various service areas to discuss how their individual practices complement one another and use that information to envision a comprehensive sustainability strategy. Organizational leadership should begin conversations with managed care plans to negotiate the inclusion of traditional healing services into their reimbursement mechanisms, much like many Federally Qualified Health Centers (FQHCs) have negotiated reimbursement for Marriage and Family Therapists despite their inability to bill for them through their Prospective Payment System (PPS) rates. UIHOs should begin to assess the expectations for future movement to the Patient Centered Health Home Model and identify ways to include traditional/cultural practices to maintain their cultural integrity as UIHOs.

Because lack of shared space is an issue at this level of integration, the roles of organizational and clinical leadership are key in these initial stages. Leadership must become champions in the movement toward integrated care. It will be important to have meeting facilitators and leadership demonstrate complete commitment to the implementation of trauma informed systems of care and to integration. These individuals must be prepared to help individuals work through any potential resistance. For example, systems have been so grounded in the medical model of clinical delivery that all other approaches to care have become ancillary to primary care. Deconstructing this hierarchal reality to rebuild a holistic approach to wellness will require leadership to have strong conflict resolution skills and demonstrate equity in value for all provider roles. Most importantly, leadership must foreground improved health outcomes for clients/patients as the core focus of integration.

> **Characteristics of Patient Experience at Levels 1 & 2:** Patient needs are treated separately. Referrals may occur, but patient remains responsible for the navigation of referrals. There is no care coordination, but the patient may experience some panel management if providers initiate collaborations.

Organizational leadership should schedule training/TA to introduce and plan for the implementation of a trauma informed system of care that is tailored to clients/patients and community members. Most importantly, assess any current use of Care Coordinators throughout the organization or system. Typically these roles are found in specific grant funded projects and are limited to assistance with a specific issue e.g., homeless case managers, HIV case managers. In particular, look at roles that can be expanded beyond a project or discipline: are there enrollment counselors, peer navigators or care coordinators dedicated to intake or enrollment? Begin to develop panel management teams to address the needs of "high risk" clients/patients as a pilot model. This can provide an opportunity to test the patient experience with the implementation of a trauma informed approach to care and to conduct a feasibility study to determine impact.

To support the sustainability of integrated client/patient care, it will be important to conduct an analysis of duplicate services amongst providers. If the assessments are currently being conducted separately and are unique to each practice, where do they intersect for clients/patients? Reducing duplicate efforts will result in immediate cost-savings, and minimize the burden on clients/patients to answer the same questions multiple times. This is also where the ethnocentric assessment should be inserted to identify strengths in addition to needs. Immediate improvements in efficiency in service delivery can occur through increased information sharing. At this point UIHOs should have begun implementation of electronic health records. In addition, conducting a cost-benefit analysis of the pilot model for "high risk" clients/patients will be important to guide expansion. Clients/patients should be surveyed to assess unmet needs. More specifically, the needs related to social determinants of health that could support cost savings, such as medical-legal partnerships, domestic violence services, and substance use treatment. Consider the use of peer navigators, care coordinators, and case managers across disciplines to connect clients/patients to these services and to monitor use and impact.

At this level of integration, clients/patients may not understand their roles in the development of the trauma informed system of care. They may want to use the training/TA session as a forum to vent public frustrations. Remember, all information is good information. It will be important to institute strong facilitation processes so that participants can hear their voices in the information collected, specifically connected to potential actions to create change. Follow-up is important, and this process will require time — note that this activity is about building trust. For example, one UIHO hosts regular town hall meetings with community members to listen to their feedback. They also conduct an "ask the CEO" question and answer session to demonstrate and to guarantee that leadership values all perspectives, and believes in taking an inclusive approach to health.

> **Characteristics of Organization at Levels 1 & 2:** There is some interest in operationalizing information sharing. Panel management may occur, but documentation is kept separate. Provider buy-in to operationalized integrated care is minimal.

At this early level of integration, setting a foundation for effective policies, protocols and operational standards is a must. This will be particularly challenging because practices are not in shared locations. It is important to operationalize every aspect of integration across all sites, departments, and disciplines. In this phase, collecting input from staff, clients/patients, and community members is vital to the development of a solid operational plan. It is imperative that all data (quantitative and qualitative) be analyzed and the outcomes shared broadly. Operational processes should be simplified to meet the needs of service providers and staff. One of the greatest concerns regarding integration is that operational systems will become more complicated and time consuming. It will require input from providers and responsivity to changes as issues arise. For some, these stages will include the implementation of electronic health records. This is the perfect opportunity to align operations with the principles of the trauma informed system of care. Most EHR software can be customized accordingly.

The foundation for sustainability will be set in this stage of integration. Cost savings require efficient systems. Also, with the movement toward the Patient Centered Health Home model, all expenses will be calculated according to current client/patient utilization costs to rationalize future payments per client/patient. There are many costs that are not covered by current funding mechanisms, e.g., MFTs are not currently billable through PPS rates for FQHCs; these costs are usually covered through other revenue streams such as grant funded projects or county funded systems. Traditional healing is another aspect of care that is funded through other revenue sources, most often grant funds. If UIHOs want the costs and utilization of the services to be considered in the Pay for Performance model, data for these services should be captured now.

There is much resistance to operational change particularly because it requires training and new protocol, which temporarily increases the workload. To overcome this resistance, ensuring a collective process to developing new operational approaches is key. Also, the goal is simplification and shared information, thus generating buy-in to achieve this goal will instill collective responsibility. Most importantly, those impacted by operational shifts must feel that their opinions and recommendations have been considered. Measures to demonstrate increased efficiency and improved patient outcomes will be important to implement.

> **Characteristics of Business Model at Levels 1 &2:** There are no shared resources or limited share resources for specific projects.

Innovative approaches to fund development are necessary to improve integration. Health care funding systems have not yet aligned with the movement toward integration; therefore, engaging staff to assess current funding mechanisms to identify areas where there is potential crossover is key. Additionally, engaging staff at every level to participate in the development of an integrative approach to finance development and management is important. Understanding missed opportunities for billable services is one initial strategy: are there peer support positions that could potentially become billable providers such as breastfeeding peer

counselors who work within the WIC department? These providers could be billable within perinatal programs if they are assigned a National Provider Identifier (NPI) number. Or HIV case managers who provide health education that are currently only funded through grant projects and are capable of providing health education related to reproductive health, which are billable providers through county contracts. Organizational leadership should be aware of other contracts that have the potential to diversify revenue. For example, the establishment of Drug Medi-Cal contracts to increase capacity for substance use treatment could offer the potential to bill for group therapy, care coordination, and peer support.

At this level of integration, sustainability planning is key and dependent on the integration of funding mechanisms to support integration. It is imperative that UIHO staff in finance roles begin to consider fund development as a part of their job and not simply limited to management of resources. Organizational leadership should offer training opportunities for CFOs and finance staff, to provide them with the tools to become active in fundraising. The California Primary Care Association is currently offering trainings to meet this shift in finance responsibilities. At this stage it is also helpful to do an assessment of current client/patient use of all services provided. Many UIHOs have discovered that there are distinct client/patient populations who access primary care and behavioral health with very little overlap. Often, those accessing traditional or cultural services do so through their Behavioral Health Departments. Planning outreach strategies to improve client/patient use of all available services will increase revenue and support sustainable integration. There has also been extensive research that demonstrates that addressing social determinants of health can result in cost savings for community clinics.

The biggest barrier to the integration of financial resources is that historically, department leaders have been responsible for the sustainability of their independent programs. There are varying degrees of success in this area, thus creating an imbalance in department resources across organizations. FQHCs, for example, offer more PPS billable services through their primary care practices, thus they have generated gains in third-party revenue. Behavioral health has less billable service options so is often largely subsidized through grant funds. Traditional health is typically funded through grants obtained by Behavioral Health Departments. There will need to be a shift to a collective culture and a departure from individualized, departmental thinking; a move toward blended funding strategies that can provide comprehensive services. The UIHO must see themselves as a team that is working toward building healthier communities rather than as individual departments that provide services. Demonstrating cost savings and a lower staff burnout that typically results from a team approach to health will be very important to highlight as this culture shift occurs. Starting with small pilot projects to assess the effectiveness of integration can be beneficial.

> **Characteristics of Traditional healing at Levels 1 & 2:** Traditional healing is only utilized through client/patient request or through recommendations made by staff members in-the-know. Traditional healers are not included in panel management, information sharing, or considered as a necessary practice when developing resource strategies.

At this level, education is key to the integration of traditional healing into UIHOs. Centering activities on cross-disciplinary learning is a good place to start. Identify staff in-the-know and traditional healers often utilized by community members to support the development of a traditional health advisory committee. Moreover, the inclusion of clients/patients who have

utilized traditional healing services can be helpful to understand the benefits of these practices. This committee should devise a training to introduce traditional healing and cultural practices to primary care and behavioral health providers. Offering training in the context of historical trauma and establishing the importance of cultural relevance in healing modalities is vital to the implementation of a trauma informed system of care. In addition, transforming organizational culture to stress collaborative approaches to healing that value cross-disciplinary expertise, will demonstrate a commitment to alleviating the burden on a single provider to provide holistic health. The next steps should focus on operationalizing traditional health services, which will include levels of information sharing, inclusivity in panel management, and funding strategies.

In this stage, an assessment of funding for traditional healing is important. Is there a traditional healing line item in the UIHO's IHS contract? If so, how are these resources used now? How are traditional healing services compensated from a community perspective? Is this sustainable for traditional healers and community members? These types of assessments will help UIHOs assess needs, determine costs and inform strategies for integration and sustainability. Are there current projects that have included traditional healing and/or the use of cultural knowledge as component of the healing modality? Such current projects might include a diabetes prevention project that includes traditional food knowledge, and cultural activities for exercise as project objectives. It will be necessary to begin collecting data to demonstrate effectiveness of such activities, which can be beneficial when identifying new funding and expanding more collaborative projects. Finally, are there traditional practices that are similar to those identified as evidence-based practices (EBPs) within primary care and behavioral health practices that can be translated into billable services? Getting leadership and the fund development team to think creatively about how to fund these services rather than dismissing them is also a very important culture shift. Please make sure to assess the organizational liability for incorporating different types of traditional healing. For example, there may be more liability in offering services that include herbal medicines than offering ceremonial services. It will also be necessary to develop a mechanism to determine who is deemed a traditional healer. One potential is to develop an organizational or community certification process similar to those used with other providers complete with background checks, references, and other means.

Keep in mind, the number one barrier to the integration of traditional healing into UIHOs is that primary care and behavioral health providers have little to no understanding of traditional healing. Offering opportunities to share in traditional and cultural activities will be important to develop understanding and to overcome bias. Because funding is either limited or non-existent for these services, the second greatest barrier is how to sustain these services. At this stage, the funding assessment is key to determine which strategies will be most effective. Increasing the incorporation of traditional healing into projects where it seems most appropriate will help to increase access, test collaborative efforts, and assess sustainability needs. Finally, communication between providers can be limited. Including traditional healers in cross-cultural medicine meetings is very important to deconstructing hierarchies associated with standard medical models of service delivery. UIHOs must treat traditional healers with the same respect they offer primary care providers, behavioral health providers, and other service providers. In order to generate a client/patient-centered approach to health, everyone must be treated with equal value within the organization.

Recommendations for UIHOs at Coordinated Levels 3 & 4

> **Characteristics of Clinical Delivery Levels 3 & 4:** Some assessments have been agreed upon between primary care and behavioral health providers. There has been no inclusion of traditional healers in this agreement. Some shared care plans and panel management teams have been established, but have predominantly focused on high-risk clients/patients. Traditional healers have not been included even when they are the initial point of contact for the client/patient. There is some knowledge of each other's practices for primary care and behavioral health provider, but still little knowledge related to traditional healers. Use of space has been adjusted to encourage more cross-disciplinary collaboration.

Use the assessment of clinical time dedicated to care coordination and case management to help establish care coordinators as a core role, and to alleviate ancillary duties. Begin implementation of the Culturally Relevant Trauma Informed System of Care. Continue cross-cultural medicine meetings to allow providers to learn about one another's practice and to build and strengthen relationships. Incorporate client/patient success stories comprised of collaborative approaches that have resulted in positive health outcomes. This will help to identify champions of integration who can offer peer support to other providers. Mandate provider attendance at CRIHB's Traditional Indian Health Gathering to receive required continuing education units and have first-hand experiences with traditional healing. Expand panel management to include care coordinators and traditional healers. Expand and tailor electronic health records to include integrated, ethnocultural assessments. Begin training traditional healers to access electronic health records and understand compliance with privacy policies and procedures.

At this level of integration, much of the assessment and planning has been accomplished. The UIHO can begin implementation of the new funding strategy that supports a cross-disciplinary approach to clinical service delivery. Begin increasing collaborative projects and begin move toward shared space. Begin integrating behavioral health providers and traditional healers into primary care and vice-versa by offering shared spaces. Implement a no wrong door policy so that wherever first contact is made, the client/patient receives the same ethnocultural assessment, and understands that they have access to all services provided. Intake coordinators should be cross-trained to offer all services. Coordinate providers from various service areas to discuss how integrated funding can initiate cost-savings and improved health outcomes. Increase advocacy efforts at the UIHO level to support the inclusion of a culturally specific trauma informed system of care as a strategy for the upcoming Patient Centered Health Home Model. Continue to develop, assess, and adapt operational systems to provide the highest quality client/patient care.

Change can be difficult. With the implementation of the Culturally Relevant Trauma Informed System of Care, allow time for processing the culture shift. Generate buy-in so all providers feel their voices are heard when presenting challenges, but also ask them to become part of the solution. Ask how as a team we can make this work instead of focusing on reasons it will not work. It will be important to build upon the integration efforts that are already occurring. Expand information sharing, panel management, and the use of care coordinators. Do not treat the change as a technical shift, meaning simply changing processes and protocol. Leadership must be prepared to address adaptive shifts necessary to transform the culture of the agency. Meet people where they are when implementing changes, focus on changes in attitudes and behavior as much as operational expectations.

> **Characteristics of Patient Experience at Levels 3 & 4:** Client/Patient health needs are treated separately within the same location. Some warm hand-offs may occur, but predominantly with high-risk clients/patients. Care coordination is often limited to high-risk clients/patients and completely dependent on panel management. Internal referrals are tracked, but external referrals to other social service providers are not. Providers use electronic records to share document progress. There is occasional collaboration because co-location makes it easier, but usually this is limited to high-risk clients/patients.

Begin implementation of the Culturally Relevant Trauma Informed System of Care for clients/patients and community members. Most importantly begin implementing ethnocultural assessment tools across disciplines to develop a more comprehensive understanding of client/patient needs, strengths, cultural and community support. Be sure to adapt EHR to include measures from these assessments. Be sure to implement or expand the use of Care Coordinators throughout the organization or system of care. Expand panel management teams beyond "high risk" clients/patients. Share results of the feasibility study regarding the outcomes of the holistic pilot projects.

At this level of integration, reviewing and analyzing all pilot projects and operational changes will offer information to identify success, barriers and areas requiring adjustments. Share the results of the assessment of duplicate services amongst providers to prompt input into potential solutions. Develop and implement a strategy to reduce duplicate efforts and to promote cost-savings; information sharing is key to the success of this task. Share results of the cost-benefit analysis derived from the pilot of holistic care for "high risk" clients/patients. Share the results of the unmet needs assessment to address social determinants of health. Implement/expand cross-funding strategies to support the use of peer navigators, care coordinators, and case managers across disciplines.

Systems changes can be jarring for clients/patients; communication is very important when implementing new systems. Hosting community town hall meetings, key community stakeholder meetings, and the use of marketing to communicate the shift into trauma informed systems of care can generate understanding, support, and can potentially encourage an expanded use of services and attract new clients/patients.

> **Characteristics of Organization at Levels 3 & 4:** Organizational leaders support integration and take a can-do approach to problem solving. There is some provider buy-in to integration, particularly in relation to making referrals work, but the shift is not yet consistent amongst all providers. Care Coordination is still limited to high-risk clients/patients and dependent on panel management. Traditional Healers are more accepted by leadership and providers, but not yet included in information sharing, such as electronic health records.

The principles of the Culturally Relevant Trauma Informed System of Care should be considered in the development of all new operational policies and protocols. In this phase, demonstrating the use of input from staff, clients/patients, and community members is vital to the establishing buy-in to the implementation of a solid operational plan. Discussions on how to include traditional healers into the information sharing procedures should begin. Traditional healers should be included in all planning related to operationalizing their services.

Even with strong referral and follow up systems in place, funding mechanisms are not currently aligned to support warm hand offs, particularly because same-day billing is not possible. In this stage, test the use of providers that are funded outside of the PPS system, for example, providers that are funded through grant funded projects or county funded systems, to become the recipients of the warm handoff, which will allow their visit to be funded through a separate line of business. Traditional healing is another aspect of care that is funded through other revenue sources. If UIHOs want the costs and utilization of these services to be considered in the Pay for Performance model, data for these services should continue to be captured in this phase. At this stage, because UIHOs have ensured a collective process to develop new operational approaches, resistance to operational change should have lessened. Consistent and timely follow-up to issues as they arise will support continued buy-in for staff at all levels. Continue to collect measures to demonstrate increased efficiency and improved patient outcomes.

> **Characteristics of Business Model at Levels 3 & 4:** Some shared facility and administrative expenses and some collaborative funding, but usually centered on a specific projects, e.g., diabetes treatment and prevention projects.

Implement integrated funding strategy developed within integration levels 1 and 2. First steps should include the expansion of collaborative projects that include primary care, behavioral health, and traditional healing. Assessments of collaborative projects should include cost-savings, increased access, and the expanded use of UIHO services. It is imperative that, at this stage, UIHO staff in finance roles understand fund development as a part of their job and not simply limited to the management of resources. Use the assessment of current client/patient use of all services to consider the target population. Initiate outreach to clients/patients who only utilize behavioral health services and encourage them to enter into primary care. Traditional healers can also be beneficial in this outreach because they may serve community members who have unmet primary care and behavioral health needs. Empower them to become advocates for holistic care. Implement trauma informed outreach strategies to increase patient enrollment in services. At this stage, there should be a clear understanding of the social determinants of health that produce unmet needs for clients/patients. Organizational leadership should make an effort to establish relationships with external organizations that are able to provide appropriate services and are willing to become part of the Culturally Relevant Trauma Informed System of Care. Memorandums of Agreement are useful to formalize relationships and to agree upon operational procedures with other social service providers such as substance use treatment and domestic violence services.

At this stage, UIHO staff will begin to see themselves as a team that is working toward collaborative services and thus, shared fund development. Leadership can support this continued effort by demonstrating cost savings and lower staff burnout to continue this culture shift. Starting with small pilot projects to assess the effectiveness of integration can be beneficial. The next challenge can involve planning how to expand integrated efforts beyond projects and into the organization/system. The UIHO should begin considering collaborative projects with external social service providers to address identified needs.

> **Characteristics of Traditional Healing at Levels 3 & 4:** There is some understanding and support from leadership, providers, and staff at all levels. There is now some acceptance of community defined practices and shared evidence-based practices. There is some use of traditional healers in collaborative projects.

Continue cross-disciplinary learning activities. Actively engage the Traditional Health Advisory Committee to facilitate trainings that introduce traditional healing and cultural practices to primary care, behavioral health providers and staff at all levels. It is vital to have a regular space where traditional services are provided. Traditional healers need to generate a spiritual environment to be able to conduct their services with integrity. Having a consistent space is key for them to be most effective. If outdoor space is available, ensuring they have access to it is best. In addition, the provision of traditional medicines or providing compensation to support the collection of such medicines should be considered. One UIHO hosts an annual sage run that involves community members in the collection of sage. Traditional healers and cultural providers offer lessons in protocol to collect medicine, and the UIHO is able to provide sage to the traditional healers and community members for the year. Continue transforming the organizational culture to feature collaborative approaches to healing that support cross-disciplinary expertise. Begin consistently including traditional healers in panel management, starting with high-risk clients/patients. At this stage, using the care coordinator role as support for traditional healers in scheduling, fulfilling documentation requirements, and engaging in information sharing can be beneficial to ensure all funding obligations and data collection needs are met. Implement a process to capture increased client/patient access, use, and impact of traditional healing services.

Utilize the assessments established in levels 1 and 2 to develop strategies for the sustainability of traditional healing. Expand projects to include traditional healing and/or the use of cultural knowledge as components of the healing modality. Continue collecting data to demonstrate the effectiveness of such activities to support the acquisition of new funding, increased collaboration, and to prepare for payment reform. Test the cultural adaptation of western practices that are similar to traditional healing practices within primary care and behavioral health, specifically those that can be translated into billable services. What the traditional health taskforce deemed as low hanging fruit: talking circles = group therapy, traditional food knowledge = nutrition education, individual sessions with traditional healers = peer support, Red Road to Wellness = substance use treatment. For those UIHOs who have County funded Prevention and Early Intervention (PEI) grants, this is an opportunity to use traditional healing as a complimentary component to primary care and behavioral health. Currently, most UIHOs think of the PEI projects as entirely separate. Shifting this type of thinking will help in sustainability planning for integration. In addition, UIHOs should be well positioned to apply for funds dedicated to support integration projects through SAMHSA, County Innovations, and Foundations.

At this stage there is increased provider buy-in to incorporating traditional healing into integrative efforts. Identify providers who are most supportive and deem them as champions for integration. Empower them to provide peer leadership to those who still may be resistant by advocating for traditional healing as a vital component of the Trauma Informed System of Care. It may at times be necessary to advocate for the use of adapted EBPs with funders. If UIHOs have experienced staff capable of this advocacy, then include this in their job descriptions, if not, utilize organizations dedicated to advocacy for support. CCUIH is a viable resource for California UIHOs, Tribal Councils and CRIHB are viable entities for tribes.

Recommendations for UIHOs at Coordinated Levels 5 & 6

Characteristics of Clinical Delivery at Levels 5 & 6: All providers use one screening tool and the results are accessible by all. Panel management for most to all clients/patients and providers work in close collaboration to develop one shared treatment plan to meet their needs. Most to all patients receive integrated panel management. Evidence-based Practices (EBPs) and Community Defined Practices (CDPs) are decided upon collectively and shared across disciplines.

At this level, UIHOs should have implemented the Culturally Relevant Trauma Informed System of Care. Continued Quality Improvement should be a top priority, so the new system and cultural environment should be assessed quarterly through client/patient engagement, and 360 reviews of not only supervisors but overall agency performance. Leadership should establish a Quality Improvement Committee following the same philosophy and representation necessary to ensure voices at all levels of the organization are heard. Information sharing is now a standard agreed upon and is utilized by all practitioners, including traditional healers. The use of one ethnocultural assessment is now standardized; there is truly no wrong door for the client/patient to enter. They will now receive access to all organizational services upon intake. Care coordinators and panel management facilitating the care of all clients/patients is also standardized and includes traditional healers. Continue to hold cross-cultural medicine meetings and encourage providers to strengthen their partnerships while taking innovative approaches to highlight success, which can offer opportunities to share best practices within the agency and with systems partners. Staff turnover is a consistent barrier to sustainable change for UIHOs. It will be necessary to invest in training and mentorship to ensure that any individual entering the UIHO as a new hire is well versed in the Trauma Informed System of Care. The development of a thorough new hire orientation is useful, but involves peer support and mentorship to ensure the individual becomes part of the team and meets all standards and expectations of the service environment.

Cross-disciplinary funding strategies are fully implemented and have now become the norm. Data is collected to represent all services, thus the organization is fully prepared to move into payment reform with true costs represented. Until payment reform is implemented across all health systems, it is be important to continue planning for cross-funded projects. At this point, the UIHO is better equipped to advocate for cultural specifications and funding distinction within policy and legislative changes as windows of opportunity arise. By this point, there should be data that demonstrates cost savings and positive health impacts to support any unique requests. This is significant because data is often the missing component when advocating for integration and cultural needs.

> **Characteristics of Patient Experience at Levels 5 & 6:** Clients/patients needs are met through a unified practice. Their care is managed through a dedicated care coordinator, and they have a team of providers working collaboratively to offer a seamless response to all of their needs. They are active participants in their care and have access to onsite primary care, behavioral health, and traditional health services. MOUs and operational systems are in place to meet needs that are outside of the organization's capacity, such as social determinants of health, housing, legal services, economic support, etc.

Continued patient engagement is important to ensure that continued quality improvement efforts are meaningful. Also, at this stage, it is wise to take careful note of success stories from clients/patients and to ask them to become advocates for your organization. There are a variety of marketing strategies available to make the best use of these stories, but it is important to choose carefully and to always keep the principles of the Trauma Informed System of Care at the heart of all decision making. Continued communication is vital to successful client/patient engagement, it can also be challenging and deemed less significant following implementation. Continue hosting community town hall meetings, key community stakeholder meetings, and the use of marketing to communicate the shift into a Trauma Informed System of Care, and to expand understanding, support, encourage expanded use of services as well as to attract new clients/patients.

Increase more efficient use of provider time by developing joint care plans that result in improved client/patient health outcomes. Panel management is now connected to a reduction in client/patient no-show rates, which can result in cost savings. In addition, the expanded use of services for current clients/patients can create more billable services. Improved client/patient satisfaction draws additional community members to the organization.

> **Characteristics of Organization at Levels 5 & 6:** All leadership support a trauma informed approach to integration; implementation is in full force. All providers support the same, and now there are dedicated staff responsible for care coordination.

The organization or system has operationalized every aspect of integration. The principles of the Culturally Relevant Trauma Informed System of Care have been considered in the development of all new operational policies and protocols. Continue to test and adapt these policies and protocols as part of consistent quality improvement activities. Establish a multi-disciplinary team to act as the Continued Quality Improvement Committee. In this phase, continue highlighting input from staff, clients/patients, and community, particularly success stories, and demonstrate responsiveness to criticisms. It is imperative that outcomes are shared broadly. Leadership and providers have complete support for the incorporation of traditional healers into information sharing procedures, and the operationalizing of their services has begun. Lack of responsiveness to needed adjustments can be a barrier to the continued support of staff at all levels. Consistent and timely follow up to issues as they arise supports continued buy-in for staff at all levels. Continue to collect measures to demonstrate increased efficiency and improved patient outcomes. Share responses to issues in a timely fashion and broadly; leadership will need to adopt a solutions-oriented attitude to be effective.

Characteristics of Business Model at Levels 5 & 6: A completely integrated funding model, utilizing multiple revenue streams has been implemented. Resources are shared across the whole practice. Billing is maximized for a single billing structure.

Continued assessments of collaborative projects should include cost-savings, increased access, and expanded use of UIHO services. This is vital to prepare for pending payment reform. Continue developing finance staff to enhance their capacity to support newly added fundraising responsibilities. Until payment reform has been fully implemented, financial planning will need to be creative and innovative to maximize the potential of all revenue sources. UIHOs should stay abreast of upcoming policy and legislative changes to monitor changes affecting sustainability for integration. Financial planning to support integration should now be an organization/system standard.

Characteristics of Traditional Healing at Levels 5 & 6: Basic knowledge and understanding of traditional healing has reached staff at all levels. It is no longer considered an ancillary service and has gained full organization/system support as a vital component of integration.

Continue cross-disciplinary learning activities. Actively engage the Traditional Health Advisory Committee in continued quality improvement efforts. Collectively make a decision regarding how traditional healers will be accepted or certified by the UIHO and the community. Also, persist in assessing the operationalization of traditional health services, and make timely adjustments as needed.

Continue collecting data to demonstrate the effectiveness of the integration of traditional healing and the Culturally Relevant System of Care to support the acquisition of new funding, increased collaboration, and to prepare for payment reform. In addition, UIHOs should use the unique nature of the incorporation of traditional healing into the broader practice to assure that they are well positioned to apply for funds dedicated to support integration projects through SAMHSA, County Innovations, and Foundations. Until policy changes have aligned to support the integration of traditional healing services, sustainability will take a consistent commitment to the incorporation of traditional healing into a unified practice.

CONCLUSION

The Culturally Relevant Model provides the opportunity for UIHOs to embrace positive change and to cast off existing hierarchical, damaging, and culturally unresponsive institutional models that have at best ignored the specific needs of AI communities. By retaining efficacious western modalities and by adopting a more egalitarian structure, AI health organizations can participate increased access to Traditional Healing and improved health outcomes. Organizations can create a collaborative environment that recognizes that everyone has a role in building an environment that fosters culturally relevant trauma informed care, and allows for the successful integration of traditional healers. This model holds a promise of better days – not in a naïve return to a romanticized past but in its clear vision of a self-determined future for AI health.

Appendix A: Resources & Links

- Summary of Analysis of Traditional Health Taskforce & Traditional Healers Committee Meeting. A narrated presentation: http://prezi.com/6vb_h6-8bszm/?utm_campaign=share&utm_medium=copy&rc=ex0share

- Integration Readiness Assessment Survey: https://docs.google.com/forms/d/1gWPqsK4lC8ia2i98mQbyCYaYw708EC0Z6WzfTMv_ZOk/viewform.

- CCUIH's Adapted Six Levels of Integration Tool http://ccuih.org/integration-tool/

Appendix B: Traditions of Health Annotated Bibliography

Cruz, C., & Spence, J. (2005). *Oregon Tribal Evidence Based and Cultural Best Practices*.

> This report voices the concerns of disparity in service delivery to Oregon tribal communities with the adoption of SB 267 in 2003 by the Oregon legislature. SB 267 requires that five state agencies, the Commission on Children and Families, Department of Corrections, Department of Human Services/Office of Mental Health and Addiction Services, Oregon Criminal Justice Commission, Oregon Youth Authority, spend 25% their program funding on evidence based programs by 2005, 50% by 2007, and 75% by 2009. With SB 267, programs developed the "Indian way" through tribal consultation as required by SB 770 are bypassed in favor of evidence-based programs. Although there exist successful tribal research programs within the Oregon native communities as provided in the report, Oregon tribal governments are required by DHS/OMHAS to collect data with Management Data System (MDS) to continue to receive funding. However, MDS measures process data (e.g., numbers and ages of participants) and not outcome data. The report provides three recommendations for Oregon tribal governments to improve service delivery in light of SB 267.

Echo-Hawk, H. et al. (2005). *System of Care Monograph Series 2005: The Role of Traditional Practices in American Indian/Alaska Native Mental Health Systems of Care*.

> Written with a relational worldview, the monograph explores how tribal communities develop systems of care for Native American children and families in the aftermath of colonization that has left native communities with a "soul wound" that manifests itself in mental illness and substance abuse. The seven participating tribal communities are from Alaska, California, Maine, Michigan, North Dakota, South Dakota, and Wyoming. Key principles and traditional practices used in the systems of care in the seven participating communities are strength-based approach, family involvement, collaboration, appropriate settings, and cultural context. Two recurring themes in these systems of care are
> (1) intergenerational trauma and post-traumatic stress, and (2) traditional belief systems and traditional practices. Successful systems of care, as observed in the monograph, are founded on cultural values and traditional practices that serve as the core principles that are then blended with compatible existing western mental health practices and models. The monograph ends with five recommendations for future studies.

First Nations Health Society. (2010). *First Nations Traditional Models of Wellness: Traditional Medicines and Practices.*

> An Environmental Scan was conducted by the First Nations (FN) Health Society to provide background information on traditional models of wellness and traditional practices/medicines to guide future endeavors and work in promoting traditional models of wellness within British Colombia for First Nations. Survey data was

collected in person, on a computer, face-to-face visits and by phone for a total of 91 respondents. Survey areas of focus are: (1) definition of traditional wellness models (practices and medicine use), (2) current practices and desired future practices, (3) roles of healers and elders, (4) integration of traditional practice with western practice, (5) role of First Nation Health Council in British Colombia, and 6) role of alternative practices and medicines in FNHC. Environmental scan reveals support for integration of western, traditional and alternative medicine in FN communities, support for more research in integration, concerns about how the integration should be done, and strong interest for FNHC to advocate for recognition and funding for traditional practices and medicines, traditional healers, and elders within communities.

Gone, J. (December, 2007). "We Never was Happy Living Like a Whiteman": Mental Health Disparities and the Postcolonial Predicament in American Indian Communities. *American Journal of Community Psychology*, 40(3-4), 290-300.

Drawing from ethnographic interviews conducted at a northern Plains Indian reservation, Gone examines the dilemma of divergent cultural practices for redressing mental health disparities in American Indian (AI) communities. Using interviews with Traveling Thunder, Gone deconstructs "discourses of distress," identifying the current mental healthcare system as a colonial arrangement that perpetuates the historically asymmetrical relationship between the federal government and AI communities. The Indian Health Services under the federal government is subtle forms of western cultural proselytization. In Gone's reflections, he concludes that what AI communities need for existing mental health disparities to be redressed does not yet exist in professional mental health care and services. Through the expansion of resources available to AI communities and the construction of radically alternative therapeutic institutions and activities that are committed to the *community psychology* of AI, can the colonial arrangement. Gone imagines this process to be of reciprocity between community psychologists and American Indians.

Gurley, D., Novins, D., Jones, M., Beal, J., Shore, J., & Manson, S. (January, 2001). "Comparative Use of Biomedical Services and Traditional healing Options by American Indian Veterans." *Psychiatric Services,* 52 (1), 68-74.

This study examines if need or availability affects service use among American Indian (AI) veterans in biomedical care and traditional healing options. The study surveyed 621 tribally enrolled AI male veterans from AI reservations in the Southwest and Northern Plains. Measures were demographic characteristics, physical and mental health conditions, and self-reports of any use of services within the past year from the Veterans Administration, Indian Health Services, other biomedical services, and traditional ceremonies or indigenous healing options. Findings indicate that service use depends more on need. However, the kind of services used varies according to availability.

Hartmann, W., & Gone, J. (October, 2012). "Incorporating Traditional healing Into an Urban American Indian Health Organization: A Case Study of Community Member Perspectives." *Journal of Counseling Psychology,* 59 (4), 1-10.

> Framed with a "bottom-up" approach, this case study investigates how traditional healing may be integrated into an Urban Indian Health Organization (UIHO) to address health disparities among American Indians. From the findings of the case study, ceremony, education, culture keepers and community cohesion are identified by four focus groups consisting of American Indian community members at a Midwestern UIHO as key components for a successful integration. Other findings suggest three potential areas of conflict: traditional protocols versus reality of urban Indian life, multicultural representation versus relational consistency with culture keepers, and uncertainties about who is trustworthy with traditional knowledge. Further discussion of focus group responses indicates a link between cultural revitalization (e.g., traditional healing) and mental health.

Native American Health Center, Inc. (2012). *Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans.*

> Under the California Reducing Disparities Project (CRDP), Native Vision is a large-scale community-based report of the Native American Health Center's investigation into developing a culturally competent behavioral health prevention and early intervention (PEI) service delivery to address mental health disparities in the Native American community. Funded by the Mental Health Services Act (MHSA) the report is a compilation of eleven regional focus groups consisting 314 participants. Citing former Surgeon General David Satcher's finding that the reflection of white America's beliefs, norms and values in the mental healthcare system makes it inadequate for treating ethnic groups, the report argues for a *community-defined evidence* approach that is more compatible with Native American cultural norms. In addition to the lack of positive and significant results from *evidence-based practices* in closing the disparities gap for Native Americans, the report provides twenty-two promising practices and effective models of *community-based evidence* in California (e.g., Gatherings of Native Americans, Holistic System of Care, sweatlodge ceremony, and traditional storytelling). The report concludes with three recommendations for improving Native American health and three suggestions to CRDP in its next steps to reduce mental health disparities in the Native American community.

Scurfield, R. (1995). "Healing the Warrior: Admission of Two American Indian War-Veteran Cohort Groups to a Specialized Inpatient PTSD Unit." *American Indian and Alaska Native Mental Health Research Journal,* 6 (3), 1-22.

> The article summarizes the clinical studies of the American Lake VA Medical Center's culturally modified Post-Traumatic Stress Treatment Program (PTSTP) for American Indian (AI) veterans. In partnership with the Northwestern Indian Veteran Association, two AI cohorts were recruited: cohort 1 (100% self-identifying AI) and

cohort 2 (50% self-identifying AI). Culturally specific additions and modifications to PTSTP included culturally-specific training for staff, hiring a local AI spiritual leader as a clinical and cultural consultant to both staff and veteran residents, building a sweatlodge on hospital grounds, and facilitating attendance to culturally-specific events. Results of the clinical study revealed a 67% graduation rate in cohort 1 and a 100% graduation rate in cohort 2. Another significant finding is that the sweatlodge is the most effective and utilized traditional support activity. The article concludes that AI traditional healing ways are beneficial to both AI and non-AI alike when approached and conducted properly.

Saylors, K. & Daliparthy, N. (February, 2006). "Violence Against Native Women in Substance Abuse Treatment." *American Indian & Alaska Native Mental Health Research Journal*, 12 (1), 32-51.

To address the absence of literature on violence against minority women, particularly American Indian and Alaskan Native (AI/AN) women who are two to three times more likely to experience violence than any other ethnic group, the authors interviewed 334 women from the Women's Circles at Native American Health Center in Oakland and San Francisco. Of those interviewed 84.7% were AI/AN. Interviews occurred first at intake, and then six and twelve months later. 89% AI/AN women reported emotional abuse, 84% physical abuse and 67% sexual abuse in their lifetime. In all three categories of abuse more than 40% had dual diagnosis for mental health and substance abuse, more than 80% had mental health disorders, and more than 50% had substance abuse. The majority of AI/AN women reported that their native identity was important to them. Suggestions for future research are to include client trauma experience, PTSD symptoms, and intimate partner violence for a more holistic understanding of AI/AN women's experience of violence. The authors recommend integrating AI/AN constructs of reconnection and healing with Western clinical treatment paradigms to understand the abuse histories of Native women.

Walls, M., Johnson, K., Whitbeck, L., & Hoyt, D. (December, 2006). "Mental Health & Substance Abuse Services Preferences among American Indian People of the Northern Midwest." *Community Mental Health Journal*, 42(6), 521-535.

With American Indians (AI) having the highest rate in frequent mental distress, and the second highest rate in unmet mental health service needs, the authors of the article examine factors that influence AI preferences between traditional services and western services for mental health and substance abuse service utilization. Preference categories are: informal traditional services, on-reservation formal services (e.g., western medicine) and off-reservation formal services. Preferences were measured by (1) enculturation, (2) perceived discrimination, (3) social support and 4) health status. Questionnaire data collected from wave one of Healing Pathways Project from 2002 and 2003 for a total of 865 parents/caretakers indicates that overall culturally traditional services are perceived as more effective than formal services on, or off the reservation. In their discussion, the authors'

recommend integrating or designing health services systems to AI preferred methods of healing. They argue that failure to acknowledge strong AI preferences for traditional ways is to ignore a valuable health resource.

Appendix C: American Indian Integration Assessment Tool

This appendix contains images of the digital American Indian Integration Assessment Tool. See Appendix A for links to the digital version, and the accompanying survey.

Core Descriptions of the Six Levels of Collaboration/Integration

COORDINATED		CO-LOCATED		INTEGRATED	
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, 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	> Have separate systems	> Have separate systems	> Share some systems, like scheduling or medical records	> Actively seek system solutions together or develop work-a-rounds	> Have resolved most or all system issues, functioning as one integrated system
> Communicate about cases only rarely and under compelling circumstances	> Communicate periodically about shared patients	> Communicate regularly about shared patients, by phone or email	> Communicate in person as needed	> Communicate frequently in person	> Communicate consistently at the system, team and individual levels
> Communicate, driven by provider need	> Communicate, driven by specific patient issues		> Collaboration, driven by need for consultation and coordinated plans for difficult patients		
		> Collaborate, driven by operational standards		> Collaborate, driven by desire to be a member of the care team	
> Communicate, driven by patient request	> Communicate, driven by client request	> Collaborate, driven by need for each other's services and more reliable referral			> Collaborate, driven by shared concept of team care
> Communicate, driven by community request	> Communicate, driven by community request		> Have regular face-to-face interactions about some patients	> Have regular team meeting to discuss overall patient care and specific patient issues	> Have formal and informal meetings to support integrated model of care
> May never meet in person	> May meet as part of larger community	> Meet occasionally to discuss cases due to close proximity	> Have a basic understanding of roles and culture		> Have roles and cultures that blur and blend
				> Have an in-depth understanding of roles and culture	
> Have limited understanding of each other's roles	> Have a theoretical understanding of each other's practice	> Feel part of a larger yet non-formal team	> Have respect for each other's practice		
		> Have basic understanding of each other's practice		> Have institutional support and encouragement for collaboration	> Have institutional support and expectation of collaboration
> Have limited understanding of each other's healing modalities	> Appreciate each other's roles as resources		> Have some institutional support for collaboration		
		> Have respect for each other's practice		> Have a basic operational structure	> Have a comprehensive operation structure
> Have limited understanding of each other's capacity	> Have little-to-no institutional support for collaboration		> Lack a basic operational structure		
		> Have some support for collaboration		> Have general protocol for collaboration, but lack QI structure to ensure collaboration	> Have a comprehensive QI structure to ensure continued quality improvement
> Skeptical about each other's effectiveness in practice			> Lack of formal protocol for collaboration		
		> Lack operational structure			
> Have no institutional support for collaboration		> Lack of formal protocol for collaboration			

Key Differentiators of the Six Levels of Collaboration/Integration

COORDINATED		CO-LOCATED		INTEGRATED	
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**
Screening and assessment based on separate PC/BH practice models	Screening and assessment based on separate PC/BH practice models, but information may be shared through formal requests	PC and BH agree on some specific screenings or other criteria for more effective in-house referral	PC and BH agree on some specific screenings, based on ability to respond to results	PC and BH have a consistent set of agreed upon screenings across disciplines, which guide treatment interventions	All practitioners use standard practice of using population-based PC and BH screenings, with results available to all and response protocols in place
Separate treatment plans for BH and PC	Separate treatment plans shared based on established relationships between specific providers	Separate treatment plans with some shared information that informs them	Collaborative treatment planning for specific patients	Collaborative treatment planning for all shared patients	One collaborative treatment plan for each patient
Treatment plans managed by individual providers	Some joint plan management in specific issues	Providers form a care management team for complex care management – high risk patients only	Providers form a care management team for complex care management – high risk patients only	Most patients receive integrated panel management	All patients receive integrated panel management
Evidence-based practices (EBP) implemented separately	Separate responsibility for care/EBPs	Some shared knowledge of each other's EBPs, especially for high utilizers	Some EBPs and training shared, focused on interest or specific population needs	EBPs shared and respected across system with some joint monitoring of health conditions for some patients	EBPs are team selected, trained and implemented across disciplines as standard practice
CDPs are not considered valid by PC and BH providers	Providers have some understanding of CDPs	Some use of CDPs , with some shared knowledge, especially for high utilizers	Some CDPs and training shared, focused on interest or specific population needs	CDPs shared and respected across system with some joint monitoring of health conditions for some patients	CDPs are team selected, trained and implemented across disciplines as standard practice

COORDINATED		CO-LOCATED		INTEGRATED	
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**
Physical and behavioral health needs are treated as separate issues	Health needs are treated separately, but records are shared, promoting better provider knowledge	Health needs are treated separately at the same location	Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers	Patient needs are treated as a team for shared patients and separately for others	All patient health needs are effectively treated for all patients by the team
Patient must negotiate referrals with varying degrees of success	Patients may be referred, but variety of barriers may prevent access	Co-location improves success of referrals, although who gets referred may vary by provider	Patients are internally referred with follow-up, with occasional collaboration	One-stop shop; care is responsive to patient needs by a team of providers	Unified practice; patients experience a seamless response to all healthcare needs
No care coordination	Care coordination is solely dependent on panel management (No designated care coordinator, case manager, etc.)	Care coordination is solely dependent on panel management (No designated care coordinator, case manager, etc.) Providers use EHR notes to track referrals	Designated care coordinator or case manager for high-risk patients Providers use EHR notes to track referrals	At least one full-time dedicated staff focused solely on care coordination for each patient	At least one full-time dedicated staff focused solely on care coordination for each patient Designated care coordinator tracks access, service, follow up

COORDINATED		CO-LOCATED		INTEGRATED	
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
No coordination or management of collaborative efforts	Some practice leadership in increasing systematic information sharing	Organization leaders supportive of integration, systematic information sharing	Organization leaders support integration through mutual problem-solving of some system barriers	Organization leaders support integration, efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced	Organizational leaders strongly support integration as practice model with expected change in service delivery, and resources provided for developmen
Little provider buy-in to integration or even collaboration	Some provider buy-in to collaboration and value placed on having needed information	Provider buy-in to making referrals work and appreciation of onsite availability	More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components	Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers	Integrated care and all components embraced by all providers and active involvement in practice change
No care coordination	Care coordination is solely dependent on panel management (No designated care coordinator, case manager, etc.)	Care coordination is solely dependent on panel management (No designated care coordinator, case manager, etc.) Providers use EHR notes to track referrals	Care coordination only for high-risk patient Providers use EHR notes to track referrals	At least one full-time dedicated staff focused solely on care coordination for each patient	Full-time dedicated staff focused solely on care coordination for each patient. Designated care coordinator tracks access, service, follow up

COORDINATED		CO-LOCATED		INTEGRATED	
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
Separate Funding	Separate Funding	Separate Funding	Separate funding, but may share grants	Blending funding based on contracts, grants or agreements	Integrated funding, based on multiple sources of revenu
No sharing of resources	May share resources for single projects	May share facility expenses	May share office expenses, staffing costs, or infrastructure	Variety of ways to structure the sharing of all expenses	Resources shared and allocated across whole practice
Separate billing practices	Separate billing practices	Separate billing practices	Separate billing due to system barriers	Billing function combined or agreed upon process	Billing maximized for integrated model and single billing structure

COORDINATED		CO-LOCATED		INTEGRATED	
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**
No institutional support for collaboration with Traditional Healers	Have little-to-no institutional support for collaboration with Traditional Healers	Have some institutional support for the use of Traditional Practices	Institutional knowledge and support for Traditional Healing access for patients	Institutional knowledge and support for the integration of Traditional Healing into system of care	Institutional support for the implementation and success of a completely integrated model, where Traditional Healing is treated with the same value as Primary Care and Behavioral Health practices
Separate treatment plans for BH and PC	Separate treatment plans shared based on established relationships between specific providers	Separate treatment plans with some shared information that informs them	Collaborative treatment planning for specific patients	Collaborative treatment planning for all shared patients	One collaborative treatment plan for each patient
Traditional Healers are not validated through licensure/certification or evidence-based practices; therefore, are not acknowledged as practicioners	Traditional Healers are acknowledged as community-defined practitioners that are utilized outside of the clinic setting, and are not acknowledged as ancillary to the continuum of care	Traditional Healers are acknowledged as community-defined practitioners that are utilized outside of the clinic setting, and are acknowledged as ancillary to the continuum of care	Traditional Healing may still be considered an ancillary service, Traditional healing is still treated as a separate service	Traditional Healing is no longer considered an ancillary service	Traditional Healing is no longer considered an ancillary service
Evidence-based practices (EBP) implemented separately	Separate responsibility for care/EBPs	Some shared knowledge of each other's EBPs, especially for high utilizers	Some EBPs and training shared, focused on interest or specific population needs	EBPs shared and respected across system with some joint monitoring of health conditions for some patients	EBPs are team selected, trained and implemented across disciplines as standard practice
CDPs are not considered valid by PC and BH providers	Providers have some understanding of CDPs	Some use of CDPs , with some shared knowledge, especially for high utilizers	Some CDPs and training shared, focused on interest or specific population needs	CDPs shared and respected across system with some joint monitoring of health conditions for some patients	CDPs are team selected, trained and implemented across disciplines as standard practice

COORDINATED		CO-LOCATED		INTEGRATED	
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**
Separate Funding	Separate Funding	Separate Funding	Separate funding, but may be funded by grant for a brief period or for limited contracted services Traditional healers still typically not considered staff	Blending funding based on contracts, grants or agreements	Integrated funding, based on multiple sources of revenue
No sharing of resources	No sharing of resources	No sharing of resources	May share office expenses, but no support for outside space costs or supplies	Traditional Healing is always considered in development plans	Resources shared and allocated across whole practice
Traditional Protocol is followed for payment i.e. tobacco, wood, food, cultural gifts. This is fine, but not sustainable in this time period.	Traditional Protocol is followed for payment i.e. tobacco, wood, food, cultural gifts. This is fine, but not sustainable in this time period.	Traditional Protocol is followed for payment i.e. tobacco, wood, food, cultural gifts. This is fine, but not sustainable in this time period.	Billing for Traditional Healing being considered and planned for the future	Billing function for Traditional Healing being tested through innovative funding options	Billing maximized for integrated model and single billing structure
Traditional Healers will often provide services without payment out of respect for cultural protocol and their commitment to their role in the community.	Often times no payment is provided because the institution views this as a community service	May receive payment for providing a one-time service through grant funding (relate to a specific project) or other institutional means, but payment never includes cost of medicines, travel, preparation, etc.	May receive payment for providing a one-time service through grant funding (relate to a specific project) or other institutional means, but payment never includes cost of medicines, travel, preparation, etc.	Variety of ways to structure the sharing of all expenses	State-level policy change to support billing for complimentary/alternative medicines i.e. Traditional Healing

Advantages and Weaknesses of Traditional Healing at Each level of Collaboration/Integration

| Advantages and Weakness of Integration | Advantages and Weakness of Traditional Health |

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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
ADVANTAGES					
Each Practice can make timely and autonomous decisions about care

Readily understood as a practice model by patients and providers | Maintains each practice's basic operating structure, so change is not a disruptive factor

Provides some coordination and information-sharing that is helpful to both patients and providers | Co-location allows for more direct interaction and communication among professionals to impact patient care

Referrals more successful due to proximity

Opportunity to develop closer professional relationships | Removal of some system barriers, like separate records, allows closer collaboration to occur

Both behavioral health and medical providers can become more well-informed about what each can provide

Patients are viewed as shared which facilitates more treatment plans | High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans

Provider flexibility increases as system issues and barriers are resolved

Both provider and patient satisfaction may increase | Opportunity to truly treat whole person

All or almost all system barriers resolved, allowing providers to practice as a high functioning team

All patient needs addressed as they occur

Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue |
| WEAKNESSES | | | | | |
| Services may overlap, be duplicated or even work against each other

Important aspects of care may not be addressed or take a long time to be diagnosed | Sharing information may not be systematic enough to effect overall patient care

No guarantee that information will change plan or strategy of each provider

Referrals may fail due to barriers, leading to patient and provider frustration | Proximity may not lead to greater collaboration, limiting value

Effort is required to develop relationships

Limited flexibility, if traditional roles are maintained | System issues may limit collaboration

Potential for tension and conflicting agendas among providers as practice boundaries loosen | Practice changes may create lack of fit for some established providers

Time is needed to collaborate at this high level and may affect practice productivity or cadence of care | Sustainability issues may stress the practice

Few models at this level with enough experience to support value

Outcome expectations not yet established |

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ADVANTAGES					
Traditional Healing remains autonomous in decision making and protocol regarding care Traditional Healing remains a community practice with no over site or input from institutionalized systems Cultural integrity of practices remains intact and true to traditions and there are no challenges to the intellectual property of such practices Traditional Healers maintain control over access for community individuals	Operational changes will not be disruptive to cultural protocol Provides some coordination and information-sharing that is helpful to both patients and providers Administrative burden for traditional systems will not be heightened	Co-location allows for more direct interaction and communication among professionals to impact patient care Referrals more successful due to proximity Opportunity to develop closer professional relationships Respect for Traditional Healing within care systems becomes more progressive Sustainability for Traditional Healing becomes more feasible	Removal of some system barriers, like separate records, allows closer collaboration to occur Institutional leaders, behavioral health and medical providers can become more well-informed about Traditional Healing and what it can provide to the overall system of care and visa versa Patients are viewed as shared which facilitates more treatment plansFosters movement toward integrated/holistic systems of care Sustainability for Traditional Healing becomes more feasible	High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans Provider flexibility increases as system issues and barriers are resolved Both provider and patient satisfaction may increase Fosters movement toward integrated/holistic systems of care Sustainability for Traditional Healing becomes more feasible	Opportunity to truly treat whole person All or almost all system barriers resolved, allowing providers to practice as a high functioning team All patient needs addressed as they occur Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue Sustainability for Traditional Healing becomes feasible A holistic, culturally relevant system of care is operationalized and built to provide individual and community healing
WEAKNESSES					
Services may overlap, be duplicated or even work against each other Important aspects of care may not be addressed or take a long time to be diagnosed Access to Traditional Healing and Culturally relevant systems of care become minimized Sustainability of Traditional Healing is close to impossible	Sharing information may not be systematic enough to effect overall patient care No guarantee that information will change plan or strategy of each providerProvider opinions of one-another may never change Referrals may fail due to barriers, leading to patient and provider frustrationInstitutional support for culturally relevant services may never change Sustainability of Traditional Healing is close to impossible	Proximity may not lead to greater collaboration, limiting value Effort is required to develop relationships Limited flexibility, if traditional roles are maintained Respect for space and outside location needs for Traditional Healers may never be considered Institutional support for culturally relevant services may never change Sustainability options for Traditional Healing remain limited	System issues may limit collaboration Potential for tension and conflicting agendas among providers as practice boundaries loosen Institutional and provider perspectives on Traditional Healing may still not be considered equal, but only as ancillary/secondary options Administrative burdens may challenge the cultural integrity for the Traditional Healer and their practice Sustainability options for Traditional Healing remain limited	Practice changes may create lack of fit for some established providers Time is needed to collaborate at this high level and may affect practice productivity or cadence of care Institutional and provider perspectives on Traditional Healing may still not be considered equal, but only as ancillary/secondary options Administrative burdens may challenge the cultural integrity for the Traditional Healer and their practice Sustainability options for Traditional Healing remain limited	Sustainability issues may stress the practice There a minimal models at this level with enough experience to support valueOutcome expectations not yet established Requires high-level systems/policy change to accept and sustain Traditional Healing and create a culturally-relevant holistic system of care