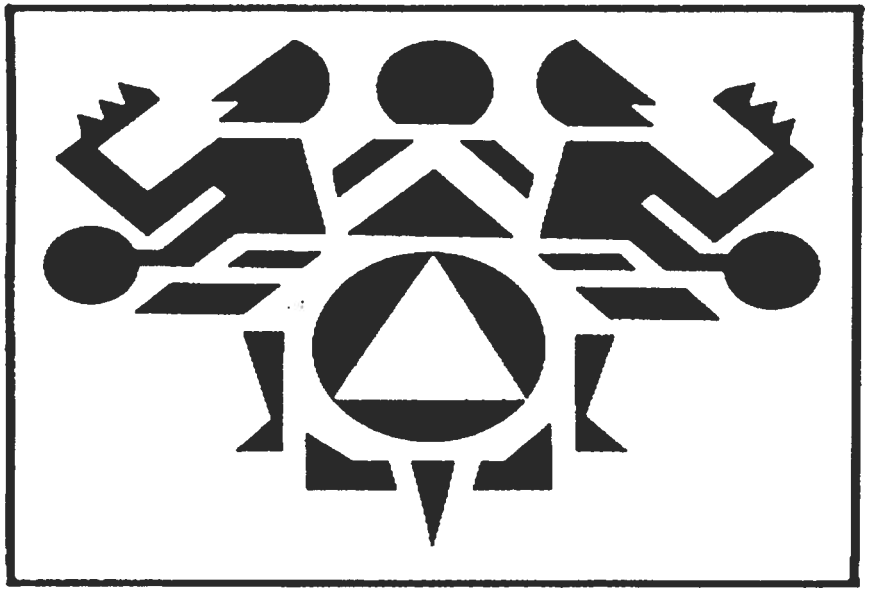
SUMMARY OF MINUTES



QUARTERLY BOARD MEETING

JANUARY 23-25, 2013

WILDHORSE RESORT & CASINO

PENDLETON OR

January 2013 Quarterly Board Meeting
Summary of Minutes

Issue	Summary	Action	Follow-Up
Area Director Report	Area Meetings: 2013 DHHS regional tribal consultations are being organized by the Secretary's office in Washington DC – Headquarters staff was working closely with Secretary's office and a letter should be coming out soon as far as dates being selected. CHS meeting has been rescheduled for 2/20-21/13 in Denver; Terry Dean will be attending.	The Health Board has sent a letter requesting dates changes because it conflicts with ATNI mid-year conference.	
Area Director Report	ARRA funding – Portland Area received nearly $12 million and 32 tribes in the Northwest benefited from these funds.	In December we were notified that we were first on several occasions; the first to obligate the project funds, the first Area to have our ARRA projects constructed & the first Area to administratively close-out all the projects; which was big thing for OMB to be able to report back to Congress.	
Area Director Report	Chief Medical Officer position is still vacant; Dr. Stephen Rudd, Clinical Director for Warm Springs Service Unit has been the Acting CMO	Permanent vacancy announcement will be out within next 30-60 days	
Area Director Report	Aberdeen Area & Headquarters oversight review – Have heard nothing since our review of administrative operations. All Areas have had their oversight reviews.	We had a lot of best practices that the team was going to recommend to Dr. Roubideaux that they institute Agency-wide. I have nothing in writing and there will be nothing until Dr. Roubideaux presents it to the SCIA	
Area Director Report	VA IHS reimbursement agreement template; it is a very good template. Working with the federal sites now. One item that kept this from moving forward was the reimbursement amount.	Headquarters was asking for the all-inclusive rate and that was accomplished and in the agreement; the VA will reimburse IHS federal facilities that & the tribes are encouraged to take the same agreement & use that as a template during negotiations or discussions with the VA. The VA asked that we start with 10 federal programs; the Portland Area	

January 2013 Quarterly Board Meeting
Summary of Minutes

		identified Warm Springs Tribe because of their previous agreements that were in place & ready to move forward	
Area Director Report	VISN 20 Director – new Director that I have not met yet. The past VISN 20 Director under the VAI/IHS agreement talked about the access to their training, ICD10, and that they had the top 2 trainers in the nation. I need to talk with new Director to ask if he will honor her previous agreement with us.	Headquarters has taken the lead on the ICD10 for the Agency.	
User Pop Numbers	Portland Area service population in FY12 approximately 190,000. The FY12 user population is just under 110,000; about a 1 1/2% increase from FY11. We had about 1 million patient visits in FY12.	These numbers have gone to Headquarters & they have not yet published these figures as final. The Fund Distribution Workgroup makes recommendations to the Area Director on how to allocate or distribute any new monies that come to the Area. RECOMMENDATION: More straight forward way of counting user pop; IHS needs to take a look at that & some kind of workgroup established with tribe's participation so that this problem can be fixed once and for all.	The Fund Distribution Workgroup are the folks who originally came up with that methodology; Area Director will work with them to address this issue
Data Repository Update	Follow-up – the reason the Health Board is considering have a data repository is to meet requirements of the Federal Government that say if research is federally funded, data must be made available. What we would be storing is data bases from the Epi Center projects that are de-identified number based data. We have developed some recommendations that would work best for us & would be doable. Long term it would be most beneficial to the tribes to have our own data repository; but realistic about the need to	First, to develop a business plan for a NW Tribal Data Repository. Supplement business plan with carryover and apply for grant funding. To meet the funding agency requirements in the next 1-2 years we use an umbrella organization. This is at least a 2 more year process to get everything lined up to go. In meantime we need something in place so that we are eligible for federal grants; once you are over a certain funding threshold, more than $250,00 in any one grant then you have to share the data.	

January 2013 Quarterly Board Meeting
Summary of Minutes

	secure funds for that on an ongoing basis.	MOTION by Cassandra Sellards-Reck, Cowlitz Tribe; seconded by Dan Gleason, Chehalis Tribe to go with Option A of developing our own repository and securing grants with caveat of having our own Repository down the road. MOTION CARRIED	
TLDC Update	TLDC meeting was held in December 2012 in Rockville MD; first one in over a year. They handed out the 2011 Congressional Report. This program has fulfilled Congress' mission & vision for the SDPI. We are leading the Nation in preventing diabetes & treating diabetes. NIHB is going to develop tool kits and one-page 'lessons learned' that can be shared with Congressional staff when tribal leaders go to the Hill.	The SDPI was renewed for another year; through 9/30/14 and that was under the American Taxpayer Relief Act of 2012; renewed at $150,000 a year. The TLDC will try to schedule their meetings the same time as the grantee meetings so everyone can know what everyone else is doing.	Would like to make TLDC updates a regular item on the board meeting agendas
Legislative Update	Portland Area conducted their FY2015 budget formulation meeting and recommended increases at 17% & 5%; the health priorities remained the same. Overall sequestration for IHS for services will be a $317 million cut; facilities will be a $36 million cut. SDPI will see a 2% cut. CSC – 1/17/13 tribal lawyers & federal lawyers met to address some of the issues including options for calculating damages; one of the most critical threshold issues. Another issue was the process, the proceeding with claims; all have been brought to contract dispute. A number of tribes have received a variety of different responses, some needing a decision fairly quickly.	It you apply that to the proposed 2013 we will be going back somewhere between 2009-2010 level of spending. Quite of bit of time was spent talking about using the shortfalls instead of the costs incurred methodology. The Agency is open minded about possibility of setting up a framework that can be used by individuals tribes in individual negotiations.	At Tribal Self Governance Advisory Committee meeting Dr. Roubideaux stated she is very happy to hear from her lawyers that the meeting was successful and productive. She is committed to coming up with a framework that these claims can be settled with. She seemed today to make comments that back off from her last DTL letter that was so strongly worded in favor of the cost incurred methodology.

January 2013 Quarterly Board Meeting
Summary of Minutes

		All lawyers agreed to a follow up meeting in 45 days.	She framed the issue as one where she understands clearly that we would like to use the shortfall. She understands that her lawyers, as of right now, are still prepping for the cost incurred methodology but she is hopeful that there will be a middle ground that will provide for a simple way for tribes to be able to do that efficiently and rapidly.
Elections: Vice Chairman	Pearl Capoeman-Baller was nominated for Vice-Chairman	Pearl Capoeman-Baller was elected Vice-Chairman	
Elections: Treasurer	Cheryle Rasar was nominated & declined nomination so she can pursue her academic career. Shawna Gavin was nominated for Treasurer	Shawna Gavin was elected Treasurer	
Elections: Sergeant-at-Arms	Greg Abrahamson and Cassandra Sellards-Reck were nominated for Sergeant-at-Arms	Greg Abrahamson was elected Sergeant-at-Arms	
Financial Report	Board member concerned that we are not reviewing our financial reports at board meeting as previously done.	Vice-Chairman stated that was correct and has not had a lot of dialogue on the financial reports and quarterly budget. Thank you for reminder – we will put that on our future agendas.	Starting April 2013 the 'Finance Report' will be added to agenda
Executive Director Report	Recognition of 10 years of service at the Health Board: Don Head Jim Roberts		
Elders Committee	Report Attached		
Veterans	Report Attached		

January 2013 Quarterly Board Meeting
Summary of Minutes

Committee			
Public Health/Behavioral Health Committee	Report Attached		
Personnel Committee	Report Attached		
Legislative Committee	Report Attached		
RESOLUTION #13-02-01	Recommendation that CDC Administrator Rescind the CDC Tribal Consultation Policy adopted on 1/8/13 and send the Proposed Policy out for Tribal Consultation	Motion by Andy Joseph, Colville Tribe; 2nd by Cassandra Sellards-Reck, Cowlitz Tribe to approve the resolution. MOTION CARRIED	
RESOLUTION #13-02-02	Recommendation that a Financial Conflict of Interest Policy be Added to the Program Operations Manual & Posted to the NPAIHB Website, in Order to Comply with Federal DHHS Regulations Impacting Grantees & Contractors	Motion by Andy Joseph, Colville Tribe; 2nd by Shawna Gavin, Umatilla Tribe to approve the resolution. MOTION CARRIED	
MOTION Minutes	Motion by Dan Gleason, Chehalis Tribe; 2nd by Cassandra Sellards-Reck, Cowlitz Tribe to approve the October 2012 minutes.	MOTION CARRIED	

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MEMORANDUM

January 23, 2013

TO: Joe Finkbonner, Executive Director
NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

FROM Geoff Strommer & Starla Roels
HOBBS, STRAUS, DEAN & WALKER, LLP

Geoff Strommer (by TAE)

RE: ***The Federal Advisory Committee Act and NPAIHB***

As you requested, we reviewed the Northwest Portland Area Indian Health Board's (NPAIHB or Board) status in terms of its employee's participation on advisory committees under the Federal Advisory Committee Act (FACA) and related laws and case law.

The Unfunded Mandates Reform Act of 1995 (UMRA), P.L. 104-4, Sec. 204, 2 U.S.C. § 1531 et seq., establishes procedures which Federal agencies must follow before promulgating regulations which impose unfunded mandates on state, local, or tribal governments. The procedures include a requirement in 2 U.S.C. § 1534(a) that federal agencies "develop an effective process to permit elected officers or state, local, and tribal governments (or their designated employees with authority to act on their behalf) to provide meaningful and timely input in the development of regulatory proposals containing significant Federal intergovernmental mandates."

Subsection 1534(b) provides that the FACA will not apply to actions in support of intergovernmental communications where "meetings are held exclusively between Federal officials and elected officers of State, local, and tribal governments (or their employees with authority to act on their behalf) acting in their official capacities." This is known as the Intergovernmental Exemption to the FACA.

Subsection 1534(c) of the FACA requires the President to issue guidelines and instructions to Federal agencies for appropriate implementation of this exemption consistent with applicable laws and regulations. Accordingly, the Office of Management and Budget (OMB) issued Memorandum 95-20 on September 21, 1995 providing such guidance and instructions to federal agencies. 60 Fed. Reg. 50651 (September 29, 1995). In the Memorandum, OMB describes the process for intergovernmental consultation as follows:

> It is important that this intergovernmental consultation process not only achieves meaningful input, but also builds a better understanding among Federal, State, local, and tribal governments. As described in Part II, below, the process required by the Federal Advisory Committee Act is not to act as a hindrance to full and effective intergovernmental consultation.

OMB explains that federal agencies should seek to consult with the highest levels of the pertinent government units. For tribes, this means tribal leaders and their designated employees with authority to act on the tribes' behalf. Additionally, the OMB explains that agencies should also consult with tribal program and financial officials and Washington representatives. With respect to "Washington representatives," the Memorandum notes as follows:

> It is also important that Federal agencies consult with Washington representatives, where available, of associations representing elected officials. These Washington representatives often know which local elected officials are the most knowledgeable about, interested in, or responsible for, implementing specific issues, regulations or programs, and can ensure that a broad range of government officials learn of and provide valuable insight concerning a proposed intergovernmental mandate.

These issues are further clarified by President Clinton's Executive Order 13175 (November 6, 2000), which requires consultation with tribal governments regarding policies that have tribal implications. The Executive Order defines "tribal officials" as "elected or duly appointed officials of Indian tribal governments or authorized intertribal organizations," (emphasis added). This clarifies that officials of "intertribal organizations" may represent member tribes in meetings with government officials for purposes of tribal consultation. President Obama's Memorandum to the Heads of Executive Departments and Agencies on Tribal Consultation (November 5, 2009) uses the same definition of "tribal officials." Likewise, this definition is used in the DHHS tribal consultation policy and the CDC tribal consultation policy.

As the NPAIHB's Executive Director, we think you qualify for participation on advisory committees under the inter-governmental exemption not only based on NPAIHB's status as an intertribal organization, but because it also serves as its member tribes' Washington representative.

The NPAIHB is a tribal organization comprised of forty-three federally recognized Indian tribes in Idaho, Oregon, and Washington. Formed in 1972, the NPAIHB engages in activities related to health promotion and disease prevention, health research, and legislative advocacy. The NPAIHB Articles of Incorporation provide as follows:

> The basic structure of the Board shall begin in the governing body of the federally-recognized member tribes in the states of Idaho, Oregon, and Washington. The governing body of the tribe, or its authorized health committee, shall designate a representative and an alternate representative to serve on the Northwest Portland Area Indian Health Board. . . . The Northwest Portland Area Indian Health Board shall be composed of the delegates, or alternates, representing all federally-recognized member tribes in the Portland Area Indian Health Service. Art 1, Sec. 1 & 3.

The mission statement of the NPAIHB is "to eliminate disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest Tribes in their delivery of culturally appropriate, high quality healthcare." To accomplish this mission, the NPAIHB carries out the following:

1. Assists tribes in developing their capacity to engage in health problems that are presented:

   - Develops epidemiology and research capability to better understand the cause and risk factors associated with death and illness in tribal communities;
   - Provides strong support for health promotion/disease prevention efforts through Area-wide campaigns and technical assistance for specific tribal interests;
   - Increases involvement in information systems development, support, and training; and
   - Increases involvement in data analysis by examining trends of deaths, disease and illness, health care costs, and unmet need.

2. Provides a forum for unified tribal positions on matters affecting health care to Indian communities.

3. Maintains an effective partnership with the IHS to strengthen and improve delivery of health services to Indian communities throughout the Northwest.

4. Develops relationships with state offices and other agencies dealing with health matters to assure that tribal interests are taken into account as health policy is formulated.

5. Provides a strong voice on health related issues at the national level.

NPAIHB is a recognized "tribal organization" under the Indian Self-Determination and Education Assistance Act (ISDEAA) and conducts programs and

projects under ISDEAA agreements with the Indian Health Service (IHS). Tribal organizations like NPAIHB, formed as a single entity to represent their member tribal governments, have also qualified for sovereign immunity and the Title VII exemption for Indian tribes under Title VII of the Civil Rights Act. *See, J.L. Ward Associates, Inc. v. Great Plains Tribal Chairman's Health Board*, 842 F.Supp.2d 1163 (D.S.D. 2012), and cases cited and reviewed by the court. As such, NPAIHB should be treated the same as individual tribes for the purposes of the FACA and the intergovernmental exemption.

Additionally, NPAIHB clearly qualifies as an "intertribal organization" for purposes of Executive Order 13175 and the tribal consultation policies of the DHHS and the CDC. As indicated in its Articles of Incorporation quoted above, NPAIHB is an extension of its member tribal governments. The Board is composed exclusively of authorized delegates of its member tribes. The Board's mission statement indicates that the Board provides, among other things: (1) a forum for unified tribal positions on health care matters affecting its member tribes; (2) a focal point for discussion of health related issues affecting its member tribes with the IHS, other federal agencies, and state offices; and (3) a voice for its member tribes on heath related issues at the national level.

As a "tribal organization" under the ISDEAA and an "intertribal organization" under Executive Order 13175, NPAIHB officials are authorized to sit on an advisory committee. The matters listed in NPAIHB's mission statement, such as epidemiology research, supporting health promotion/disease prevention efforts, development of information systems, and data analysis are also consonant with CDC's mission.

We understand that the Centers for Disease Control (CDC) removed you as the NPAIHB's Executive Director from participation on a CDC advisory committee, which we think is contrary to the intergovernmental exemption, Executive Order 13175 and DHHS and CDC tribal consultation policies, which include "elected or appointed officials of Indian tribal governments or authorized intertribal organizations." The definition of "intertribal organization" does not require that individual officials of intertribal organizations receive in writing a specific authorization from a member tribal government to represent that tribe at consultation meetings. This undermines the purpose of tribes forming intertribal organizations to represent them and, in the words of the OMB Memorandum, "act[s] as a hindrance to full and effective intergovernmental consultation."

NPAIHB's Executive Director also qualifies for participation on CDC's advisory committee as the Washington representative of NPAIHB's member tribes, under the OMB Memorandum. The NPAIHB not only maintains a Washington, D.C., office for use by its officials when visiting Washington, D.C., but is a focal point for developing unified positions of its member tribes for consultation with the IHS and other federal and state agencies, both locally and nationally, including the CDC.

NPAIHB believes that the reference to "Washington representatives" in the OMB Memorandum includes officials of tribal associations and organizations like NPAIHB that are authorized to represent their member tribal governments in Washington, D.C., where the consultation meetings are likely to be held. We urge the CDC to keep in mind that the OMB's Memorandum requires federal agencies to facilitate full and effective intergovernmental consultation. In fact, the Memorandum states that "in accordance with the legislative intent, the exemption should be read broadly to facilitate intergovernmental communications."

Should you have any questions about this memorandum or require additional assistance, please do not hesitate to contact us at 503-242-1745 or gstrommer@hobbsstraus.com, sroels@hobbsstraus.com.

Veterans Committee

Tuesday January 22, 2013
WildHorse Resort, Pendleton, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Brent Simcosky	Jamestown	
2	Stella Washines	Tribal Council / Yakama	
3	Rennae Granados	NPAIHB - Umatilla	
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Northwest Portland Area Indian Health Board
Quarterly Board Meeting
January 2013

Staff: Ronda Metcalf, Jamestown Health Director, Stella Washines, Rennea Grandaos (NPAIHB Staff)

Brent Simcosky, Jamestown Health Director discussed that Jamestown wanted to start working on an MOU with the VA that models the first draft of one Alaska had done earlier this year. He indicated it is nothing like the template that IHS Director as made. He would like to know if other Washington tribes would be would be interested in a discussion with the VA.

That was all that was discussed.

Public Health Committee

Tuesday January 22, 2013
WildHorse Resort, Pendleton, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Cheryle Kennedy	Confed Tribes Grand Ronde	5038795211
2	Rachel Ford, PH Improvement Mgr.	NPAIHB	
3	Colleen Bird	Suquamish Tribe	360 [illegible]
4	Greg Abrahamson	[illegible]	[illegible]
5	Lisa Guzman	Healthcare Advocate Kalispel Tribe	509-789-7617
6	Holly Fenton	The Tulalip Tribes	360-425-4188-7723
7	Lavette Lane	Sauk-Suiattle Tribe	360-436-0131 ext 223
8	Brigid Cahill	NPAIHB	
9	Nicole Hernandez	Lummi Nation	2382715233
10	Jessica Leston	NPAIHB	
11	Colbie Caughlan	NPAIHB	
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NPAIHB Quarterly Board Meeting
Public Health & Behavioral Health Committees
January 23, 2013

Agenda Topics:

1. **VA MOU Concerns**
    - What mental health services are reimbursable for Tribes?
    - What level of provider must a clinic have in order to get full reimbursement?
        - Some Tribal clinics do not have a psychologist or psychiatrist so will they be ineligible for the reimbursements? Would tele-health be possible so that clinics without psychologists or psychiatrists could tele-conference with those providers but have their counselor's carry out the plans?
    - How many visits can a Vet have before their visits are not covered anymore?
    - Can the Board assist with developing language for Tribes to create their own MOUs with the VA? Maybe have a template for each NW Tribe to use so that the MOUs are similar but cater to each Tribe's specific needs? Maybe check out Alaska Tribes' MOUs as examples?
    - Can we get VA psychiatrists or psychologists stationed at Tribal clinics?
    - Have any Tribal clinics in the NW been successful at getting staff trained to the VA standards in order to be reimbursed at the highest rate?

2. **Medicaid Reimbursement Agreements Concerns**
    - These agreements do not seem to fit how the Tribal Clinics operate. Can the Board look into these agreements?
    - Does the language of these agreements match the needs of Tribal Clinics?
    - Can the Board research what is included in the agreements? What is reimbursable under Behavioral Health i.e. PTSD and A&D treatment?

3. **Autism in children**
    - What is the research? Have the rates of autism in children in the NW been increasing?
    - Will the Board bring in a trainer or presenter to a future QBM to educate us about the autism spectrum?
    - There is a lot of talk about autism and immunizations having a correlation and we would like to know more about the pros and cons studies.
    - Can the Board find out if it is CMS and/or WA state that is taking autism and ADHD off of the Dx list for mental health disabilities?
    - What is the prevalence of autism in Indian Country? Is it underreported? If so, why? Are our physicians aware of how to diagnose autism correctly?
    - How do we teach our communities, educators, and clinical services about autism and how to approach the various types?

- Literature or resources about what a parent/guardians rights are for their child who is living with autism. We need Advocacy!
- Does PAO IHS have a psychiatrist or any social workers, i.e. in the past they had Dr. Gregory or Connie Hunt, to help with these questions.

4. **Pill addictions and the use of suboxone as treatment**
   - Many Tribes have been successful with this include Swinomish (presentation at one of the last 2 QBMs).
   - Have there been more successes?
   - We would like a presentation or training on suboxone vs. methadone and how to deal with overall pain management and pill seekers.
   - There was a great presentation at the last IHS Clinical Director's meetings – maybe we could get that presenter to come out? (Tom Weiser or Jessica Leston can help identify this presenter)
   - Concern that pill seeker community members have become very vocal and political within the Tribe about pointing out certain doctors and trying to get them reprimanded or fired. These are the doctors that have denied these people's request for more pain pills. How do we address this in the community and put a stop to it.

5. **WA and CO Marijuana laws**
   - Anyone know if there will be research coming out about whether the new legalization laws correlate with increases of other drugs in peoples' systems or not.

6. **Adolescent Health Action Plan**
   - PRT and THRIVE staff brought the 2nd draft of the Adolescent Health Action Plan and asked committee members to review and comment on the plan. This plan will help guide the adolescent health projects at the Board over the next 5 years.

Personnel Committee

Tuesday January 22, 2013
WildHorse Resort, Pendleton, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Cassandra Rich	Confed Tribes	360-613-1243
2	[illegible]	CTUIR	541-969-8429
3	MARTIN Estrada Health Director	Skokomish	mestrada@skokomish.org
4	Jacqueline Left Hand Bull	NPAIHB Site	
5	Bobby Puffin H.R. Coordinator	NPAIHB	
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Northwest Portland Area Indian Health Board
Quarterly Board Meeting
Personnel Committee
January 23, 2013

Present:
Cassandra Sellards-Reck, Chair
Shawna Gavin, Member

Bobby Puffin, Human Resources Coordinator
Jacqueline Left Hand Bull, Administrative Officer

Martin Estrada, pending Delegate

Decisions:

The Personnel Committee reviewed the Financial Conflict of Interest Policy to be considered for inclusion in the Program Operations Manual and posted on the NPAIHB website.

- Motion: Recommend presenting the draft policy to the Board Delegates for approval, with the provision that it will be reviewed and approved by legal counsel for correctness.
  Vote: Unanimous approval.

The Personnel Committee reviewed decisions made at the October 2012 QBM, and made the following decisions:

- Bobby will continue to research policies from other organizations to prepare to recommend to the Committee a revision of the NPAIHB's policy on Returning Employment, page 8 in the POM, to allow employees who leave the Board to pursue a degree to retain full tenure while they are in school, and have their tenure reinstated when they return to work for the Board. He will present his findings to the Committee at the April QBM.

- Bobby will organize and implement an Employee Satisfaction Survey with NPAIHB employees by the middle of March 2013, and will present the results to the Committee about a month before the April 16th QBM.

Adjourned: 12:45 p.m.

Legislative/Resolution Committee

Tuesday January 22, 2013
WildHorse Resort, Pendleton, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Paul Chairman Baller	Quinault	pballer@quinaultnation.com
2	Cheryle Kitsap	SUQUAMISH	ckitsap@suquamish.nsn.us
3	Leslie Wosnig	Suquamish	LWosnig@suquamish.nsn.us
4	Tim Gilbert	Yellowhawk	timgilbert@yellowhawk.org
5	TanyaMcElfresh	Nimiipuu Health	tanyam@nimiipuu.org
6	Sal Sahme	Warm Springs	ssahme@gmail.com
7	John Stephens	Suquamish	JStephens@suquamish.nsn.us
8	Jack Fox	Port Gamble S'Klallam	360 710 0728 efax@pgst.nsn.us
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Legislative Committee Meeting
January 23, 2013

In attendance:
Victoria Warren-Mears, Staffing
Pearl Capoeman Baller
Cheryl Rasar
Leslie Wosnig
Tim Gilbert
Tanya McElfresh
Sal Sahme
John Stephens
Ed Fox

Primary Actions:
Approval to forward resolution for vote of Board regarding: **"Recommendation that CDC Administrator Rescind the CDC Tribal Consultation Policy adopted on January 8, 2013 and send the Proposed Policy out for Tribal Consultation"**

The NIHB letter was presented to the Legislative Committee, with time provided to review letter.
Pearl stated that CDC is correct that tribal leaders are important to the voice of issues, but tribal leaders also count on technical input from knowledgeable staff.
The Legislative committee suggested a cc to President Obama, since there is an Executive Order related to consultation with tribes. It was stated that this is a political issue. The Legislative committee is supportive of the letter, stating that the intent is strong and we should take a position likewise.
This is a political issue.
The resolution prepared by Jim Roberts with regard to this letter was reviewed in the committee.
Motion and second to approve resolution as written. Motion carried. Motion to be forwarded to the entire Board for voting.

Round table:
Need feedback from Tribes on Priority Issues.

PFAC – don't set it on the back burner
Suggest that we request proceeding with the last request for funding with governance and funding for the regional site. Especially with ACA and Medicaid reimbursement potential. Business plan did not have revenue included, and should be revised to include revenue projectionsShould put this on the PFAC agenda.

ACA and Medicaid expansion – where are all the tribes on this? Rolling up. Moving forward at Warm Springs. WA state has had a number of meetings. WA state has funds – Lummi, Tulalip and another tribe were visited. Most tribes are speaking of access to exchange. Need to think about how premiums are worked. More tribal expansion. Can we get more information for those who have not been at trainings? Jim and Joe can be invited to Nez Perce.

TA to Tribes: Contracts with QHPs: Working out contracts with QHPs – is negotiation done singularly or in multi-tribal situations. Large insurers are working out ways to gain advantage in tribal contracting.

This is a priority topic. Cannot use state money to do this. (AIHC) – Board can fill a role here in contract negotiation. Legal assistance and administrative issues which are tribal specific. TA role for NPAIHB.
WA state insurance commissioner – Certify health plans if provide help to tribes.
Tribes cannot meet with plans – against anti trust rules. Insurance commissioner can call meeting and include all parties.

Statutory protections in law – specific legal assistance to help tribes.
For Idaho and Oregon, WA legislature said premium sponsorship was law. Will Idaho allow tribes to sponsor premiums. Tribes, churches and unions can sponsor premiums.

Idaho questions must be moved on quickly. Late summer is the timeline.
Go-live on line is September. Oregon has state tribal liaison. WA has an open position at HCA, AIHC, Insurance Exchange, and Medicaid.
Idaho's HIE does not have tribal representative of concern.

Have tribal clinics been contacted by carriers? Some contact. Limited Swinomish – has not been contacted. Cowlitz was early. Non-disclosure about rates. May benefit from Boards legal assistance. Multi-tribal negotiations. May need to have Hobbs – Strauss (or other appropriately chosen attorney[s]) work on this issue for all Tribes. NPAIHB should explore the best attorney group for the job.

User Population:
Discussion good, but increased more questions than gave answers. Significant issues exist with NDW. Inconsistent data in leads to inconsistent data out. Regional differences are more intense. Rational use of data is different in all areas. Use of data is for resource allocation. Huge issues between NW and other areas due to lack of specialty care. Conflicts persist.

Some areas are double counted. Unduplicated counted in this area. Duplicated count.
Part of the solution required identification of inconsistent application of policy in some areas.

Marginal area improvements could be obtained however, they would be small within area compared to national. Questions to consider: How much new and additional money is there? What is the return to the Area to push for active discussion? If not more money people may be more willing to negotiate.

Opiate replacement clinic – daily clinic with direct therapeutic observation. Swinomish is doing this. One doctor for suboxone comes in once a week. Additional counselors have been hired. Suquamish has done suboxone for quite a few years. Each member of the committee with treatment option would do this again if they had the opportunity. People have anecdotally become employable who were unable to function adequately. It is worthwhile to save families. 30+ families at Swinomish. CTUIR does not do suboxane. Tougher policies for access. Connection between clinical directors meeting and health directors meetings. Is it time to bring the two together. Could ask Jon and Cheryl to present their program at a QBM.

Needs:

- Hospitals to go "oxy-free"
- ER policy and capitation
- Mock policies

Could NPAIHB gather and analyze existing "pain management" or equivalent policies? Would be useful to discuss.

National Indian Health Board

DRAFT LETTER

January 17, 2013

Thomas R. Frieden, MD, MPH
Centers for Disease Control
Administrator, Agency for Toxic Substances and Disease Registry (ATSDR)
United States Department of Health and Human Services
1600 Clifton Road
Atlanta, Georgia 30333

RE: CDC Tribal Consultation Policy and Tribal Advisory Committee

Dear Dr. Frieden:

I am writing on behalf of the National Indian Health Board (NIHB) to express our deepest concerns regarding recent actions of the Center for Disease Control and Prevention (CDC) regarding tribal consultation and the reformation of the Tribal Advisory Committee (TAC). [1] We are extremely disappointed that you signed a revised Tribal Consultation Policy notwithstanding the fact that the members of the TAC had in open session voiced concerns about the policy and rescinded by a majority vote the action of the TAC taken in a closed session to adopt the new consultation policy. For reasons we discuss in greater detail below, we request that you

1. suspend operation of the CDC/ATSDR Tribal Consultation Policy (TCP), as updated January 8, 2013, and restore operation of the policy of the same name, as issued October 18, 2005, until CDC conducts formal consultation regarding the revisions; and
2. maintain membership on the TAC as provided in the 2005 TCP, including representatives of national tribal organizations, until such time as it has been the subject of formal tribal consultation; and
3. honor the government to government relationship and the processes established to maintain foundational trust between the tribes and the US government.

TRIBAL CONSULTATION

At the last TAC meeting held in Connecticut in August 2012, the 2005 TCP, and proposed revisions to it, were discussed in a closed session of the TAC. Apparently a vote to adopt revisions to the 2005 TCP occurred in that closed session. During the same meeting, but after the closed session, the majority of members of the TAC rescinded that action adopting the revisions. Members speaking in favor of rescinding the action adopting the revisions spoke to the fact that they had not been able to adequately inform the tribes in their areas about the proposed changes, certain provisions in the policy and the fact that the vote occurred in a closed session.

When Tribal consultation requirements are considered the discussion principally centers around the requirements of the Presidential Executive Orders and Memoranda on the issue. Tribal consultation policies are supposed to fulfill certain fundamental principles with regard to formulating or implementing policies that have tribal implications:

[1] The TAC is referenced as the Tribal Consultation Advisory Committee (TCAC) in the CDC's 2005 Tribal Consultation Policy. For ease of communication, we are using the newly adopted title of Tribal Advisory Committee or TAC.

> (a) The United States has a unique legal relationship with Indian tribal governments as set forth in the Constitution of the United States, treaties, statutes, Executive Orders, and court decisions. Since the formation of the Union, the United States has recognized Indian tribes as domestic dependent nations under its protection. The Federal Government has enacted numerous statutes and promulgated numerous regulations that establish and define a trust relationship with Indian tribes.
>
> (b) Our Nation, under the law of the United States, in accordance with treaties, statutes, Executive Orders, and judicial decisions, has recognized the right of Indian tribes to self-government. As domestic dependent nations, Indian tribes exercise inherent sovereign powers over their members and territory. The United States continues to work with Indian tribes on a government-to-government basis to address issues concerning Indian tribal self-government, tribal trust resources, and Indian tribal treaty and other rights.
>
> (c) The United States recognizes the right of Indian tribes to self-government and supports tribal sovereignty and self-determination.[2]

"'Policies that have tribal implications'"

> "Policies that have tribal implications" refers to regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effects on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.[3]

In our view policies about how an agency of the United States government will consult with tribes is quintessentially a matter that falls within this definition, particularly for an agency like CDC.

As important as these Presidential policies are, it is important to note that Tribal consultation is not merely a matter of policy. It is, in fact, a matter of law. On March 22, 1995, the President signed into law the "Unfunded Mandates Reform Act of 1995" (hereafter "Unfunded Mandates Act").[4] It has only three provisions:

> (a) requires "an effective process to permit elected officers of State, local, and tribal governments (or their designated employees with authority to act on their behalf) to provide meaningful and timely input in the development of regulatory proposals containing significant Federal intergovernmental mandates."
>
> (b) creates an exemption from FACA for meetings between "Federal officials and elected officers of State, local, and tribal governments" or their designated employees; and
>
> (c) required the President to issue "guidelines and instructions to Federal agencies for appropriate implementation of subsections (a) and (b)".[5]

OMB issued the required guidelines on September 29, 1995.[6] They should be studied in close detail with regard to the matters addressed in this letter. Among the guidelines, however, of special relevance to the discussion of the need for tribal consultation regarding the consultation policy, is this provision:

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[2] Executive Order 13175, Sec. 2, 65 Fed. Reg. 67249 (November 9, 2000).
[3] *Id.*, Sec. 1(a).
[4] Originally enacted in Pub. L. 104-4, codified at 2 U.S.C. § 1534.
[5] The function of issuing guidelines was delegated by the President to the Office of Management and Budget (OMB). *Memorandum of President of the United States*, Aug. 25, 1995, 60 Fed. Reg. 45039.
[6] 60 Fed. Reg. 50651-4 (hereafter "OMB Guidelines").

> Each agency needs to develop an intergovernmental consultation process for that agency. ***To do so, the agency should first develop a proposal for that process, and consult with State, local, and tribal governments (as appropriate) concerning this proposed process***, as soon as possible.[7]

The decision to adopt the revised CDC TCP without having sent it out for prior consultation may have seemed expedient, but it violates not only the fundamental principles articulated in the Executive Order, is inconsistent with the Department of Health and Human Services (HHS) Tribal Consultation Policy and the practice of the Secretary Sebelius when she was implementing that policy in 2010. She wrote to every tribe in the nation seeking comments regarding on the proposed HHS TCP and held regional meetings to obtain further feedback before ultimately adopting the HHS TCP, but also the OMB guidelines for compliance with the Unfunded Mandates Act. No meaningful argument is available that there was a compelling need to adopt the revisions to the CDC TCP without engaging in prior tribal consultation since there was a policy in place that CDC could continue to follow in the meantime, enhanced to the extent necessary by the HHS TCP provisions.

The CDC has failed to sufficiently correspond (per a poll with TAC membership) with Tribes about the proposed revisions, as provided for in the HHS TCP,[8] and incorporated by reference in the CDC TCP you signed January 8, 2013,[9] the CDC undermines any confidence tribal leaders could have in the agency's commitment to fulfilling the purposes of the consultation policy or that it will seek comply with its own policies on matters of peculiarly within the purview of CDC. Trust is an essential component of strengthening government-to-government relationships.

Given the responsibilities of the CDC with regard to prevention and control of communicable diseases and other diseases, injuries and disabilities, any evidence that CDC fails to take its obligation to consult seriously, or perhaps to understand what that means, is of grave concern. Throughout the country, there are Indian elders who still remember the effects of epidemics that swept through their communities disrupting and destroying families and all semblance of normal life. Fear of being experimented on or ignored while efforts are focused elsewhere are still present in a very real way. A close and respectful working relationship between tribes and CDC is critical to overcoming these memories and fears, and to building a partnership that can extend the reach of CDC's positive work into rural areas were tribal governments may have the only meaningful infrastructure for response to natural and manmade disasters.

While it may seem insignificant, failure to consult regarding the policy on consultation, looms large with us. It brings into doubt the training and commitment of staff and leadership.
As President Obama said in his *Memorandum for the Heads of Executive Departments and Agencies*,

> History has shown that failure to include the voices of tribal officials in formulating policy affecting their communities has all too often led to undesirable and, at times, devastating and tragic results. By contrast, meaningful dialogue between Federal officials and tribal officials has greatly improved Federal policy toward Indian tribes. Consultation is a critical ingredient of a sound and productive Federal-tribal relationship.[10]

CDC should prove its understanding of this and its commitment to complying with the plain meaning and intent of the Unfunded Mandates Act and to fulfilling the principles underlying tribal consultation until it has sought and considered the outcome of meaningful consultation with all tribes regarding the revised tribal consultation policy.

Tribal Advisory Committee

The 2005 CDC TCP provided for a Tribal Consultation Advisory Committee (TCAC) composed of 15 members, including one from each of the 12 areas based on the Indian Health Service (IHS) Area Office structure, and 3 "representatives

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[7] *Id.* at 50652 (emphasis added).
[8] HHS TCP, Sec. 8.A.
[9] Sec. 3.A.
[10] p. 1 (November 5, 2009).

of national tribal organizations that have been designated by tribal leaders to act on their behalf."[11] Under these rules, the National Indian Health Board, National Congress of American Indians, Direct Service Tribes and Tribal Self-Governance Advisory Committee members all were "principal members' of the TAC. Under the revised 2013 CDC TCP all the detail about membership on what is now referred to as the Tribal Advisory Committee (TAC) has been deleted. A Charter for the CDC TAC is available on the CDC website that fails to identify membership or selection directly, but says

> The TAC will provide a forum for meetings between Federal officials and elected or appointed Tribal leaders (or their designated employees with authority to act on their behalf); as well as representatives of national Tribal organizations designated by Tribal leaders to act on their behalf, in compliance with exemptions to FACA.[12]

As of today's date, the current membership of the TAC does not appear on the CDC website even though a meeting is scheduled for February 5, less than three weeks from now.

We believe it is critical that when the meeting occurs in February all seats, including the national organization seats, be filled and that the individuals in them are the designees of those organizations. But, at this moment we are completely unsure about the status of membership. The Board members of the National Indian Health Board (NIHB), had designated its chair, Cathy Abramson, Councilwoman of the Saulte Ste. Marie Chippewa, to be the member of the CDC, and her designee is the NIHB Executive Director. The Executive Director received a November 30, 2012, letter thanking her for her service on the CDC TAC, and, although it did not say so directly, seemed to suggest that she would no longer be serving on the TAC.[13] Moreover, to date, NIHB has not received any new request for an appointee even though the Charter, cited above, references national organizations. We assume NIHB's appointee (or her designee) will be welcomed as a member of the TAC at the February meeting, but to date there is no indication of that from the CDC staff responsible for this meeting.

We are aware that the Federal Advisory Committee Act (FACA)[14] is often cited as a justification for limiting membership on various federal committees, however, we believe such limitations are misplaced. First, the exemption from FACA, found at 5 U.S.C. § 240(b)[15] provides an express exemption from the application of FACA for meetings "between Federal officials and elected officers of State, local and Tribal governments (or their designated employees with authority to act on their behalf" acting in their official capacities". Additionally, this was addressed directly in the OMB Guidelines, which provided direction about with whom agencies should consult and how the FACA exemption should be applied.

In its discussion of "With Whom Should Agencies Consult," OMB Instructed that

> An agency will be able to obtain the fullest range of meaningful input from State, local, and tribal governments by undertaking the following kinds of consultation.
>
> (1) Heads of Government
>
> Agencies should seek to consult with the highest levels of the pertinent government units, e.g., the Office of the Governor, Mayor, or Tribal Leader (or their designated employees with authority to act on their behalf). These officials are the ones elected to represent the people and are the ones that the public holds directly accountable for the actions of those government units.
>
> (2) Both Program and Financial Officials

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[11] 2005 CDC TCP, Sec. VIII.B.

[12] CDC, Charter, updated November 20, 2012 (http://www.cdc.gov/tribal/TCAC/charter.html) (downloaded 1/16/13).

[13] We understand that other regional representatives received the same very ambiguous letters.

[14] 5 U.S.C. App. 2

[15] Enacted in the Unfunded Mandates Reform Act, Pub. L. 104-4, Sec. 204, March 22, 1995, (codified at 2 U.S.C. § 1534(b).

Many regulatory agencies have functional counterparts in State, local, and tribal governments, e.g., those government officials who implement or enforce regulatory responsibilities required in whole or part by the Federal agency. These local officials tend to be
those most familiar with the Federal agency's regulatory program, and should be consulted as a source of important information concerning the likely effects of, or effective alternatives to, Federal
regulatory proposals.

In addition, agencies should consult with those State, local, and tribal officials most directly responsible for ensuring the funding of compliance with the Federal mandate, e.g., the applicable treasury, budget, tax collection, or other financial officials. These officials are institutionally responsible for balancing the competing claims for scarce State, local, or tribal resources.

(3) Washington Representatives

It is also important that Federal agencies consult with Washington representatives, where available, of associations representing elected officials. These Washington representatives often know which local elected officials are the most knowledgeable about, interested in, or responsible for, implementing specific issues, regulations or programs, and can ensure that a broad range of government officials learn of and provide valuable insight concerning a proposed intergovernmental mandate.

(4) Small Governments

Agencies should make special efforts to consult with officials of small governments, and to develop a plan for such consultation under section 203 of Title II of the Act. Agencies may wish to consider several mechanisms for reaching small governments, including special task forces, periodic mailings through small government associations, or communication through rural
development councils.[16]

OMB elaborates on the role of Washington representatives in its discussion of the FACA exemption in addition to providing direction about the legislative intent underlying the exemption.

In order to facilitate the consultation process, section 204(b) of the Act provides an exemption from the Federal Advisory Committee Act ("FACA") (5 U.S.C. App.) "for the exchange of
official views regarding the implementation of public laws requiring shared intergovernmental responsibilities or administration."

This exemption applies to all Federal agencies subject to FACA, and is not limited to the intergovernmental consultations required by Section 204(a) but instead applies to the entire range of intergovernmental responsibilities or administration. ***In accordance with the legislative intent, the exemption should be read broadly to facilitate intergovernmental communications on responsibilities or administration.***

This exemption applies to meetings between Federal officials and employees and State, local, or tribal governments, acting through their elected officers, officials, employees, ***and Washington representatives***, at which "views, information, or advice" are exchanged concerning the implementation of intergovernmental responsibilities or administration, including those that arise explicitly or implicitly under statute, regulation, or Executive order.

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[16] OMB Guidelines at 50652 (emphasis added).

> ***The scope of meetings covered by the exemption should be construed broadly*** to include any meetings called for any purpose relating to intergovernmental responsibilities or administration. Such meetings include, but are not limited to, meetings called for the purpose of seeking consensus; exchanging views, information, advice, and/or recommendations; or facilitating any other interaction relating to intergovernmental responsibilities or administration.[17]

Rather than a narrow and constricting view of how consultation should occur and the breadth of the FACA, OMB, acting for the President and consistent with Congressional intent, clearly directs a broad construction favoring exemption from FACA and inclusion of a range of State, local and tribal elected leaders and officials (or their designees) and their Washington representatives. This certainly suffices as both authority for, and a mandate to, encourage the Washington-based organizations that represent tribes to be members of the TAC.

Conclusion

The role of CDC is an essential one for all of the United States and for all tribes. We are bewildered by the turn in the relationship between CDC and the tribes and their Washington representatives toward what appears to be CDC dictating outcomes to tribes, rather than soliciting their advice and consultation on all matters with tribal implications, including the process by which consultation with them will occur. We hope that you will act to reverse this course prior to the February 5 TAC meeting (1) by ensuring that all members who were seated on the TCAC are invited and allowed to fully participate (unless, of course, the Area or organization they represented has substituted in writing a new member), and (2) by suspending your January 8, 2013, approval of the revisions to the CDC TCP, until it has been subjected to full, formal tribal consultation.

Thank you for consideration of this request.

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[17] *Id.* at 50653 (emphasis added; footnotes deleted).

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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Resolution #13-02-01
Recommendation that CDC Administrator Rescind the CDC Tribal Consultation Policy Adopted on January 8, 2013 and Send the Proposed Policy Out for Tribal Consultation

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the NPAIHB is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

WHEREAS, the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) adopted a Tribal Consultation Policy under the guidance of the HHS Tribal Consultation Policy on October 15, 2005. The purpose of the CDC/ATSDR Tribal Consultation Policy is to establish a meaningful consultation and collaborative process with Tribal governments and their representatives to meet with CDC on a government-to-government basis before any policy action is undertaken that will have significant effect on Indian Tribes; and

WHEREAS, the Obama Administration has committed to regular and meaningful consultation and collaboration with tribal officials in policy decisions that have tribal implications and issued a Whitehouse Memorandum, "Guidance for Implementing E.O. 13175, "Consultation and Coordination with Indian Tribal Governments" to all Executive Agencies; and

WHEREAS, the CDC Tribal Consultation Policy establishes the CDC Tribal Consultation Advisory Committee (TCAC) to "...provide a complementary venue wherein tribal representatives and CDC staff will exchange information about public health issues in Indian country..." and later describes that the "...TCAC will support, and not supplant, any other government-to-government consultation activities that CDC undertakes..."; and

WHEREAS, CDC recently adopted a revised Tribal Consultation Policy despite the fact that the members of the TCAC had recommended to CDC that the revised Tribal Consultation Policy not be adopted by the CDC Administrator and that the proposed Policy should be sent out for Tribal Consultation in order to obtain Tribal leader comments and recommendations on the

proposed changes. This action was recommended pursuant to the pending CDC Tribal Consultation Policy and the HHS Tribal Consultation Policy and is consistent with past Department and Agency practice prior to finalizing and adopting revisions to tribal consultation policies (see HHS, IHS, CMS, SAMHSA, etc.); and

NOW THEREFORE BE IT RESOLVED, that it is the position of Northwest Tribes that CDC is out of compliance with its Tribal Consultation Policy and the HHS Tribal Consultation Policy and that the revised CDC Tribal Consultation Policy effective January 8, 2013, should be rescinded until a formal Tribal Consultation process can be followed that will allow for broader Tribal leader input on the proposed changes to the Policy.

BE IT FURTHER RESOLVED, the input and recommendations developed by the CDC-TCAC should not ever supplant any government-to-government consultation activities that CDC is responsible to undertake under Executive Order 13175, the HHS Tribal Consultation Policy and most importantly, pursuant its own CDC Tribal Consultation Policy. The proposed changes to such an important document as the CDC Tribal Consultation Policy must be vetted among all federally-recognized Tribes and respectful of the United States government-to-government relationship with Tribal governments.

BE IT FINALLY RESOLVED, that the NPAIHB and its forty-three member Tribes located in Idaho, Oregon, and Washington respectfully request the CDC Administrator to suspend operation of the January 8, 2013 CDC Tribal Consultation Policy and restore operation of the Policy established October 15, 2005, which was developed with the opportunity for input from all federally-recognized Tribes in the United States.

CERTIFICATION

NO. 13-02-01

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 29 **for, _____against, _____abstain on** Jan. 25, 2013.

Andrew C. Joseph Jr.
Chairman

1-25-13
Date

Secretary

NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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Resolution #13-02-02

Recommendation that a Financial Conflict of Interest Policy be Added to the Program Operations Manual and Posted to the NPAIHB Website, in Order to Comply with Federal DHHS Regulations Impacting Grantees and Contractors

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the NPAIHB is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the NPAIHB dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

WHEREAS, the NPAIHB Tribal Epidemiology Center receives funds from agencies in the federal Department of Health and Human Services for projects that include research components with a purpose of providing various health data to participating tribe in support of the primary goal; and

WHEREAS, the Congress has passed a regulation regarding financial conflict of interest in research funded by the Department of Health and Human Resources that took effect in August 2012; and

WHEREAS, the new regulation requires that all contractors and grantees doing research must have a policy regarding financial conflict of interest containing specific items such as Investigator disclosure of such conflict of interest, reporting of the conflict of interest, a plan for addressing such conflict, and the posting on a publicly accessible website the policy and any conflicts of interest; and

WHEREAS, the NPAIHB maintains a Program Operations Manual that contains Personnel Policies that already include a policy regarding Research Misconduct, and the Program

Operations Manual would be the appropriate place to include a financial conflict of interest in research policy; and

WHEREAS, the NPAIHB maintains a website that is accessible to the public and that website already posts organization documents, including the Program Operations Manual; and

WHEREAS, the NPAIHB Personnel Committee has reviewed a draft conflict of interest in research policy prepared by staff, per the NPAIHB requirements of any changes in the Program Operations Manual

NOW THEREFORE BE IT RESOLVED that the draft policy reviewed by the Personnel Committee be added to the Program Operations per its decision of January 23, 2013.

CERTIFICATION

NO. 13-02-02

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 29 **for, _____ against, _____ abstain on** Jan. 25, 2013.

Andrew C. Joseph Jr.
Chairman

1-25-13
Date

Secretary