

## Department of Health Services & WI Indian Tribes Consultation Implementation Plan June 2010 - November 2010

The Wisconsin Department of Health Services (DHS) and the federally recognized Indian Tribes in Wisconsin held their semi-annual consultation meeting on June 16, 2010. This Implementation Plan is the product of the consultation meeting. The plan is a set of mutually agreeable short and long term strategies to address health and human services issues. The Department and Wisconsin Indian Tribes agree to collaborate and provide staff as required to successfully achieve these outcomes.

### MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

**Issue 1: Tribal Youth Treatment Center** (Modified and carried over from previous plan)

The Inter-Tribal Treatment Facility Workgroup has been meeting monthly since October 2009. The workgroup was charged with two primary duties: assess the need for an inter-tribally operated treatment facility designed to meet the clinical needs of dually diagnosed Native youth and, if the facility is warranted, create a business plan for the development of the facility. The initial data collected by the workgroup indicates that there are a sufficient number of Native youth currently being placed in similar programming to sustain an inter-tribal facility.

Deliverable	Due Date	Party/ies Responsible	Status of Deliverable
1. Identify an appropriate organization to administer funding for development and operation of treatment facility.	August 2010	David Rynearson, DHS/TAO, 608-261-6728, and Workgroup Members	Great Lakes Inter-Tribal Council has agreed to act as a fiscal agent if planning funds are secured prior to establishing an inter-tribal nonprofit agency.
2. Obtain planning funds to coordinate and expedite the business plan development and community engagement processes by examining all possible sources.	November 2010	David Rynearson, DHS/TAO, 608-261-6728, and Workgroup Members	The workgroup decided it was not necessary to obtain development funding until after a nonprofit organization was formed. GLITC has offered the workgroup up to \$3,000 for FFY 11 to be used to offset costs of setting up the nonprofit agency.

3. The workgroup will develop a comprehensive business plan that will be presented to tribal and state leadership.	December 2010	David Rynearson, DHS/TAO, 608-261-6728, and Workgroup Members	A final draft of the business plan will be presented to the 11/4/10 GLITC Board of Directors and at the 11/10/10 DHS-Tribal Consultation meeting
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**Issue 2: The Cost for AODA Treatment & Mental Health Services has Exceeded the Counties' and Tribes' Ability to Fund Required Services.** (Modified and Carried over from previous plan.)

Federal funding for mental health and AODA services has been decreasing for the past several years. The costs for these services continues to rise and leaves little funding for prevention/diversion programming. Opportunities exist for tribal governments to access federal dollars through the delivery of an array of MA 100% FMAP reimbursable behavioral health services. The provision of these services can increase revenues and provide enhanced prevention/intervention services. Services such as Comprehensive Community Services (CCS), Targeted Case Management (TCM), Community Support Programs (CSP), 1915-I Waivers and Crisis Services are included in this category. For a number of reasons tribes have not opted to become certified providers of these services.

Consequently significant potential federal funding opportunities have gone untapped.

Deliverable	Due Date	Party/ies Responsible	Status of Deliverable
1. Based on survey of WI Tribes, design and conduct a day long seminar for tribal staff, that provides an overview of the MA reimbursable services. The seminar will provide the information necessary for tribes to decide which, if any, of these service certifications they wish to pursue.	October 2010	David Rynearson, DHS/TAO, 608-261-6728 and Gail Nahwahquaw, DHS/DMHSAS 608-261-8883	Based on the survey results, a seminar that gave an overview on six MA reimbursable behavioral health services was conducted on 10/7/10. The seminar was attended by representatives of all eleven tribes.
2. Provide technical assistance, as required and requested by tribes in order to facilitate the implementation of the desired programming.	Ongoing	David Rynearson, DHS/TAO, 608-261-6728 and DHS Staff	The seminar evaluations indicated considerable interest in follow-up sessions on several of the services. The evaluations show a preference for individual site visits to tribal communities and/or service specific sessions

			that will provide detailed information. A 10/26/10 meeting was conducted with LDF to explore program options. An internal DHS meeting is set for 11/1/10 to plan next steps.
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**Issue 3: Intoxicated Drivers Program (IDP)** (Initiated June 2010)

The State statues only grant counties the authority to establish Intoxicated Drivers Programs. Tribal governments have no input into the design of the IDP nor receive any state funds to assist tribal members seeking tribal services to fulfill their drivers' safety plan. The cultural awareness training for IDP assessors is inadequate and the driver's safety plans developed by county assessors are often culturally ineffective.

Deliverable	Due Date	Party/ies Responsible	Status of Deliverable
1. DHS and Tribal-State Collaboration for Positive Change (TSCPC), an ongoing tribal-state behavioral health workgroup, will identify the tribes that wish to establish an IDP.	September 2010	Gail Nahwahquaw, DHS/DMHSA (608) 261-8883	At the July TSCPC meeting 7 of 11 Tribes asked to be included in the county share of IDP funding or receive funds for the tribes to provide IDP services. TSCPC member, Dr. Dakai provided input into the revised training manual and has presented cultural competency training to IDP Assessors.
2. The TSCPC will develop an issue paper that includes the legislative/jurisdictional implications and recommendations for actions to be taken.	November 2010	Gail Nahwahquaw, DHS/DMHSA (608) 261-8883 and TSCPC workgroup	Dr. Dakai wrote a white paper describing the issue of tribes and the IDP. The legislative and jurisdictional implications and recommendations are still to be determined.

**Issue 4: Family Services Program (FSP)** (Initiated June 2010)

The FSP is a consolidation of 12-13 health and human service programs funded through state and federal sources from the DHS and

DCF. Tribes and DHS representatives consolidated these funds to provide tribes with program and fiscal flexibility necessary to meet the unique needs of each tribal community. The FSP is a team-based approach to family-centered human service provision that relies on evaluation to show success. Each tribe writes a three-year work plan and submits a budget annually. The basic premise of the FSP is to provide flexible funding so that several tribal departments or agencies can form teams with the ability to resolve a wide variety of children and family issues. Because human service needs rarely occur in isolation, the FSP treats the whole person, the family, and the wider community. There are two issues currently impacting the FSP: First, program allocations have not increased over time while community service needs and operational expenses (overhead, salaries & fringe benefits) have increased. This has resulted in insufficient funding for services. Secondly, the DCF is considering removing its department funding from the FSP, which will impact all aspects of program services to tribal communities.

Deliverable	Due Date	Party/ies Responsible	Status of Deliverable
<p>1. Tribal representatives will compile relevant information for each tribe's FSP Program that outlines the need for additional funding. Data compiled will include information identifying the current level of need compared to services being provided, the amount of fiscal shortfall, possible reallocation of existing funding to be included in the FSP, and the potential impact of not providing sufficient services. This information will be considered in the 2011-2013 budget.</p>	<p>August 1, 2010</p>	<p>Tribal Representatives</p>	<p>Tribal representatives will determine the need to compile this information based on the results of the November 4, 2010 meeting referenced below.</p>
<p>2. DHS, DCF, and tribal representatives will form a workgroup to examine the impact to tribes as a result of the proposed removal of DCF funding from FSP. Recommendations will be provided to the DHS and DCF at their respective November Consultation Meetings.</p>	<p>November 2010</p>	<p>Mark Mitchell, DCF/TAO, 608-264-9836, Jim Weber, DHS/TAO, 608-267-5068 and FSP Tribal Representatives</p>	<p>A workgroup meeting is scheduled for November 4, 2010 in Wausau in conjunction with the quarterly Family Services meeting.</p>

## LONG TERM CARE REFORM

### Issue 1: Long Term Care Reform (Carried over from previous plan.)

Questions exist about how tribal members will access long-term care services for elders and individuals with physical or developmental disabilities when Family Care expands. Most tribes provide health care, personal care, and aging services to elders but often must reach outside the tribal system for specialized health care and services for individuals with development disabilities. DHS and Tribes need to examine all options available to ensure that tribal members will have access to the full range of services in the new managed care environment. The Department recognizes and respects the unique circumstances facing each of the 11 Wisconsin tribes. DHS will provide technical assistance to address these special circumstances in developing systems that meets the tribes' long term care needs.

Deliverable	Due Date	Party/ies Responsible	Status of Deliverable
<p>1. DHS/DLTC and Oneida Tribe will continue to collaborate to develop a Family Care Expansion model that meets the needs of the Oneida community.</p>	<p>August 2010</p>	<p>Fredi Bove, DHS/DLTC 608-261-5987</p>	<p>Since January 2010, the Department has been engaged with the Oneida Tribe in in-depth discussions on Family Care implementation. Through the discussions, the Oneida Tribe has concluded it will pursue the Tribal ADR Specialist option and seek Tribal Government representation on the two ADRC Boards in its area. In addition, Oneida Tribe identified its interest in participating as a provider in the MCO network for care management, nursing home, FQHC, and possibly other services. As part of the talks, the Department developed the methodology and process for providing 100% FMAP reimbursement in the Family Care program for services provided by</p>

			the Oneida Tribe to tribal Family Care members. The Department and Oneida Tribe are pursuing discussions with the federal CMS to seek approval for treating Oneida Tribe as a unified entity that can be served by the MCOs in the two Family Care service areas in which the Tribe is located (i.e., Brown and Outagamie Counties).
2. DHS/DLTC will arrange regional meetings between tribes and partnering counties/entities to explore ways that tribal service providers could become part of the MCO network.	November 2010	Monica Deignan, DHS/DLTC 608-261-7807	Regional meetings have been replaced by meetings between specific tribes and the managed care organization(s) in the tribe's area, when the tribe is ready and interested in such meetings. DHS participates in or facilitates these meetings. DHS has or will hold meetings with the following tribes to explain the possible relationships and roles for the Tribe with the Family Care MCOs: Oneida (January-October 2010); Sokaogon, Lac du Flambeau, and Forest County Potawatomi (September 2010); Ho-Chunk (October 20, 2010); and Menominee (October 25, 2010). In September 2010, the Oneida Tribe met and began discussions with the Northeast Wisconsin (NEW) MCO planning consortium regarding possible roles for the Tribe as a provider in the MCO network.

<p>3. DHS/DLTC will work with Tribes to expand to three additional Tribes the Chronic Disease Self-Management Program (CDSMP), an evidence-based prevention program for people with chronic diseases such as diabetes, heart conditions, etc. through the following steps:</p> <ul style="list-style-type: none"> <li>a. Subject to receipt of federal ARRA funds, support the two CDSMP Master Trainers in the Oneida Tribe to provide training to other Tribes.</li> <li>b. CDSMP Master Trainers from the network will provide training to Tribes.</li> </ul>	<p>December 2010</p>	<p>Gail Schwersenska, DHS/DLTC, 608-266-7803</p>	<p>Currently two tribes have organized CDSMP workshops: Oneida (4 workshops) and Stockbridge- Munsee (1 workshop).</p> <p>Oneida tribe is an active member of Department's CDSMP Advisory committee and ARRA grantee meeting.</p> <p>Oneida plans CDSMP leader training for February 2011 which will be open to all tribes.</p> <p>St. Croix and Bad River Tribes have already expressed interest in participating in CDSMP leader training.</p> <p>Presentation on CDSMP was made at the Diabetes conference in April 2010 at the Lac du Flambeau Tribe, generating interest by new participants.</p> <p>A number of Tribes, including Bad River, Red Cliff, Lac du Flambeau, La Courte Oreilles, Mole Lake Sokaogon, and Oneida will be invited to the Living Well Consortium in Ashland on November 4.</p>

<p>4. Tribes will be funded for their choice of ADRC options.</p>	<p>Ongoing</p>	<p>Janice Smith, DHS/DLTC 608-266-7872</p>	<p>All Tribes have implemented, are beginning or are engaged in the planning process for the ADRC option of their choice.</p> <ul style="list-style-type: none"> <li>• <b>St Croix Tribe</b> has partnered with Polk and Burnett counties and formed a tribal/county ADRC.</li> <li>• <b>Red Cliff, Bad River and LCO</b> have chosen to apply for state funds to make available a Tribal Aging and Disability Resource Specialist. Red Cliff hired and Bad River and LCO have contracts in process.</li> <li>• <b>LDF and Mole Lake Sokaogon</b> have chosen to join 5 counties (Vilas, Oneida, Forest, Florence, Taylor). Active planning is underway. <b>Forest Co Potawatomi</b> has not yet indicated which option it will pursue.</li> <li>• <b>Oneida</b> is planning for the Tribal Aging and Disability Specialist position.</li> <li>• <b>Menominee and Stockbridge Munsee Tribes</b> are partnering and actively planning a tribal/county ADRC with Shawano, Oconto and</li> </ul>
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			Menominee Counties. <ul style="list-style-type: none"> <li>• <b>Ho Chunk</b> has expressed interest in pursuing the Tribal Aging and Disability Specialist option.</li> </ul>
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**MEDICAID**

**Issue 1: Data Exchange Project and 100% Federal Reimbursement for Tribal Members** (Carried over from previous plan.) States can claim 100% federal Medicaid reimbursement (FMAP) for services provided to American Indian/Alaska Natives at tribal clinics that have a 638 Agreement with Indian Health Services. There are two interrelated issues at the center of the effort to increase MA reimbursements to tribal clinics. First the percentage of patient services otherwise eligible for 100% reimbursement is grossly unclaimed due to an under-identification of patients as eligible for IHS services delivered by tribal clinics. Second, an appropriate methodology must be established for tracking and distributing, to the tribal clinics, the increased federal share of revenues generated by the delivery of qualified services to individuals eligible for IHS services through tribal clinics.

<b>Deliverable</b>	<b>Due Date</b>	<b>Party/ies Responsible</b>	<b>Status of Deliverable</b>
1. Continue efforts to increase the percentage of MA eligible tribal clinic patient services that can claim 100% federal reimbursement.	November 2010	Tribal Health Directors and Jim Weber, DHS/TAO, 608-267-5068	<p>Tribal Health Directors and DHS continue their efforts to increase 100% federal MA reimbursement for tribal provided services. The Health Directors meetings are the primary forum for this collaborative effort.</p> <p>A strategy has been adopted that focuses on:</p> <ol style="list-style-type: none"> <li>1. A new manner to identify MA and BC+ members, who are Native Americans and who have received a service through a tribal health clinic.</li> <li>2. PCG will work with tribes to resubmit cost reports for past</li> </ol>

			<p>years where additional Medicaid claiming is identified &amp; to submit cost reports for past periods, where none was provided.</p> <p>3. PCG will train tribal health clinic staff to submit cost reports for 2010 and will provide a new web-based system to make this an easier process.</p> <p>4. DHS will change the methodology for cost-based reimbursement to include pharmacy encounters and to eliminate the current cap on overhead expenditure claiming.</p>
2. DHCAA will release the PCG consultant's report which outlines the methodology options for distributing additional MA funds to tribal clinics that are generated through the 100% FMAP project.	July 2010	Jim Jones, DHS/DHCAA, 608-266-8922,	The Department provided a summary of the report to tribal health directors in August 2010 with updates provided in September 2010.
3. DHS/DHCAA and Health Directors select options for distribution of additional Medicaid funds claimed by DHS.	August 2010	Jim Jones, DHS/DHCAA, 608-266-8922 and Tribal Health Directors	See #1.
4. DHS/DHCAA submits Medicaid State Plan amendments, if necessary, to support selected option(s) of distributing additional Medicaid funds.	September 2010	Jim Jones. DHS/DHCAA, 608-267-5068	Whether a SPA will be needed for the pharmacy encounters is still being discussed and the methodology will be dependent

			upon PCG's review of tribal cost-reporting claims.
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**Issue 2. Statewide Medicaid and BadgerCare Plus Transportation Broker.** (Carried over from previous plan.)

The Department of Health Services will postpone the implantation of a statewide, non-emergency transportation management initiative for Medicaid and BadgerCare Plus members until at least April 2011. Many details important to tribal communities related to conversion to the new system remain unanswered. The DHS is committed to working with tribal communities to address their concerns and facilitate a transitional process that minimizes untoward effects on tribal consumers.

Deliverable	Due Date	Party/ies Responsible	Status of Deliverable
1. DHCAA will continue communicating with tribal IM agencies regarding the transition to the state-wide system.	April 2010 or until implemented	Marlia Moore DHS/DHCAA, 608-266-9749	DHS continues to communicate with tribal IM agencies and tribal Health Directors. We will continue to do so as implementation moves forward.

**Issue 3. Tribal Clinics as BadgerCare Plus HMO Providers.** (Carried over from previous plan.)

DHS, in consultation with tribes, has drafted and submitted HMO contract language for CMS approval. The contract language addresses issues related to tribal clinics as providers to tribal members who are enrolled in BadgerCare Plus HMOs.

Deliverable	Due Date	Party/ies Responsible	Status of Deliverable
1. DHS will share CMS' response to the submitted BadgerCare Plus HMO contract language and engage tribal Health Directors as necessary.	November 2010	Makalah Wagner, DHS/DHCAA 608-266-9248	The BadgerCare Plus & Medicaid SSI 2010-2011 HMO contract and the Southeast RFP BadgerCare Plus HMO 2010-2013 contract will be amended to add proposed language:  <u>Indian Health Care Access and Payment Requirements</u>  For Native American members enrolled in the HMO, the HMO

		<p>must ensure access to an Indian Health Care Provider or Service (Indian Tribe, Tribal Organization, or Urban Indian Organization, or I/T/U), when available. If such a provider agrees to serve in the network as a PCP and has capacity, the member must be allowed to select that provider as her or his PCP. If no such provider is contracted, the HMO must allow the member to see the provider out of network. The Department encourages HMOs to contract with any Indian Health Care Providers or Services within the HMO's service area.</p> <p>Indian Health Care Providers, whether participating in the network or not, must be paid for the provision of services or items to Native American members at a rate that is negotiated between the HMO and an Indian Health Care Provider, or a rate that is no less than what a non-Indian Health Care Provider would be paid for the same services or items. Indian Health Care providers must receive the full Medicaid payment rate for services provided to tribal health members enrolled in the HMO.</p>
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			Native American members are exempt from payment of fees, co-payments, or premiums for services provided by an I/T/U organization or provider, or through referral by an I/T/U.
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**PUBLIC HEALTH**

<p><b>Issue 1: Adoption and meaningful use of electronic health records (EHRs) in tribal health clinics and participation in health information exchange (HIE).</b> (Carried over from previous plan.)          To achieve statewide adoption and meaningful use of EHRs, tribal health clinics need to be included in the state health information technology (HIT) and HIE planning and implementation activities. Eligible health professionals practicing in tribal clinics that meaningfully use a certified EHR system can receive Medicaid HIT incentive payments beginning in January 2011.</p>			
<b>Deliverable</b>	<b>Due Date</b>	<b>Party/ies Responsible</b>	<b>Status of deliverable</b>
1. DHS will continue to include the Tribal Health Director's in all eHealth communications to stakeholders. The Health Directors' meetings will be used as a forum to discuss and coordinate the adoption of EHR systems within tribal entities.	November 2010	Denise Webb, DHS/DPH eHealth Program (608) 267-6767	Communications with Health Directors is ongoing. We are attending Health Directors' quarterly meetings to provide updates, and are sending eHealth updates as well through our listserv.
2. DHS will work with the Wisconsin HIT Extension Center to arrange technical assistance visits to each tribal health clinic.	November 2010	Denise Webb, DHS/DPH eHealth Program (608) 267-6767	To date, the Wisconsin Regional Extension Center (WHITEC) has received one application from a tribal health center (Oneida) and a couple of their HIT Specialists are meeting with them Nov 3. They have tried contacting another tribe in-person and via phone, but haven't received any response.

		<p>They finally had a conversation with the project director of the National Indian Health Board (NIHB) Regional Extension Center (REC) two weeks ago. Based on that conversation, it seems clear that any of the tribal health centers that are IHS-operated and using RPMS are to work with the NIHB REC. If a center is tribally-operated and not using that system; however, WHITEC would be free to work with them. WHITEC has requested that the Office of the National Coordinator (ONC) for Health IT provide some sort of policy about this so there is better clarity about which REC the individual tribes should look to for services; no word on whether that will happen.</p> <p>WHITEC has also been in communication with Jason Douglas from the Bemidji Area IHS office and is in the process of setting up a call with him and Alan Fogarty, as well as representatives from WHITEC and the NIHB REC. They want to schedule that call for next week.</p>
<p><b>Issue 2: ACHIEVING EQUITY FOR NATIVE AMERICAN COMMUNITIES.</b> (Carried over from previous plan.)  The disparity Native Americans experience in health outcomes, environmental risks, human service outcomes, and economic opportunities when compared to the state’s general population is well documented. The lack of parity experienced by tribal</p>		

communities is not unique to Wisconsin and has its roots in centuries of misguided public policy that has undermined the cultural, social, economic and familial foundation of Native American societies. The Tribal-State Workgroup for Achieving Equity for Tribal Communities was established at the November 2008 DHS-Tribal Consultation Meeting. The workgroup has established an intervention strategy based upon a social-ecological model that will be implemented following the principles of community engagement.

<b>Deliverable</b>	<b>Due Date</b>	<b>Party/ies Responsible</b>	<b>Status of Deliverable</b>
1. Secure funding to support the workgroup's activities during FFY 2011.	October 2010	David Rynearson DHS/TAO, (608) 261-6728 and Workgroup Participants	\$5,000 in funding has been secured from the DHS/DMHSAS in order to carry out workgroup activities/consultations during FFY 2011.
2. Develop a handbook, based upon the lessons learned through the Menominee Nation's pilot project which can be used by other tribes as they establish their own initiatives.	November 2010	Workgroup Participants	Information about the Equities Workgroup, the social-ecological model, community engagement process, completed intervention frameworks and the Menominee and Red Cliff initiatives has been developed for inclusion in the DHS Tribal Affairs Office website.
3. Adapt and employ the intervention framework and community readiness (CR)/community engagement (CE) processes with two additional tribal initiatives.	November 2010	Workgroup Participants	Menominee has expanded their efforts to include the development of initiatives and intervention frameworks in the areas of childhood obesity, diabetes and binge drinking.
4. Adapt and employ the intervention framework and CR/CE processes to the activities of the five tribes engaged in the tobacco prevention and control lead through the GLITC.	November 2010	Workgroup Participants, GLITC tobacco prevention staff	As the federal tobacco prevention grant received by GLITC requires specific planning and implementation processes, the

		and the five tribes involved in the tobacco grant.	methods developed by the Equities workgroup will not be utilized at this time.
<p><b>Issue 3: The Affordable Care Act.</b> (Initiated June 2010)  The Patient Protection and Affordable Care Act offers numerous partnering opportunities for DHS and tribal entities that can positively impact tribal communities. Effective communication and deliberate coordinated actions between the DHS and tribal communities will be essential if funding opportunities and other benefits are to be fully realized.</p>			
<b>Deliverable</b>	<b>Due Date</b>	<b>Party/ies Responsible</b>	<b>Status of Deliverable</b>
1. The Tribal Health Directors and DHS will identify tribal health priorities and seek relevant funding opportunities available through the IHCA and the PPACA legislation.	November 2010	Tribal Health Directors and Jim Weber, DHS/TAO, (608) 267-5068	Health Directors and DHS continue to identify tribal health priorities during their meetings. DHS and Health Directors will collaborate as needed to maximize health care reform funding to tribal communities. Depending on a grant's requirements, one or more tribes may apply for a grant, DHS and tribes may collaborate on a grant application or DHS may apply for a grant and involve tribes in the implementation of the grant.
2. DHS will continually review the funding opportunities available to the state through the health care reform legislation that offer the potential for tribal-state partnerships. These opportunities will be communicated to the tribal Health Directors.	November 2010	Jim Weber, DHS/TAO, (608) 267-5068	A representative from the DHS Office of Health Care Reform attended the September Health Directors' meeting to provide an overview of the Office and activities related to WI Tribes. The Office monitors health care reform funding opportunities available to tribes through the Patient Protection and Affordable

			Care Act and the Indian Health Care Improvement Act. Health Directors, Social Service Directors, Elderly Services Directors and other tribal staff receive email communication from the office relating to grant opportunities, federal and state initiatives, and proposed rule changes that may impact the tribes as these items become available.
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**Issue 4: Acknowledging Traditional Native American Health Practitioners.** (Initiated June 2010)

Currently state administrative codes and Medicare/Medicaid regulations do not acknowledge traditional Native American practitioners as credentialed or billable providers. Many studies indicate that the application of traditional healing practices or the integration of traditional and dominate-culture-based treatment modalities can enhance treatment outcomes. If traditional services are offered through tribal entities, the expenses are currently absorbed by the tribes. At this time there are no guidelines for credentialing or granting administrative rule waivers or extending MA provider status to traditional Native American practitioners.

<b>Deliverable</b>	<b>Due Date</b>	<b>Party/ies Responsible</b>	<b>Status of Deliverable</b>
1. The Tribal Health Directors will discuss the topic of acknowledging traditional NA health practitioners at their next meeting(s). Recommended next steps will be discussed with DHS.	December 2010	Tribal Health Directors	Acknowledging traditional Native American practitioners is an agenda item for the December 8, 2010 Health Directors' meeting.
2. If necessary, an internal DHS workgroup will be established to explore the legal, legislative and practical issues/barriers related to granting traditional Native American practitioners' provider status or credentials. The workgroup will consult with tribal representatives during the course of the study and report at the June 2011 DHS-Tribal Consultation meeting.	June 2011	Gail Nahwahquaw DHS/DMHSAS (608) 261-8883 and Dave Rynearson DHS/TAO (608) 261-6728	Exploring what other states have done with regard to recognition of native traditional practitioners. 08/10 Email and phone conversation with MN State Treatment Services Consultant. Minnesota does recognize traditional healers in both individual counselors' definitions

			as well as larger, facility licenses standards, both on and off reservation soil. A specific workgroup has not been formed. DHS staff needs to determine how tribes wish to proceed with this effort.
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