The American Indian Health Commission for Washington State:

A Model for Tribal-State Collaboration

March 2004

Suggested Citation

Johnston, Rebecca Donovan. The American Indian Commission for Washington State: A Model for Tribal-State Collaboration. Seattle, WA: American Indian Health Commission for Washington State, 2004.

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Funding Source

This project was funded by the U.S. Department of Health and Human Services, Indian Health Service, Office of Self-Governance, through the Jamestown S'Klallam Tribe, Sequim, WA.

Introduction

In this time of shrinking federal and state discretionary dollars and the devolution of federal programs to the state and local levels, it is more important than ever that tribes and states work together to improve the health status of American Indians and Alaska Natives (AI/ANs). In Washington State, tribes and urban Indian health clinics have been working formally to advance tribal-state collaboration on the delivery of health care services for a decade.

The American Indian Health Commission for Washington State (AIHC) was created in 1994 following the enactment of sweeping health care reform legislation[1] in Washington State. Tribes, concerned about the Act's implementation, came together to guide their collective needs in ensuring the availability of quality and comprehensive health care to all American Indians and Alaska Natives in Washington State.

Today, AIHC is a model of tribal-state collaboration that may serve as a useful framework as tribes and states work toward forming partnerships on health care issues. This report is designed to serve as a toolkit and specifically:

- Outlines the steps taken by Washington tribes and urban Indian organizations to establish relationships with the state
- Describes the tribal-state model in terms of organizational structure, authority, and focus
- Identifies key components for success
- Lists successful linkages between state health programs and tribes

Where possible, resource documents have been included at the conclusion of the report narrative or as links in footnotes.

Framework for Tribal-State Relations in Washington State

Government-to-Government

The government-to-government relationship between tribes and the United States is unambiguous. Article I, Section 8 of the Constitution states that "the Congress shall have the power to . . . regulate commerce with foreign nations, and among the several states, and with the Indian tribes . . ." This fundamental principle recognizes the sovereign status of Indian nations and firmly establishes the government-to-government relationship between the United States and tribes. Since the formation of the United States to the present day, tribal sovereignty has been reaffirmed in numerous treaties, statutes, U.S. Supreme Court decisions, Executive Orders, and administrative policies.

Government-to-government relations are a fundamental principle in tribes' interactions with states, and developing and maintaining this interaction is an ongoing, two-way process.

[1] Much of the Health Services Act of 1993 was repealed in 1995.

Centennial Accord and New Millennium Agreement

In an effort to recognize and bolster the government-to-government relationship between Washington State and the federally recognized tribes located in the state, then-Governor Booth Gardner and tribal chairs signed the Centennial Accord[2] in 1989. The Centennial Accord states that:

> Each Party to this Accord respects the sovereignty of the other. The respective sovereignty of the state and each federally recognized tribe provide paramount authority for that party to exist and to govern. The parties share in their relationship particular respect for the values and culture represented by tribal governments. Further, the parties share a desire for a complete accord between the State of Washington and the federally recognized tribes in Washington reflecting a full government-to- government relationship and will work with all elements of state and tribal governments to achieve such an accord.

The intent of the Washington State Centennial Accord is to enhance and strengthen the government-to-government relationship that exists between the tribes and the state. In furtherance of this goal, it stresses the importance of state agencies and the legislative branch in working with tribes to develop and implement policy which affects tribal communities and Indian people.

In November 1999, Washington State tribal leaders and state officials reaffirmed and strengthened the Centennial Accord by signing the New Millennium Agreement.[3] This document moves state/tribal relations forward by setting more specific goals for mutual commitment. Due to a lack of substantive protocols or processes, agency-level implementation guidelines for the Centennial Accord were developed. These include information on background, consultation process, dispute resolution processes, structure for Centennial Accord Plans, and roles and responsibilities.

Under the Centennial Accord, the Governor directs each Washington State agency to "establish a procedure by which the government-to-government policy shall be implemented." Each agency's Centennial Accord Plan should include:

- Programs (list of programs and services available)
- Funding Distribution (funding methodologies developed in collaboration with tribes)
- Definitions (relevant terms as they apply to agencies)
- Consultation Process (procedures for policy and program development, as well as the implementation of funding distributions)
- Dispute Resolution Process

Each tribe also is encouraged to develop its own Centennial Accord Plan to "document a system of accountability" and to promote the government-to-government relationship with state agencies. Tribal plans should include:

- Tribal Resolution (policy statement on communicating with state agencies in the spirit of the Centennial Accord)

[2] http://www.goia.wa.gov/govtogov/centennial.html
[3] http://www.goia.wa.gov/govtogov/agreement.html

- Tribal Organization (list of key staff, policy contacts, and organizational structure)
- Decision-Making Process (process the tribe will use relevant to state agencies)
- Consultation (outline of tribal process for outreach to state agencies for tribal actions or initiatives that may affect state interests)

Agency-Level Centennial Accord Plans

There are four state agencies with significant responsibilities for health, and they each have had varying levels of participation in the Centennial Accord Plan process, as summarized in the following table.

	Key Responsibilities	Centennial Accord Plan[4]
Department of Health (DOH)	Public health, prevention programs, environmental health, bioterrorism, rural health, health professional licensing, numerous related programs	DOH published its first Centennial Accord Plan in 2001 and has updated it annually to reflect areas for further collaboration.
Department of Social and Health Services (DSHS)	Medicaid, mental health, chemical dependency treatment, social services, Indian policy support services, numerous "welfare" related programs	DSHS historically has had an administrative directive, issued by the Secretary and called Administrative Policy 7.01, which addresses how DSHS will work with tribes. 7.01 plans are written every other year and reviewed in the odd years. 7.01 plans, which are either statewide or regional, are more program-specific than Centennial Accord Plans, and there is wide diversity among the DSHS regions in terms of content and tribal participation during development.
Health Care Authority (HCA)	Basic Health Plan, state employees health purchasing, state funding for medical and dental community clinics	In 2003, HCA developed its first-ever Centennial Accord Plan and Consultation Policy in close collaboration with tribes and AIHC.
Office of Insurance Commissioner (OIC)	Patient's Bill of Rights, private health insurance plan regulation (excluding Taft-Hartley and self-insured employer plans)	OIC has not developed a Centennial Accord Plan and is not technically required to do so because the Insurance Commissioner is an elected position and therefore not subject to the Governor's directive.

[4] Current agency plans are available at http://www.aihc-wa.org/Resources/resources.htm#accord

American Indian Health Care Delivery Plan

In recognition of the health disparities facing AI/ANs, Washington State as part of its 1993 health care reform legislation authorized the Health Care Authority to develop an American Indian Health Care Delivery Plan (AIHCDP).[5] Upon repeal of the Act in 1995, responsibility for the plan was transferred to DOH under RCW 43.70.590, which states:

> Consistent with funds appropriated specifically for this purpose, the department shall establish in conjunction with the area Indian health services system and providers an advisory group comprised of Indian and non-Indian health care facilities and providers to formulate an American Indian health care delivery plan. The plan shall include:
>
> (1) Recommendations to providers and facilities methods for coordinating and joint venturing with the Indian health services for service delivery;
>
> (2) Methods to improve American Indian-specific health programming; and
>
> (3) Creation of co-funding recommendations and opportunities for the unmet health services programming needs of American Indians.

Since its first publication in 1997, the AIHCDP and its subsequent updates have been the result of active collaboration between tribes, tribal organizations, and DOH. Through the auspices of AIHC, tribes have been the driving force in the report's contents and scope.

The AIHCDP has several important objectives. It paints a picture of the current health status of AI/ANs in Washington using quantitative data so that progress can be benchmarked and areas in need of improvement can be identified. It also highlights successful strategies that tribes and the state have used to address health disparities in the AI/AN population. Finally, it lays out concrete recommendations and objectives developed over the biennium for tribal, urban health programs, and state policymakers.

"The disparity of health care coverage between Indian and non-Indian communities is extremely disheartening. AIHC has become an essential and effective model that has significantly improved the relationships between tribes and Washington State to address this gap through legislative and policy initiatives."

W. Ron Allen
Chairman
Jamestown S'Klallam Tribe

The most recent AIHCDP was published jointly by DOH and AIHC in July 2003. In the cover letter accompanying the report's release, DOH Secretary Mary Selecky and AIHC Chair Marilyn Scott reaffirmed the shared commitment to take positive steps toward improving the health status of AI/ANs in Washington State.

[5] http://www.aihc-wa.org/AIHCDP/aihcdp.htm

American Indian Health Commission for Washington State

History

Following enactment of sweeping health care reform legislation in 1993, tribes in Washington came together in an effort to ensure that the collective needs of tribal governments and Indian organizations were met as the Act was implemented statewide.

The DOH Office of Community and Rural Health provided a grant to the Squaxin Island Tribe to host a three-day Tribal Leaders Health Summit in August 1994. This meeting was attended by 15 of the 26 federally-recognized tribes, four of the eight unrecognized tribes, and eight Indian organizations, as well as by the Governor and key state agency directors. At the Summit's conclusion, participants determined that state health policy issues needed an ongoing tribal effort. "Probably one of the most crucial strategic planning concepts . . . was to develop a policy level advisory group. This group would not circumvent the sovereign authority of the tribal governments but would provide a forum . . . to communicate their views and concerns that pertain to health care."[6]

After the Summit, Jamestown S'Klallam Chairman W. Ron Allen wrote to each tribe in the state requesting that they review and comment on issue papers developed during the meeting and that they pass tribal resolutions in support of the American Indian Health Commission.

The initial AIHC meeting was held in October 1994 and the first issue discussed was whether the group should be an advisory committee to the state or a stand-alone organization. The group decided to form a separate commission with official delegates from each tribe. By-laws were developed over the next nine months, with one of the most difficult issues to resolve being commission membership because there were several non-federally recognized tribes and two urban Indian health clinics located in Washington State. Ultimately, the by-laws provided for six "at-large" seats – one for each of the two urban Indian health programs and up to four seats to allow for representation for individual AI/ANs living in Washington State.

Following a period of waning tribal and state participation in AIHC due to concerns that the group had lost some of its original focus and that it was becoming increasingly difficult to sustain the organization on an almost exclusively volunteer basis, in September 1997 the AIHC Executive Committee met with the Northwest Portland Area Indian Health Board and DOH to explore ways to strengthen AIHC and implement the AIHCDP. Several options were identified, including hiring a 0.5 FTE through DOH, developing an IPA-type agreement with a DOH epidemiologist, assembling a multi-disciplinary group, or contracting with the AIHC through a tribe.[7] The last option was agreed upon because it would allow for staff support and a more focused work effort, and subsequently DOH entered into a contract with the Jamestown S'Klallam Tribe. This contract, which has been renewed on a biennial basis, was subcontracted to the Northwest Portland Area Indian Health Board through June 2003 (the 2001 – 2003 biennium).

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[6] Molly Aalbue, Squaxin Island Planner, "Report on Tribal Leaders Summit," August 1994
[7] AIHC Executive Committee Minutes, September 9, 1997

In 2003, the Jamestown S'Klallam Tribe received funding from the Indian Health Service Office of Self-Governance to support the work of the AIHC as a model for tribal-state collaboration on health care issues. This funding has allowed AIHC to have a full-time staff member for the first time in its history and has contributed to recent growth in its activities and success.

Organizational Structure

The authority and strength of AIHC is derived from its member tribes and urban Indian health clinics. Of the 29 federally recognized tribes located in Washington, 25 have passed resolutions naming delegates to the Commission. In addition, the two urban Indian health clinics – the Seattle Indian Health Board and the N.A.T.I.V.E. Project – have at-large delegates, as does the Small Tribes of Western Washington, a tribal organization that includes non-federally recognized tribes.

An executive committee consisting of a chair, vice chair, secretary, treasurer, and at-large delegate is elected for a two-year term at the AIHC annual meeting. The chair or another executive committee member presides over AIHC meetings.

AIHC generally meets every other month for a half-day. Agenda topics focus on addressing opportunities and challenges for tribal-state collaboration. Meeting notices and agendas are posted to the AIHC website well in advance of the meeting date. The focus is on interactive discussion between AIHC members and presenters, with the goal of building bridges and resolving outstanding concerns. Discussion is open to delegates and to meeting attendees. Simple parliamentary procedure is followed when delegates take official action, though the emphasis is on reaching decisions through consensus.

Every other year, AIHC conducts a Tribal Leader's Health Summit, a 1.5 day meeting in which pressing tribal-state health issues are discussed and position papers are developed and modified. These position papers form the basis for the recommendations set forth in the AIHCDP and for AIHC priorities.

Tasks are delegated primarily to the AIHC staff director or to a volunteer member for follow-up. Minutes of all meetings are posted to the AIHC website within a week.[8]

Mission and Goals

The mission of the AIHC is to achieve unity and guide the collective needs of tribal governments in providing high-quality, comprehensive health care to American Indians and Alaska Natives in Washington State. Its ultimate goal is to improve the health status of American Indians and Alaska Natives by influencing state health policy and resource allocation through the promotion of increased tribal-state collaboration.

Key Activities

The following activities form much of the day-to-day work of the AIHC in carrying out its mission and goals:

[8] Meeting notices, agendas, and minutes are available at http://www.aihc-wa.org/Meetings/meetings.htm

- Identify health policy issues and advocate strategies to address tribal concerns
- Coordinate policy analysis
- Solicit and collect information from the state for tribal review and response
- Disseminate information to tribal health programs and leaders
- Promote the government-to-government relationship between tribes and state health programs

Components for Success

Over the years, AIHC has been a successful tool for establishing working relationships and effective partnerships between the tribes, urban Indian health clinics, and Washington State. There are a number of other critical components, some philosophical and some organizational, that have played a large role in AIHC's success. These ingredients are highlighted below.

Washington State and tribes have an existing framework for consultation and government-to-government relations.

The Centennial Accord and New Millennium Agreement are the cornerstones for tribal-state relations in Washington. Under the Accord, tribes and the state recognize and respect each other's respective sovereignty to exist and to govern. The purpose of the Accord and subsequent agency plans are to provide for improved service delivery and the resolution of issues of mutual concern. The Centennial Accord and New Millennium agreement create an atmosphere within state health agencies in which working with tribes is no longer an option or a unique circumstance.

AIHC exists within this broad framework for tribal-state relations. The Commission does not circumvent the sovereign authority of the tribal governments, but seeks unity among AI/AN health care providers. As such, AIHC makes it clear in its interactions with state agencies that, while the Commission is an appropriate venue for ongoing communication and coordination, consultation must be held with each tribe in accordance with the Centennial Accord.

AIHC is a tribally-controlled organization.

AIHC is tribally-controlled organization rather than an official state advisory committee, allowing it the flexibility it to work collaboratively and to partner with a wide range of public and private organizations, including Indian organizations, federal and state agencies, local governments, universities, and private and non-profit entities. As a tribal organization, AIHC takes its policies, priorities, and direction from – and is ultimately accountable to – the tribal political leadership in Washington State.

AIHC meetings allow for regular contact with state officials.

By convening every other month, AIHC delegates have the opportunity to address timely issues directly with state agency officials. This often allows for concerns and questions to be raised and addressed during the initial stages of the policy development and implementation process. It also

creates an atmosphere of accountability where delegates may request that agency officials return to the Commission with updates and resolution of issues by a date certain.

AIHC allows for timely, effective communication on issues of importance to tribal health programs.

In addition to its bi-monthly meetings, AIHC facilitates the coordination and dissemination of information to tribes, tribal organizations, and state officials through a number of database-driven tools, including broadcast fax, postal mail, and electronic list-serve. These tools have allowed for the regular distribution of issue papers, legislative and agency updates and alerts, and funding opportunities. Currently, several state health agencies turn to AIHC for assistance in distributing materials to tribal health programs because of the Commission's communications system.

AIHC's website, which receives more than 4,000 hits monthly, includes issue papers and policy analyses, legislative updates and tools, funding opportunities, and extensive links to tribal, state, and health care resources. Visitors also may sign up to receive electronic updates from AIHC for up-to-the-minute information about tribal-state health issues. Several tribes, tribal organizations, and state agencies have linked to the site, including the Northwest Portland Area Indian Health Board, National Congress of American Indians, Affiliated Tribes of Northwest Indians, Washington Department of Health, Washington Department of Social and Health Services, Washington Health Foundation, Jamestown S'Klallam Tribe, and Pechanga.net. Furthermore, the site is registered with major search engines, including Google, MSN, and Yahoo.

AIHC serves as a venue for ongoing collaboration with tribal leadership, state programs, and other Indian organizations.

AIHC executive committee members and staff provide formal and informal issue updates to tribes during quarterly meetings of the Northwest Portland Area Indian Health Board and the Washington Department of Social and Health Services Indian Policy Advisory Committee, as well as at Affiliated Tribes of Northwest Indians and Association of Washington Tribes gatherings.

"The Commission is a place where tribes and others – including state, federal, and community organizations – can share information to effectively meet the needs of tribal communities."

Mary C. Selecky
Secretary
Washington State Department of Health

In addition, AIHC executive committee members and staff have participated in large-scale and one-on-one meetings with officials from the Washington Department of Health, Medical Assistance Administration, Health Care Authority, Washington Health Foundation, Washington Dental Services Foundation, Portland Area IHS, Governor's Office of Indian Affairs, Fred Hutchinson Cancer Research Institute, Bastyr University, Northwest Regional Primary Care Association, University of Washington School of Public Health, State Board of Health, and Department of Health and Human Services Region X.

Successful Linkages

Using the strengths listed above, AIHC has been able to forge a number of linkages with state health agencies. One such ongoing collaboration, described earlier in this report, is the joint publication with DOH of the American Indian Health Care Delivery Plan each biennium. The AIHCDP provides important benchmark data and policy priorities, but is best seen as an evolving framework for the efforts by tribes and the State of Washington to address heath care issues. Some recent efforts that resulted in measurable success are outlined below.

Health Care Authority Centennial Accord Plan and Consultation Policy

At AIHC's 2002 Tribal Leaders Health Summit, a number of specific recommendations to enhance government-to-government relations were identified and endorsed. These recommendations later were adopted by tribal delegates at the Commission's 2002 Annual Meeting and were included in "Working Together: The 2003 American Indian Health Care Delivery Plan." Included was a policy priority that the AIHC work with agencies without Centennial Accord plans to identify issues of mutual concern and to assist them in developing plans.

AIHC throughout 2003 provided technical assistance to the Health Care Authority during the agency's development of its first-ever Centennial Accord Plan and consultation policy. At the Commission's May 16 meeting, HCA Acting Administrator Pete Cutler announced that the agency would be developing a Centennial Accord Plan and requested AIHC input during the process. At the September 12 AIHC meeting, HCA staff provided copies of the draft documents to all delegates and alternates, and AIHC staff subsequently mailed them to all delegates and alternates and posted them to AIHC's website for technical review. HCA adopted all comments received from AIHC members and staff, and Commission delegates on November 6 voted to endorse the distribution of the drafts to tribal leaders for review and comment. HCA then mailed the drafts to all tribal leaders and, receiving no additional comments, adopted both documents without further revision.

Emergency Preparedness Funding

AIHC always has been involved in promoting public health bridges between DOH and local health jurisdictions. These relationships will continue to develop as efforts to successfully prepare for and respond to public health crises strengthen the capacity of tribes to meet everyday public health needs.

The 2003 AIHCDP set forth a policy recommendation that AIHC should work to ensure that tribes have funding for community health assessments. At the July 2003 AIHC meeting, delegates discussed this critical need with John Erickson, Director of Washington State's Public Health Preparedness Program, and Suzanne Swadener, Assistant Director of the Northwest Center for Public Health Practice at the University of Washington.

As a result of this outreach and subsequent follow-up conversations between AIHC staff, DOH, the University of Washington, and the Northwest Portland Area Indian Health Board, DOH allocated $650,352 of its federal Health Resources and Services Administration grant to facilitate tribal needs

assessments and participation in regional planning activities. Of these funds, $510,500 is allocated for general tribal preparedness and $139,852 is allocated for tribal clinic preparedness.

At the January 9, 2004 meeting of the American Indian Health Commission for Washington State, delegates reviewed three funding distribution methodologies and adopted a recommendation that DOH distribute the funds using the consensus tribal allocation formula agreed to by tribes for the distribution of DOH tobacco program funds. The clinic funds are based on a modified version of this same formula. DOH also will allocate $35,000 of these HRSA funds for distribution to the Northwest Portland Area Indian Health Board EpiCenter for costs associated with conducting the preparedness assessments.

Sue Crystal Indian Health Act

Sue Crystal was a champion and friend of Washington's tribes. She had a profound understanding of the importance of health care for American Indian communities, and she had a special ability to bring divergent personalities and political interests together to unite for a common cause. Prior to her death from cancer in August 2001, Sue Crystal had served as administrator of the Washington Health Care Authority, a position she assumed after serving as Governor Locke's policy director and deputy policy director and as health and Indian policy advisor to former Governor Mike Lowry.

In November 2001, Senator Pat Thibaudeau approached AIHC to express an interest in developing legislation to honor Ms. Crystal's memory. At a joint meeting of AIHC and the State Board of Health in January 2002, various legislative options were discussed. Ultimately, tribes supported the concept of draft legislation to strengthen existing efforts between the state and tribes to work collaboratively on health-related issues.

The Sue Crystal Indian Health Act would codify the principles of the Centennial Accord and New Millennium Agreement for health-related state agencies and the Office of the Insurance Commissioner. While state law cannot mandate that tribes participate in these types of collaborative activities, the Sue Crystal Indian Health Act would provide a more structured approach for those tribes that choose to work with the state on joint initiatives. The legislation would encourage shared ownership of efforts to improve the health status of AI/ANs in Washington by laying out specific responsibilities for the Governor, state agencies, and tribes. It also would require the development of performance and outcome measures so that the state and tribes can build on successful policies and identify areas for improvement.

AIHC staff worked to secure support resolutions on the bill from the Northwest Portland Area Indian Health Board and the Affiliated Tribes of Northwest Indians.

The bill was introduced by Senator Thibaudeau on January 27, 2004 as SB 6608[9] and was cosponsored by Senators Rasmussen, Winsley, Prentice, Kohl-Welles. It was referred to the Senate Health and Long-Term Care Committee but was not considered before the Committee's cut-off date of February 6. Even though the bill did not advance beyond its initial committee referral in the short legislative session, its introduction helped to lay groundwork for its consideration in the upcoming 2005 session.

[9] http://www.leg.wa.gov/wsladm/billinfo/dspBillSummary.cfm?billnumber=6608

AIHC is working with Senator Thibaudeau to perfect the bill language for its reintroduction and to secure a House companion bill.

Medicaid Budget Cuts and Premiums

Prior to the 2003 legislative session, AIHC staff provided budget analysis and support to tribes regarding proposed cuts to health programs, including the possible elimination of adult dental, vision, and hearing services for adult Medicaid enrollees. AIHC estimated that, under the Governor's proposed budget, tribal health care providers would have lost at least $4.4 million and that more than 10,000 American Indians and Alaska Natives would have lost access to health care coverage under Medicaid.

AIHC worked successfully with MAA and legislators to include in the budget a provision instructing MAA to submit a waiver request to the Centers for Medicare and Medicaid Services (CMS) to exempt tribes from any optional Medicaid services that were eliminated as part of the budget, to the extent that the services are provided through the Indian health system and are covered under the 100% FMAP.

When the Legislature enacted its final 2003-2005 budget, it rejected the call to eliminate optional Medicaid services outright and instead imposed monthly premiums on children in higher-income Medicaid families. AIHC subsequently partnered with the MAA to request a Medicaid waiver that exempted AI/ANs from these premiums. CMS recently informed the state that it will be apply the strict scrutiny test under the Civil Rights Act of 1964 to the request and that it needs additional information from the state before making a final determination on this issue. AIHC continues to work with the state to seek a positive outcome.

State Board of Health Membership

When Joe Finkbonner, the first-ever American Indian to serve on the State Board of Health, resigned in late 2003, AIHC worked to recruit qualified AI/ANs to fill the vacancy and urged Governor Locke to appoint an American Indian to the post. As a result of these efforts, the Governor in February 2004 named Colville Tribal Council Member Mel Tonasket, a respected national and regional leader on Indian health and tribal sovereignty issues, to the Board.

Health Disparities Legislation

In January 2004, Senator Rosa Franklin introduced SCR 8419, [10] legislation to create a joint select committee on health disparities. The joint committee would evaluate and collect data, as well make specific recommendations for improving health status in communities of color.

Upon reviewing the draft proposal, AIHC recommended that a provision to ensure that tribes are afforded the opportunity provide input throughout the deliberative process, in keeping with the government-to-government relationship, be added to the bill. As a result, SCR 8419 requires the committee to request input from the American Indian Health Commission, as well as from the

[10] http://www.leg.wa.gov/wsladm/billinfo/dspBillSummary.cfm?billnumber=8419

Commission on African-American Affairs, the Commission on Asian Pacific American Affairs, and the Commission on Hispanic Affairs.

AIHC staff also provided technical comments on the bill to the Governor's Office of Indian Affairs prior to a hearing by the Senate Health and Long-Term Care Committee. As of the date of this report, SCR 8419 has passed the Senate and House.

Tobacco Settlement Funding

> *My experience with AIHC has been that this is a unique, culturally appropriate, and needed opportunity to meet face-to-face with information and updates, direct questioning, and sharing across tribal, county, and state agencies. The added benefit to collaboration via communication is that AIHC's web updates bring instant connectivity to emerging issues and news that impact American Indians and Alaska Natives.*
>
> *Emma Medicine White Crow*
> *Outreach Manager, Leader Engagement*
> *Washington Health Foundation*

When DOH received tobacco settlement funds, it approached AIHC for guidance on how to involve tribes in new activities. A delegate from AIHC was appointed to sit on the state tobacco committee. As a result of that representation and direct discussions with AIHC, DOH adopted a tribal distribution formula that was supported by the tribes and that helped to provide adequate base funding for both small and large tribes. Tribes applied to DOH for the funding in a non-competitive process that was streamlined to encourage funds to be spent on activities and limit administrative barriers and costs. The outcome of those efforts produced an impressive list of tribal activities with active participation by almost all tribes in the state.

In addition, DOH has developed a cooperative relationship with the Northwest Portland Area Indian Health Board to provide centralized functions such as training and technical assistance to tribes.

Patient's Bill of Rights

Since 2000, AIHC has worked with the Office of the Insurance Commissioner (OIC) to identify and resolve barriers that tribes and the Indian Health Service experience in contracting with health carriers (insurance plans and HMOs). There have been two major problem areas – contract language and credentialing.

A variety of obstacles to contracting, billing, and payment were resolved in 2001, when OIC adopted regulations[11] requiring all health plans to reimburse Indian health programs for the services they provide, even if they did not have a contract with the plan. The WAC also clarifies that carriers are not responsible for credentialing providers and facilities that are part of the Indian health system.

AIHC has worked with private plans and tribes to make sure clinics and programs receive third party reimbursement for their insured patients and has helped tribes resolve collection problems. [12]

[11] WAC 284-43-200(7), available online at http://www.leg.wa.gov/wac/index.cfm?fuseaction=Section&Section=284-43-200

[12] Sample collection problem letters and carrier contracts are available online at http://www.aihc-wa.org/Resources/patients_bill_of_rights.htm

Tribes have reported that, in most cases, the regulation has resulted in payment from private third-party payors. AIHC has posted to send to plans on its website, and implementation of this rule has been successful with the major carriers. If reimbursement cannot be resolved between a tribe and plan, OIC has agreed to intervene.

Resource Documents

- Washington Centennial Accord and New Millennium Agreement
- Centennial Accord Plans for the Department of Health, Department of Social and Health Services, and Health Care Authority
- American Indian Health Care Delivery Plan Executive Summary
- AIHC By-Laws
- AIHC Membership and Executive Committee
- 2003 – 2004 AIHC Meeting Agendas

Centennial Accord and New Millennium Agreement

CENTENNIAL ACCORD between the FEDERALLY RECOGNIZED INDIAN TRIBES in WASHINGTON STATE and the STATE OF WASHINGTON

I. PREAMBLE AND GUIDING PRINCIPLES

This ACCORD dated August 4, 1989, is executed between the federally recognized Indian tribes of Washington signatory to this ACCORD and the State of Washington, through its governor, in order to better achieve mutual goals through an improved relationship between their sovereign governments. This ACCORD provides a framework for that government-to-government relationship and implementation procedures to assure execution of that relationship.

Each Party to this ACCORD respects the sovereignty of the other. The respective sovereignty of the state and each federally recognized tribe provide paramount authority for that party to exist and to govern. The parties share in their relationship particular respect for the values and culture represented by tribal governments. Further, the parties share a desire for a complete accord between the State of Washington and the federally recognized tribes in Washington reflecting a full government-to- government relationship and will work with all elements of state and tribal governments to achieve such an accord.

II. PARTIES

There are twenty-six federally recognized Indian tribes in the state of Washington. Each sovereign tribe has an independent relationship with each other and the state. This ACCORD, provides the framework for that relationship between the state of Washington, through its governor, and the signatory tribes.

The parties recognize that the state of Washington is governed in part by independent state officials. Therefore, although, this ACCORD has been initiated by the signatory tribes and the governor, it welcomes the participation of, inclusion in and execution by chief representatives of all elements of state government so that the government-to-government relationship described herein is completely and broadly implemented between the state and the tribes.

III. PURPOSES AND OBJECTIVES

This ACCORD illustrates the commitment by the parties to implementation of the government-to-government relationship, a relationship reaffirmed as state policy by gubernatorial proclamation January 3, 1989. This relationship respects the sovereign status of the parties, enhances and improves communications between them, and facilitates the resolution of issues.

This ACCORD is intended to build confidence among the parties in the government-to-government relationship by outlining the process for implementing the policy. Not only is this process intended to implement the relationship, but also it is intended to institutionalize it within the organizations represented by the parties. The parties will continue to strive for complete institutionalization of the government-to-government relationship by seeking an accord among all the tribes and all elements of state government.

This ACCORD also commits the parties to the initial tasks that will translate the government-to-government relationship into more-efficient, improved and beneficial services to Indian and non-Indian people. This ACCORD encourages and provides the foundation and framework for specific agreements among the parties outlining specific tasks to address or resolve specific issues.

The parties recognize that implementation of this ACCORD will require a comprehensive educational effort to promote understanding of the government-to-government relationship within their own governmental organizations and with the public.

IV. IMPLEMENTATION PROCESS AND RESPONSIBILITIES

While this ACCORD addresses the relationship between the parties, its ultimate purpose is to improve the services delivered to people by the parties. Immediately and periodically, the parties shall establish goals for improved services and identify the obstacles to the achievement of those goals. At an annual meeting, the parties will develop joint strategies and specific agreements to outline tasks, overcome obstacles and achieve specific goals.

The parties recognize that a key principle of their relationship is a requirement that individuals working to resolve issues of mutual concern are accountable to act in a manner consistent with this ACCORD.

The state of Washington is organized into a variety of large but separate departments under its governor, other independently elected officials and a variety of boards and commissions. Each tribe, on the other hand, is a unique government organization with different management and decision-making structures.

The chief of staff of the governor of the state of Washington is accountable to the governor for implementation of this ACCORD. State agency directors are accountable to the governor through the chief of staff for the related activities of their agencies. Each director will initiate a procedure within his/her agency by which the government-to-government policy will be implemented. Among other things, these procedures will require persons responsible for dealing with issues of mutual concern to respect the government-to-government relationship within which the issue must be addressed. Each agency will establish a documented plan of accountability and may establish more detailed implementation procedures in subsequent agreements between tribes and the particular agency.

The parties recognize that their relationship will successfully address issues of mutual concern when communication is clear, direct and between persons responsible for addressing the concern. The parties recognize that in state government, accountability is best achieved when this responsibility rests solely within each state agency. Therefore, it is the objective of the state that each particular agency be directly accountable for implementation of the government-to-government relationship in dealing with issues of concern to the parties. Each agency will facilitate this objective by identifying individuals directly responsible for issues of mutual concern.

Each tribe also recognizes that a system of accountability within its organization is critical to successful implementation of the relationship. Therefore, tribal officials will direct their staff to communicate within the spirit of this ACCORD with the particular agency which, under the organization of state government, has the authority and responsibility to deal with the particular issue of concern to the tribe.

In order to accomplish these objectives, each tribe must ensure that its current tribal organization, decision-making process and relevant tribal personnel is known to each state agency with which the tribe is addressing an issue of mutual concern. Further, each tribe may establish a more detailed organizational structure, decision-making process, system of accountability, and other procedures for implementing the government-to-government relationship in subsequent agreements with various state agencies. Finally, each tribe will establish a documented system of accountability.

As a component of the system of accountability within state and tribal governments, the parties will review and evaluate at the annual meeting the implementation of the government-to- government relationship. A management report will be issued summarizing this evaluation and will include joint strategies and specific agreements to outline tasks, overcome obstacles, and achieve specific goals.

The chief of staff also will use his/her organizational discretion to help implement the government-to-government relationship. The office of Indian Affairs will assist the chief of staff in implementing the government-to-government relationship by providing state agency directors information with which to educate employees and constituent groups as defined in the accountability plan about the requirement of the government-to- government relationship. The Office of Indian Affairs shall also perform other duties as defined by the chief of staff.

V. SOVEREIGNTY and DISCLAIMERS

Each of the parties respects the sovereignty of each other party. In executing this ACCORD, no party waives any rights, including treaty rights, immunities, including sovereign immunities, or jurisdiction. Neither does this ACCORD diminish any rights or protections afforded other Indian persons or entities under state or federal law. Through this ACCORD parties strengthen their collective ability to successfully resolve issues of mutual concern.

While the relationship described by this ACCORD provides increased ability to solve problems, it likely will not result in a resolution of all issues. Therefore, inherent in their relationship is the right of each of the parties to elevate an issue of importance to any decision-making authority of another party, including, where appropriate, that party's executive office.

Signatory parties have executed this ACCORD on the date of August 4, 1989, and agreed to be duly bound by it commitments.

Institutionalizing the Government-to-Government Relationship in Preparation for the New Millennium

The work of the 1999 Tribal and State Leaders' Summit will be the foundation upon which our children will build. A stronger foundation for tribal/state relations is needed to enable us to work together to preserve and protect our natural resources and to provide economic vitality, educational opportunities, social services and law enforcement that allow the governments to protect, serve and enhance their communities.

The undersigned leaders of American Indian Nations and the State of Washington, being united in Leavenworth, WA on November 1, 2 and 3, 1999 in the spirit of understanding and mutual respect of the 1989 Centennial Accord and the government-to-government relationship established in that Accord, and desiring to strengthen our relationships and our cooperation on issues of mutual concern, commit to the following:

- Strengthening our commitment to government-to-government relationships and working to increase the understanding of tribes' legal and political status as governments;

- Continuing cooperation in the future by developing enduring channels of communication and institutionalizing government-to-government processes that will promote timely and effective resolution of issues of mutual concern;

- Developing a consultation process, protocols and action plans that will move us forward on the Centennial Accord's promise that, "The parties will continue to strive for complete institutionalization of the government-to-government relationship by seeking an accord among all the tribes and all elements of state government."

- Enhancing communication and coordination through the Governor's commitment to strengthen his Office of Indian Affairs and the member tribes' commitment to strengthen the Association of Washington Tribes;

- Encouraging the Washington Legislature to establish a structure to address issues of mutual concern to the state and tribes;

- Educating the citizens of our state, particularly the youth who are our future leaders, about tribal history, culture, treaty rights, contemporary tribal and state government institutions and relations and the contribution of Indian Nations to the State of Washington to move us forward on the Centennial Accord's promise that, "The parties recognize that implementation of this Accord will require a comprehensive educational effort to promote understanding of the government-to-government relationship within their own governmental organizations and with the public.";

- Working in collaboration to engender mutual understanding and respect and to fight discrimination and racial prejudice; and,

- Striving to coordinate and cooperate as we seek to enhance economic and infrastructure opportunities, protect natural resources and provide the educational opportunities and social and community services that meet the needs of all our citizens.

We affirm these principles and resolve to move forward into the new millennium with positive and constructive tribal/state relations.

Health Agency Centennial Accord Plans

Washington State Department of Health
Centennial Accord Plans

November 21, 2002

As mandated in the Centennial Accord, the Department of Health (DOH) is submitting its 2002 Centennial Accord Plan. The Department proposes the following priority areas for tribal consultation and collaboration.

DOH proposes to work with tribal representatives to review and assess the significance of these priorities or identify other areas of mutual concern for the purpose of developing an amenable Centennial Accord Plan. DOH will also engage tribal representatives in reviewing and further developing its existing Centennial Accord process.

1. Programs-Priorities

Efforts to enhance government-to-government relationships:

During the past year, the Department of Health (DOH) has worked to develop the infrastructure systems needed to improve consultation and collaboration between DOH and tribal communities. The following includes a summary of these efforts and plans to continue this effort over the next year.

A tribal liaison was appointed to strengthen relationships between the Department of Health and tribes. Under this leadership and the direction of the Office of the Secretary, the following efforts were undertaken:

Establishment of internal processes that help agency staff identify opportunities for working with tribes. These efforts have resulted in:

- Increased consultation to agency staff to familiarize them with appropriate methods for reaching out to tribal communities.
- Increased effort by agency staff to consult with tribal communities regarding program and process development and decisions.
- Establishment of an internal process to effectively implement the Centennial Accord, Government-to-Government relationship.

Development of an interactive tribal connections web site to improve internal agency communication capacity for working with tribal communities. The site provides:

- A method for sharing internal knowledge and experiences regarding working with tribes;
- Information about the 29 recognized tribes including connections to existing tribal web

sites; and
- Links to other state and federal tribal information.

The site enhances understanding of tribal communities, facilitates appreciation of tribal sovereignty and understanding of tribal issues. The site also provides an effective vehicle for reaching out to tribal communities to involve them in decisions affecting their communities.

Effective dissemination of tribal training opportunities and emphasis on the importance of attendance at training.

Implementation of Tribal issues forums.

Collaborative Opportunity:
Over the next year, the DOH proposes to work with the American Indian Health Commission, (AIHC) Northwest Portland Area Health Board (NWPAIHB), local public health jurisdictions and other interested parties to review Accord Plan specifications, build on the document and identify other areas of mutual concern for inclusion in future Centennial Accord Plans.

Emergency Preparedness:
To facilitate communication with tribal communities regarding emergency preparedness issues, the DOH has solicited names of tribal Public Health and emergency preparedness and response contacts in tribal communities. These names have been included on the DOH Tribal Connections web site and have been provided to emergency preparedness staff.

Concern continues, however, regarding the tribal community's preparedness and ability to respond to public health emergencies on tribal land.

Collaborative Opportunity:
Because of the importance of tribal involvement in emergency preparedness planning, The DOH proposes to work with tribal representatives to identify an agency tribal emergency preparedness liaison. The person would function as a coordinator between tribal communities and DOH to ensure that:
- Tribes are knowledgeable and involved in regional emergency preparedness planning;
- Tribal needs are identified and understood by local and regional public health representatives; and
- Tribal communities are effectively prepared to respond to public health emergencies.

Health Careers Issues:
An increased focus on encouraging Native American youth into health careers is essential in addressing health disparities among American Indians.

The DOH, Office of Rural and Community Health's, Health Occupations Preparatory Experience (HOPE) project provides an opportunity for high school students from rural and ethnically diverse populations to serve an internship in a health career to become more interested in pursuing a career in that health field. Of the approximately 140 student applications received, roughly 12 were from American Indian students. Increasing the number of American Indian student applicants is important in increasing the number of American Indian students that participate.

Collaborative Opportunity:
Increasing involvement of tribal communities and American Indian students in this program is essential. The DOH proposes to work with interested parties to identify barriers, opportunities and approaches for addressing this issue.

Shellfish user fees-Collaborative Opportunity:
A budget decision made by the 2002 State Legislature affected all shellfish companies, licensed by the DOH Shellfish Program, including tribal. This decision changed the type of funding that covers the cost of paralytic shellfish poison (PSP) testing for commercial samples. The testing had previously been done with state general fund money.

- Effective July 1, 2002, the cost of the testing was be covered through fees from commercial shellfish companies.
- Under the 1995 consent decree, tribes do not pay fees for shellfish licenses. Because the PSP testing fees are not considered to be license fees, they are charged to both tribal and non-tribal shellfish companies.
- The new fees have resulted in significant costs to the tribes, especially for geoduck testing. In addition to PSP fees for inter-tidal harvesting that range from $173 to $1189 per license, there are additional fees for geoduck harvesting ranging from $555 - $11,595 a year.
    - The geoduck fees were calculated using a two-year average of the number of PSP tests that were done for each geoduck harvester (tribes and DNR). The two-year average was used to determine the percentage of the total tests for each harvester.
    - The geoduck harvesters were assessed a fee equal to their percentage of the total cost of providing the service ($58,000). The fees will be updated annually to reflect the most recent usage data.

Collaborative Opportunity
Tribes have been supportive of the need to contribute to the cost of PSP testing. The DOH anticipates that ongoing discussions with the tribes will be necessary regarding the most equitable way to split the cost of PSP testing for geoducks.

Fish Advisories Issues:

DOH is currently in the process of standardizing the evaluation of fish sampling data into a fish advisory program. Most of the fish advisories released by DOH and local health departments are of significant interest to tribes. More fish sampling is critical for good assessments and updates regarding the health risks associated with environmental contaminants in fish. These risks are primarily attributable to chemicals that are persistent and bio accumulative such as methyl mercury, polychlorinated biphenyls (PCBs) and dioxins.

- Concerns may arise about DOH actions regarding findings of pollutants in Columbia River fish. DOH has existing advisories for mercury in walleye and dioxin in fish that are specific to Lake Roosevelt. These advisories need to be updated but lack the necessary fish sampling data.
    - The upper Columbia River/Lake Roosevelt is currently being investigated as Superfund site by the U.S. Environmental Protection Agency (EPA) because of contamination associated with various mines and smelters located on the river in both the U.S. and Canada. A decision will be made in 2003 as to whether this portion of the river will be listed on EPA's National Priorities List. As the Confederated Tribes of the Colville Reservation own land along this water body, they will be interested in following this issue.
    - The lower Columbia River may also be an area of concern for tribes since EPA recently released a study indicating exposures to contaminants in fish could be of concern for high-end consumers such as tribal members.
    - The Columbia River Intertribal Fish Commission (CRITFC) study conducted in the mid-90's showed that tribal consumption is 6 –11 times higher than the national average. This study continues to form the basis for the increased health concerns associated with exposure of tribal members to contaminants in Columbia River fish.
    - EPA is currently conducting a four-year screening level study targeting 500 lakes nationwide. Year 1 is complete and includes 143 lakes nationwide five of which are located in Washington; Lake Chelan, Okanogan River, French Hills Lake, Walla Walla River. This sampling reveals that DDT is elevated throughout this region.
    - The Suquamish, Duwamish and Muckleshoot Tribes are following the Lower Duwamish Waterway NPL site with interest. While DOH has expressed concern over

the consumption of bottom fish, the Suquamish and Muckleshoot will be acutely aware of any statements made regarding salmon, which are harvested from the Duwamish by both tribes.

Collaborative Opportunity (Underway):
DOH is making an effort to increase collaboration in assessing impacts of environmental contamination on tribal lands. Tribes emphasize that such assessments must consider future "high-exposure" land use that often may require more cleanup than is needed under current exposure conditions. To address this issue, the Department of Health;

- Is conducting an exposure investigation of dioxin in crab and geoduck on tribal fishing grounds with the Lower Elwha Tribe through our cooperative agreement program with the Agency for Toxic Substances and Disease Registry (ATSDR).
- Has met with the Suquamish, Duwamish and Muckleshoot Tribes to ensure that their concerns were considered in the Lower Duwamish Waterway public health assessment.
- Has met with the Yakama Nation to explain the process and findings of a health consultation dealing with wood-treatment contaminants at the Boyville Hop Ranch.

Tobacco Program Collaboration:
The current relationship between Tobacco Prevention and Control (TPC) and the tribes is working well. The quality of tribal work plans is greatly improved. TPC will work with tribal tobacco prevention coordinators, American Indian Health Commission (AIHC), and Northwest Portland Area Indian Health Board (NPAIHB) to make annual work plan documents more culturally appropriate to Native American communities.

- Training was provided to tribes on the CATALYST (Community Action on Tobacco Evaluation System) this fall.
- The first of two annual meetings, specifically for tribal tobacco coordinators, was held on Oct 30, 2002. The all day agenda was jointly designed by DOH and the tribal coordinators
- The TPC program is developing a strategic plan for addressing disparities in Native American and other underserved communities. The Northwest Portland Area Indian Health Board (NPAIHB) has been very helpful in this process.
- TPC may be offering "community capacity building funds" to tribal communities. To date, TPC funding has encouraged tribes to build capacity and conduct community activities in 26 of 29 federally recognized tribes. TPC will recommend that new funds support projects that benefit all tribes (written and audiovisual materials, training, on-site

technical assistance, etc.). In December, TPC staff will meet with NPAIHB's tobacco prevention staff to discuss ways to improve and increase technical assistance available to WA tribes

- Next Spring, TPC will sponsor a 3-5 day tobacco prevention and control "leadership institute" for members of underserved communities. TPC also plans to conduct a statewide conference next state fiscal year to launch its new strategic plan for identifying and addressing tobacco-related disparities. Tribes will be invited to both.

Collaborative Opportunity:
TPC will seek greater input from tribes to ensure TPC expectations and support of tribal programs is realistic and culturally relevant. Together, TPC and NPAIHB will help tribal tobacco prevention programs to become more effective through community assessments and enhanced technical assistance. Continued participation by tribes and urban Indians will guide the implementation of the new TPC strategic plan for identifying and eliminating disparities. Working collaboratively with community-based TPC contractors (local health departments/non-profit organizations and educational service districts/schools) tribes can access additional resources for tribal communities.

2. **Funding Distribution**-List of funding distribution methods currently available to tribes.

Enhancing Government to Government Relations
No specific set-aside funding is available

Emergency Preparedness
No specific set-aside funding is available.

Health Careers Issues
Project HOPE has funds available for approximately 100 students. There is no American Indian student "set aside" and selection criteria are applied to all students. Of the approximately 140 student applications roughly 12 were from American Indian students.

Shellfish User Fees
The Department funds an individual for the purpose of assisting the tribes in developing expertise in matters of public health and shellfish sanitation.

Fish Advisories Issues
No specific set-aside funding is available.

Tobacco Program Collaboration
Annually, the Department makes funds available to all federally recognized Washington tribes to help establish and support tribal tobacco prevention programs. Currently $558,000 is available annually to federally recognized tribes, up from $360,000 in the

first year. Each year, funding "unclaimed" by eligible tribes is distributed to participating tribes that apply or used in other ways to support tribal efforts. This year, tribes were encouraged to access additional resources by partnering with a local, community-based community based TPC contractor. Additional funds may soon be available through TPC efforts to identify and eliminate tobacco-related disparities.

3. Definitions-Detailed definitions of relevant terms as they apply to agencies

Enhancing Government to Government Relations

Centennial Accord Plan – The procedure by which the government-to-government policy is implemented. The document delineates specific mutual state/tribal goals for enhancing and strengthening government-to government relationship and addressing issues affecting tribal communities and Indian people.

Emergency Preparedness

Public Health emergency. preparedness and response – Preparation for and ability to respond to acts of bio-terrorism, other outbreaks of infectious disease, public health threats and emergencies.

Health Careers Issues

Project HOPE - A project that provides an opportunity for high school students from rural and ethnically diverse populations to serve an internship in a health career to become more interested in pursuing a career in that health field.

Shellfish User Fees

None included.

Fish Advisories Issues

- Bio-accumulation – Refers to the process of biological magnification whereby certain substances such as pesticides or heavy metals move up the food chain, work their way into rivers or lakes, and are eaten by aquatic organisms such as fish, which in turn are eaten by large birds, animals or humans. The substances become concentrated in tissues or internal organs as they move up the chain. Examples of chemicals that bio-accumulate in fish are methyl mercury, polychlorinated biphenyls.
- Methyl Mercury, PCBs and dioxin – Methyl mercury, polychlorinated biphenyls (PCBs) and dioxin are three contaminants of concern in fish. These chemicals are persistent in the environment and bio-accumulate up the food chain. Methyl mercury is created through the conversion of elemental mercury in the environment. Dioxins are created through combustion of fossil fuels, bleaching processes used in paper production and other sources. PCBs are no longer produced in the Untied States.
- Superfund site - A hazardous waste site listed under the federal Superfund law (Comprehensive, Environmental Response, Compensation and Liability Act - CERCLA). Superfund sites undergo an investigative process that determines what actions, if any, are needed to clean up the site and whether the site should be placed

on the National Priorities List.

- U.S. Environmental Protection Agency (EPA) - Established in 1970, EPA is the lead federal agency for enforcing laws that protect the environment. EPA formulates rules and policies to achieve compliance with these laws. It is an executive agency whose administrator is appointed by the President.
- Contaminants - Any physical, chemical, biological, or radiological substance or matter that has an adverse effect on air, water, or soil.
- Columbia River Intertribal Fish Commission (CRITFC) study - – Refers to the study entitled "A Fish Consumption Survey of the Umatilla, Nez Perce, Yakama, and Warm Springs Tribes of the Columbia River Basin" published by the Columbia River Intertribal Fish Commission (CRITFC) in October 1994. This study surveyed fish consumption rates among these Native American tribes living along the Columbia River and has contributed significantly to our understanding of freshwater fish consumption among tribes.
- DDT - Dichlorodiphenyltrichloroethane. The first chlorinated hydrocarbon insecticide. It has a half-life of 15 years and can collect in fatty tissues of certain animals. EPA banned registration and interstate sale of DDT for virtually all but emergency uses in the United States in 1972 because of its persistence in the environment and accumulation in the food chain.
- NPL site - National Priorities List site. These are the most contaminated of the Superfund sites and are the responsibility of the US EPA. There are currently 47 NPL sites in the State of Washington.

Tobacco Program Collaboration -

- Capacity-building - knowledge, skills and data developed through training, technical assistance or community assessments
- Infrastructure - dedicated staff time; community leader/member involvement as advisors, volunteers, advocates; strategic plan and means of evaluating progress
- Technical assistance - one-on-one consultation provided via personal visit, in writing, or by phone.
- Disparities – high rates tobacco use or exposure to second-hand smoke resulting from race/ethnicity, age, gender, disability, sexual orientation, geography, income and education. Populations most effected include those underserved and/or targeted by the tobacco companies.

4. Consultation Process-Procedures (including policy development, program development and implementation of funds distribution).

Enhancing Government to Government Relations

Over the next year, the DOH proposes to work with the American Indian Health Commission, Northwest Portland Area Health Board and other interested parties to review the Accord Plan, build on the document and identify other areas of mutual concern for possible inclusion.

Emergency Preparedness

The DOH proposes to work with American Indian Health Commission, Northwest Portland Area Indian Health Board and other tribal representatives to identify an agency tribal emergency preparedness liaison

Health Careers Issues

The program contact for Project HOPE has principally been the school system and this may not be the most effective way to reach American Indian student.

While Project HOPE has desired to include more American Indian students in this program, few have participated during its first two years of operation.

Opportunities for increasing exposure of this project will be explored with tribes, the American Indian Health Commission and the Northwest Portland Area Indian Health Board. To increase American Indian participation in Project HOPE more direct contact with the tribes and tribal schools or youth programs may be necessary.

Shellfish User Fees

DOH is currently engaged in a consultation process with Tribes licensed to harvest geoducks to develop the most equitable way to split the cost of PSP testing.

Fish Advisories Issues

DOH responds to both tribal and other governmental agency concerns regarding fish issues. The Department collaborates with local health jurisdictions to issue fish advisories. The Department relies on existing risk assessment guidance to evaluate sampling data and provide recommendations regarding fish consumption.

As noted in the "Priority Issues", DOH is currently collaborating with tribes to:

- conduct exposure investigation of dioxin in crab and geoduck (on fishing grounds),
- ensure tribal concerns are considered in public health assessments and
- explain the process and findings of a health consultation related to wood-treatment contaminants.

DOH also has a cooperative agreement with the Agency for Toxic Substances and Disease Registry (ATSDR) to address exposure to hazardous waste in the environment. ATSDR provides an additional avenue for Washington State tribes to access DOH concerning fish issues. Some of the sites that are involved, through our ATSDR program, include the Spokane River and Rayonier-Port Angeles sites.

DOH will conduct seafood consumption surveys for tribal populations as necessary. The recent consumption survey performed by the Suquamish Tribe was funded by ATSDR through DOH.

Tobacco Program Collaboration

TPC seeks advice from American Indian Health Commission, tribal tobacco prevention

coordinators, and Northwest Portland Area Indian Health Board to ensure proper support is provided and to continually improve its working relationship with federally recognized tribes. Topics may include funding, contract requirements, culturally appropriate prevention and cessation approaches and materials, community assessments, etc.

This fiscal year, for the first time, tribal tobacco coordinators will meet twice to receive training and share ideas, strategies, solutions and materials.

Tribes and urban Indians continue to be included in all strategic discussions related to disparities.

5. **Dispute Resolution Process-**Describes dispute resolution processes and outlines when particular processed may be used.

Enhancing Government to Government Relations
No dispute resolution process is currently outlined for this issue.

Emergency Preparedness
No dispute resolution process is currently outlined for this issue.

Health Careers Issues
No dispute resolution process is currently outlined for this issue

Shellfish User Fees
No dispute resolution process is currently outlined for this issue.

Fish Advisories Issues
No dispute resolution process is currently outlined for this issue.

Tobacco Program Collaboration
No dispute resolution is currently in place. However, TPC has specified a contract manager to negotiate and administer all tribal tobacco contracts.

Washington State Department of Health
American Indian Health Commission
Centennial Accord Update
Maria C. Gardipee, Tribal Liaison
September 12, 2003

Efforts to enhance government-to-government relationships:

The DOH proposed to work with the American Indian Health Commission, (AIHC) Northwest Portland Area Health Board (NWPAIHB), local public health jurisdictions and other interested parties to review Accord Plan specifications, build on the document and identify other areas of mutual concern for inclusion in future Centennial Accord Plans. During the past few months the following areas have been identified as areas for further collaboration.

Outbreak Notifications & Distribution of Public Health Information to Tribal Communities

DOH EPI, Health Statistics & PHL staff are working with NPAIHB EPI Center staff and AIHC Executive Director to develop and enhance communications with tribal communities to address EPI issues related to outbreak notification/non-infectious and Infectious disease issues in Indian Country on a regular and emergency need basis. Efforts will include identification of a method for reaching tribal representatives when such notification is necessary after regular work hours.

Notification and communication with the appropriate tribal entity in Indian country is essential when outbreaks occur or a need to provide information on other potential PH issues surfaces. Establishment of a process will provide the opportunity for "pre-emptive" notification to tribal communities regarding these issues when necessary. Discussion may include:

- Providing information and updates re: west Nile virus, SARS etc.
- Establishing a procedure for outbreak notification (24-7).
- Discussion of opportunities for (and/or barriers to) participation by tribal representatives in higher level (i.e. CDC) communications regarding current outbreaks or other Public Health issues.
- An opportunity to discuss other EPI issues of interest?

These Discussions will be an opportunity to collaboratively identify a process to address issues noted above and to establish them as sustainable processes/systems within EPI and DOH.

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Child Profile/Immunization

Working in collaboration with the NPAIHB, the Department of Health will invite Tribal clinics to become a CHILD Profile registered user. CHILD Profile is an immunization registry and health promotion system administered by the Washington Department of Health. The program's goal is to ensure all Washington children are immunized and receive appropriate preventive healthcare. Currently, about one-third of Washington children are not fully immunized by age two.

A connection to CHILD Profile will allow Tribal clinics to access immunization data about patients who may have received services from another provider. This will enable them to have more complete records. Sharing immunization data will also ensure that the child's health information continues to be updated in one central location.

The registry is a secure and permanent record accessible only to health care providers who have registered to participate. The Department of Health has developed technical and procedural safeguards to ensure that information in the registry is protected against unauthorized use. Participation and sharing of information with CHILD Profile is allowed under HIPAA guidelines for participating health care providers.

This collaborative effort will provide tribal clinics the opportunity to participate in a system that is FREE and easy to use. This web accessible system requires no special software. Clinics and communities will experience benefits from the CHILD Profile Immunization Registry immediately because it allows clinics to:

- Print immunization records quickly for parent and school requests
- Generate patient-specific immunization recommendations easily
- Produce a variety of immunization related reports - recall, vaccine accountability & more

Clinics will also be able to request a current list of the (over) 200 participating provider organization

Contact:

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American Indian Health Care Delivery Plan

Earlier this year the AIHC requested that DOH include language in the Accord demonstrating continued commitment to preparation of the American Indian Health Care Delivery Plan.

The DOH has historically provided funding and staff support for development of this report. The most recent version, 2003 report, was completed 2 months ago and provides a picture of the current health status of AI/AN's in Washington using data to chart progress and identify areas of need. It highlights successful strategies that tribes and the state have used to address health disparities in the AI/AN population and offers recommendations and objectives for tribal and urban health programs, and state policymakers.

Recently, the DOH Senior Management Team discussed and approved the following language for inclusion in the Centennial Accord.

Status & Proposed Language:
American Indian Health Care Delivery Plan:
Since 1997, tribes and the Department of Health have developed a biennial report highlighting the ongoing efforts to improve the health status of Washington's American Indian and Alaska Native population (AI/AN). This plan, American Indian Health Care Delivery Plan, has provided a policy framework for work and future progress on health status issues of AI/AN in Washington. The American Indian Health Care Delivery Plan includes a request that work on the plan be continued and that the department maintain this activity as a priority.

The American Indian Health Care Delivery Plan is an important element in working to improve the health status of AI/AN in Washington state, the DOH supports continuation of this activity within available resources.

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Public Health Emergency Preparedness & Response:
Because of the importance of tribal involvement in emergency preparedness planning, The DOH proposed to work with tribal representatives to identify an agency tribal emergency preparedness liaison. The person would function as a coordinator between tribal communities and DOH to ensure that:

- Tribes are knowledgeable and involved in regional emergency preparedness planning;
- Tribal needs are identified and understood by local and regional public health representatives; and
- Tribal communities are effectively prepared to respond to public health emergencies.

Status:
The Public Health Emergency Preparedness and Response Program has been very active this past year. A main thrust of this initial year was to begin development of a regional structure allowing the implementation of some initial local and regional emergency response planning for bio-terrorism, other infectious disease and other public health threats and emergencies.

In a number of these regions local health representatives working with their tribal public health emergency preparedness and response contacts have formed a partnership and begun the emergency response planning process that has resulted in some tribes actively participating in (some of the) drills and exercises. In other regions this process has just begun to develop.

DOH Officials have addressed tribal meetings and conferences to enlist participation in planning efforts. Most recently, they have discussed the program with the American Indian Health Commission and have enlisted their

help in developing a strategy to begun a tribal funding process to allow tribes to actively participate in the development and testing of local and regional plans.

Funds being made available by HRSA will allow us to provide initial funds to the 22 tribally owned health care facilities to will allow them to participate in a "needs assessment" expected this coming year.

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Health Careers Issues:

Reducing health disparities in Native Americans has been linked to increased numbers of Native Americans participating in health careers. The DOH, Office of Rural and Community Health's, proposed increasing these numbers by encouraging Native American youth into health careers through participation in Health Occupations Preparatory Experience (HOPE) project.

This project provides an opportunity for high school students from rural and ethnically diverse populations to serve an internship in a health career to become more interested in pursuing a career in that health field.

Status:

The DOH has proposed working with interested parties to identify barriers, opportunities and approaches for addressing this issue. Recent statistics indicate further efforts will be necessary during the next program year to improve participation.

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Shellfish User Fees

A budget decision made by the 2002 State Legislature affected all shellfish companies, licensed by the DOH Shellfish Program, including tribal. This decision changed the type of funding that covers the cost of paralytic shellfish poison (PSP) testing for commercial samples. The testing had previously been done with state general fund money.

Since Tribes had been supportive of the need to contribute to the cost of PSP testing, the DOH anticipated that ongoing discussions with the tribes would be necessary to identify the most equitable approach for splitting the cost of PSP testing for geoducks.

Status
The Shellfish user fees for paralytic shellfish poison (PSP) testing were implemented in 2002. The Shellfish Program worked with the Tribes and the Department of Natural Resources to refine the method of assessing the 2003 fees for testing PSP in geoducks. The DOH however, anticipates that ongoing discussions with the tribes will continue to be necessary.

Contact:
Jennifer Tebaldi, Director
Food Safety and Shellfish Programs
Washington State Dept. of Health
(360) 236-3325
FAX (360) 236-2257

Fish Advisories Issues:
DOH is currently in the process of standardizing the evaluation of fish sampling data into a fish advisory program. Most of the fish advisories released by DOH and local health departments are of significant interest to tribes. More fish sampling is critical for good assessments and updates regarding the health risks associated with environmental contaminants in fish. These risks are primarily attributable to chemicals that are persistent and bio accumulative such as methyl mercury, polychlorinated biphenyls (PCBs) and dioxins.

- Currently EPA is conducting a four-year screening level study targeting 500 lakes nationwide. Year 2 is complete and includes 143 lakes nationwide five of which are located in Washington; Lake Chelan, Crescent Lake, Lake Dorothy, Frenchman Hills Lake, and Rimrock Lake. This sampling, as well previous studies has shown that DDT is elevated throughout the eastside of the Cascades.

DOH continues efforts to increase collaboration in assessing impacts of environmental contamination on tribal lands. Tribes emphasize that such assessments must consider future "high-exposure" land use that often may require more cleanup than is needed under current exposure conditions.

Status
One such effort is the Department of Health's discussions on how to proceed on doing an evaluation of a wind blown sediment at Lake Roosevelt. The study was recommended by the Colville Tribe and ATSDR and will be available in September 03. DOH is sensitive to the fact that the Tribe may want ATSDR to handle the evaluation.

Contact:
Robert Duff, Acting Director
Office of Environmental Health Assessments
Washington State Department of Health
P.O. Box 47846
Olympia, WA. 98504-7846
Phone: 360-236-3371
Fax: 360-236-3383
E-mail: robert.duff@doh.wa.gov

Other Fish Advisory Activity

As the result of an Inter-Agency Fish Advisory Meeting, coordinated by DOH staff, an inter-agency fish advisory group will be formed and will include representatives of Native American groups having an interest in fish.

- A preliminary internal group in this effort has met to explore issues around outreach and communication.
- A technical group will meet within the next few months.
- Once these two groups meet, DOH will facilitate inclusion from other agencies, and then to the broader community.
- It is anticipated that the larger group will begin meetings this Fall.

Preliminary internal discussions are being held to identify approaches for effectively involving and communicating with the tribes and tribal organizations.

Contact:

Madeline P. Beery, M.Ed.
Office of Environmental Health Assessment
Department of Health
Bldg 2 Airdustrial Park
Olympia, WA 98504
360-236-3189

Status Tobacco Program Collaboration:

The current relationship between Tobacco Prevention and Control (TPC) and the tribes is working well. The quality of tribal work plans continues to improve.

Two annual meetings, specifically for tribal tobacco coordinators, were held on Oct 30, 2002 and March 12, 2003. The one-day meeting in October provided opportunities for tribal sharing and updates from TPC. The March meeting was part of the 3-day state tobacco conference, sponsored by the state tobacco program (TPC).

Tribes received instruction on how to apply for funds for SFY 2004, updates from TPC and participated in a variety of workshops. October 8, 2003 is the next full day meeting and may focus on CATALYST training, cessation strategies, the state's new plan for addressing tobacco-related disparities, and updates on new state initiatives on secondhand smoke and strategic planning.

- The TPC program will contract with the Northwest Portland Area Indian Health Board (NPAIHB) Western Tobacco Prevention Project to provide additional training and technical support to tribes in Washington.
- TPC will be contracting with the Seattle Indian Health Board to plan and coordinate statewide activities in Urban Indian communities.
- Again in SFY 2004, TPC funding will contract with 26 of 29 federally recognized tribes.
- During SFY 2004, TPC will sponsor 3- day tobacco prevention and control "Leadership Institute" for members of Urban Indian and four other underserved

communities, and a statewide conference on tobacco-related health disparities. A leadership forum for all tribal communities will be considered for SFY 2005.

Through its partnership with NPAIHB, TPC will seek greater input from tribes to ensure TPC expectations and support of tribal programs is realistic and culturally relevant. Together, TPC and NPAIHB will help tribal tobacco prevention programs to become more effective through community assessments and enhanced technical assistance. Continued participation by tribes and urban Indians will guide the implementation of the new TPC strategic plan for identifying and eliminating disparities. Working collaboratively with community-based TPC contractors (local health departments/non-profit organizations and educational service districts/schools) tribes can access additional resources for tribal communities.

Contact:

David G. Harrelson
Washington State Department of Health
P.O. Box 47848
7211 Cleanwater Lane
Olympia, WA 98504-7848
PH: 360/236-3685
FX: 360/236-3646
david.harrelson@doh.wa.gov

ADMINISTRATIVE POLICY NO. 7.01

SUBJECT: American Indian Policy

INFORMATION CONTACT: Office of Indian Policy and Support Services (IPSS)
MS 45105 (360) 902-7818

AUTHORIZING SOURCE: Office of the Secretary

EFFECTIVE DATE: November 1, 1987

REVISED: ~~March 1, 2000~~ May 1, 2002

APPROVED BY: _____
Assistant Secretary for Management Services

SUNSET REVIEW DATE: ~~March 1, 2002~~ May 1, 2004

PURPOSE:

This policy is to state the Department of Social and Health Service's (DSHS) commitment to planning and service delivery to American Indian governments and communities.

SCOPE:

A. The Office of Indian Policy and Support Services (IPSS) is charged with the overall coordination, monitoring, and assessment of department relationships with American Indian governments, communities and participants.

B. All department staff are charged with implementation of the American Indian Policy in consultation with the Office of IPSS.

C. The department's American Indian Policy follows a government to government approach to establishing policies and procedures for working with American Indian tribes. This is in compliance with the Washington State 1989 Centennial Accord and current federal Indian policy as outlined by Executive Directive signed by the president in 1995 which promotes Government to Government relationships with American Indian tribes.

POLICY:

A. The department shall provide necessary and appropriate social and health services to people of American Indian governments, landless tribes, off-reservation American Indian communities and participants in a manner which is in harmony with agency philosophy and compliments and complies with: treaties, executive orders, state/federal laws, court cases, and state/federal policies related to American Indian people.

B. To ensure implementation of this policy, continued exchange of information, and resolution of issues with Indian tribes and organizations, the department shall maintain the standing, Indian Policy Advisory Committee (IPAC). IPAC shall be composed of various American Indian leaders designated by their respective American Indian tribe or organization and appointed by the Secretary. The Director of IPSS, IPSS staff, and various American Indian Liaisons of DSHS, designated by Administrators or Division Directors, will serve as staff support to the committee. The Secretary of DSHS will communicate with the committee and review their comments and recommendations.

C. In making policy on Indian issues, the department shall consider:

1. The sovereignty of American Indian tribes.

2. The unique social/legal status of American Indian tribes under the Supremacy Clause and Indian Commerce Clause of the United States Constitution, federal treaties, executive orders, Indian Citizen's Act of 1924, Indian Child Welfare Act of 1978, The Centennial Accord and other relevant statutes, and federal/state court decisions.

3. Recognition of the unique American Indian property ownership and income rights related to the trust status of land and communal ownership of tribal assets consistent with WAC 388-470-0015.

4. American Indian self-determination and self-governance without the termination of the unique status of American Indian tribes.

5. Recognition of elected tribal governments as the political governing bodies of sovereign American Indian tribes.

6. The department's support and cooperation in the areas of planning, program development, administration, and service delivery with the governments of American Indian tribes, landless tribes, Canadian Indian tribes, representatives of off-reservation American Indian organizations, and Alaska Native organizations.

7. Cooperation and coordination with the Governor's Office of Indian Affairs.

D. Each Administrator is responsible for the following objectives:

1. To ensure the opportunity for, involvement, and consultation of tribal governments, landless tribes, off-reservation American Indian organizations, and American Indian participants to provide meaningful input in department relations, plans, budgets, policies, manuals, and operational procedures which affect American Indian people.

2. To ensure programs and services provided recognized tribes, landless tribes, off-reservation American Indian communities and individuals are culturally relevant and in compliance with this policy.

3. To ensure that programs and services provided to reservation and off-reservation American Indian communities are in harmony with department philosophy and are based on goals and objectives designed to address American Indian social and health needs as defined by cooperative agreements with the respective communities.

4. To ensure the agency and contractor/licensee is in compliance with all American Indian-related sections of the Washington Administrative Code and manual material pertaining to the specific area of authority of the administration.

5. To make measurable efforts to utilize American Indian organizations and social and health providers when providing services to American Indian tribes, communities and participants.

6. To conduct periodic evaluations of the above responsibilities to identify progress and outstanding issues.

7. To initiate contact with the Office of IPSS for consultation and recommendations to the planning of policy and procedures, which will have a unique or special effect on American Indian governments, communities and participants prior to decisions being made.

8. To develop a relevant data collection process in conjunction with ISSD, ORDA and other stakeholders. This data should show statewide and tribal specific patterns.

9. To appoint and provide culturally-specific training to tribal liaisons if and when the administration, division or program has significant contact with American Indian tribes or communities.

10. To develop policies outlining sanctions for failing to comply with any or all of the DSHS American Indian Policy.

11. To develop specific, written protocols establishing how each individual program or administration is going to work cooperatively with other administrations to:

    a. Coordinate services and contracts with American Indian tribes and other communities, and

    b. Further the purposes and goals of the DSHS American Indian Policy.

E. By April 2 of each even-numbered year, prior to the development of the biennial budget request, each administration shall develop a biennial service plan for American Indian tribes, communities and participants, and shall submit the plan to the Director of IPSS. The biennial service plan is to be regional and headquarters specific. The purpose of the plan is to establish fiscal needs and/or possible administrative or legislative changes, and shall include, but not be limited to:

1. Pertinent statistics on American Indian community and participant populations, numbers of American Indian participants served, and all other relevant data.

2. Descriptions of American Indian employment patterns as they relate to: affirmative action, participant populations, at risk populations and other service delivery considerations.

3. Description of any local tribal-state agreements, protocols, or other similar documents in effect.

4. Method and frequency of communication with tribal governments, landless tribes and off-reservation American Indian organizations for purposes of information sharing, joint planning, and problem solving, including a current listing of all department and American Indian contact people.

5. Descriptions of how American Indian participants and community needs, relevant to specific program and Indian policy objectives, have been met, or not met, and how is the administration working toward developing a positive working relationship, by implementation of the plan.

6. Descriptions of outstanding issues and gaps in services. Suggest recommendations for meeting needs and resolving outstanding issues, and translate those needs into specific performance expectations which can be implemented, monitored, and evaluated.

7. Description of how the administration will facilitate training of DSHS staff on major principles of federal American Indian law.

F. By April 2 of each odd-numbered year, each administration shall submit to the Director of IPSS a biennial updated report on the status of the division plans.

G. All DSHS local and statewide contractors are subject to this policy. Division Administrators and their regional program representatives for contracted services are responsible for ensuring implementation of the DSHS Indian Policy.

H. The Office of IPSS shall:

1. Advocate for the relevant delivery of departmental services to American Indian communities and participants.

2. Provide consultation to management, regional program representatives and DSHS contractors in achieving the agency's American Indian Policy commitments, and assist in achieving policy objectives.

3. Monitor departmental services related to American Indian issues on an agency-wide basis, bring issues to the attention of the appropriate administrator for efficient resolution, and recommend specific actions to resolve issues in compliance with this policy.

4. Provide consultation, technical assistance, and monitoring services to administrative staff and programs, regional administrators and directors, regional coordinating councils, contractors and field staff.

5. Provide consultation and information on an ongoing basis with American Indian tribal governments, landless tribes, off-reservation American Indians, and Alaska Native communities in order to keep them advised of departmental matters, secure their input, and ensure thorough consideration of all suggestions and recommendations *(includes former H.3.)*.

6. Provide staff support to the standing IPAC Committee for meetings, implementing plans/reports and developing departmental recommendations.

7. Provide consultation to each administration and regional field services staff in the development of biennial plans for services to American Indian communities and participants.

8. The director of IPSS shall schedule reviews of the biennial American Indian policy plan or update with each administration. On the basis of these reviews, the director shall work with administrators to resolve issues of concern.

9. Ensure timely access to all DSHS services for American Indian communities described in this policy.

Washington State Health Care Authority
Centennial Accord Plan

January 2004

Introduction

As mandated in the *Centennial Accord*, each state agency is to establish a procedure to implement government-to-government policies embraced by both state and tribal officials. The Washington State Health Care Authority's (HCA) plan utilizes the guiding principles and critical elements identified in the 1989 Centennial Accord[1] http://www.goia.wa.gov/govtogov/centennial.html, 1999 New Millennium Agreement[2] http://www.goia.wa.gov/govtogov/agreement.html, and the 1999 Centennial Accord Implementation Guidelines http://www.goia.wa.gov/govtogov/guidelines.html. The HCA is fully committed to the principles cited in the Centennial Accord and the New Millennium Agreement. ***See Tribal Consultation Policy (Attachment A).*** Modification to the HCA plan will be made as areas of mutual interest are identified and new collaboration opportunities develop with tribes in Washington State.

The HCA Centennial Accord Plan includes an introduction to the agency, followed by program areas, agency activities, and definitions. The organizational charts and agency contact information also are attached. (See Attachments B and C, respectively.)

Pete Cutler, Acting Administrator of the Washington State Health Care Authority, was appointed to serve on the Executive Cabinet by the Governor Gary Locke on March 4, 2003.

HEALTH CARE AUTHORITY (HCA) http://WWW.HCA.WA.GOV/
Statutory Authority Revised Code of Washington (RCW) 41.05
http://www.leg.wa.gov/RCW/index.cfm?fuseaction=chapterdigest&chapter=41.05

Washington State Administrative Code (WAC) Title 182
http://www.leg.wa.gov/wac/index.cfm?fuseaction=title&title=182

The Health Care Authority (HCA) administers three health care programs: Basic Health (BH), Community Health Services (CHS), and Public Employees Benefits Board (PEBB). Through these programs, HCA is able to provide access to high-quality health care for more than 500,000 Washington residents. The HCA also oversees the Uniform Medical Plan (UMP), a state-administered, self-insured preferred provider plan that is available to those covered under PEBB. Additionally, HCA is responsible for development of a Prescription Drug Program as mandated by the passage of SB 6088.

Funding for HCA programs is authorized by the legislature to provide health service delivery to those eligible for participation in the Public Employees Benefit Board and Basic Health, as well

[1] Centennial Accord between the Federally Recognized Indian Tribes in Washington State and the State of Washington, August 4, 1989, executed by Governor Booth Gardner and 26 Tribal Chairs.
[2] New Millennium Agreement, signed 1999.

as to Community Health Services grant awardees. Funding for these programs is allocated from the Washington State Health Services Account (HSA) and the State General Fund.

Mission and Vision

The Health Care Authority's mission is to provide access to quality, affordable health care. The HCA's vision is to deliver the best value in health care.

Goals for the 2003-05 Biennium

- Provide the best value in health care through agency programs, initiatives, and purchasing.
- Provide leadership and coordination in state health care policy and purchasing.
- Practice sound business principles and financial stewardship.
- Make it easy to do business with the HCA.
- Promote customer participation in responsible health care decision-making.
- Attract, develop, retain, and reward a high-performing and diverse workforce.

Programs/Services

- Basic Health (BH)
- Community Health Services (CHS)
- Public Employees Benefits Board (PEBB)
- Uniform Medical Plan (UMP)/Prescription Drug Plan (PDP)

Administrative Support Divisions

- Communications
- Human Resources
- Information Technology and Administrative Services
- Internal Audit
- Internal Quality and Strategic Planning
- Finance, Legal, and Policy
- Office of the Medical Director

Jan Ward Olmstead is HCA's Tribal Liaison. She can be reached by phone at (360) 923-2803 or by e-mail at jolm107@hca.wa.gov. The Tribal Liaison position is within Community Health Services.

The Tribal Liaison's role is to coordinate and manage relationships between the HCA and tribes by:

- Working with the Governor's office of Indian Affairs, tribal entities, and tribal organizations to minimize health care barriers and enhance quality of health care
- Collaborating with tribes and tribal entities to identify opportunities for partnerships in HCA program areas

BASIC HEALTH (BH) http://www.basichealth.hca.wa.gov/
Statutory Authority RCW 70.47
http://www.leg.wa.gov/RCW/index.cfm?fuseaction=chapterdigest&chapter=70.47

WAC chapter 182-25 http://www.leg.wa.gov/wac/index.cfm?fuseaction=chapterdigest&chapter=182-25

Basic Health is a state-sponsored program that provides affordable health care coverage to low-income Washington residents whose incomes fall below 200% of the Federal Income Guidelines (FIG). Monthly premiums are based on family size, income, age, and the health plan selected. Coverage is available to eligible Washington residents through eight private health plans.

Due to severe cuts in the 2003-05 biennium budget, BH has undergone significant changes resulting in enrollment reduction and program modifications. The enrollment level was cut from 130,000 to 100,000; the reduction of enrollees is being accomplished by natural attrition. (Reduction by natural attrition refers to disenrollments due to a change in eligibility status, non-payment of premium, moving out of state, Medicare eligible, non-compliance to recertificaton, and voluntary disenrollment.) New applications are only being accepted from specific groups, including new members of an existing tribal sponsor group, until the targeted reduction is achieved.

Starting in January 2004, enrollees will be responsible for a larger share of the costs than was required in the 2003 coverage year. Also, in 2004, copayments will be required for most services, with the exception of preventive care, skilled nursing, hospice, home health, and maternity care. There is an annual deductible of $150 and a 20% coinsurance payment applied after payment of the deductible. There is an out-of-pocket maximum of $1,500 per year, per person. For those who qualify for Basic Health, state funds are used to help pay a portion of the monthly premium. Members may pay as little as $17 per month for each enrolled adult. To qualify, applicants must meet Basic Health's income guidelines, live in Washington State, not be eligible for Medicare, and not be institutionalized at the time of enrollment.

Basic Health Financial Sponsor Program
Statutory Authority RCW 70.47.010(5)(b)
http://www.leg.wa.gov/RCW/index.cfm?fuseaction=section&section=70.47.010

RCW 70.47.060(2)(c) http://www.leg.wa.gov/RCW/index.cfm?fuseaction=section&section=70.47.060
WAC 182-25-070 http://www.leg.wa.gov/wac/index.cfm?fuseaction=Section&Section=182-25-070

The Financial Sponsor program allows employers and other financial sponsors to assist in purchasing health care by paying all, or a portion of the premium, rate, or any other amount on behalf of subsidized or nonsubsidized enrollees. (Nonsubsidized coverage is not applicable in 2003 or 2004, since no financial sponsor chose to contract for it.)

Tribes, like other financial sponsors, may pay the premiums for their enrollees and assist them with the BH application process.

Services Available to Tribes: Basic Health Financial Sponsor Program. Tribal organizations and members participate in Basic Health through a contractual agreement with HCA. Currently, Basic Health has sponsorship agreements with the Jamestown S'Klallam Tribe, the Port Gamble S'Klallam Tribe, the Quinault Nation, and the Lummi Tribe to provide BH coverage to eligible tribal members through the Basic Health Financial Sponsor Program.

Funding Method Currently Available to Tribes: Funding is not allocated specifically to tribes.

Consultation Processes and Procedures: Varying degrees of consultation and coordination can be initiated by contacting the operational staff, the tribal liaison, or through communication with the Assistant Administrator and/or the Administrator. The quarterly tribal sponsors meetings, Basic Health Advisory Board, and the American Indian Health Commission for Washington State will be used as venues for on-going communication and coordination. Consultation will be held in accordance with the HCA Consultation Policy (see Attachment A).

Dispute Resolution Processes: There is no formal dispute resolution process in place.

COMMUNITY HEALTH SERVICES (CHS) http://www.chs.hca.wa.gov
Statutory Authority RCW 41.05.220
http://www.leg.wa.gov/RCW/index.cfm?fuseaction=section&section=41.05.220
WAC Chapter 182-20 http://www.leg.wa.gov/wac/index.cfm?fuseaction=chapterdigest&chapter=182-20

The Community Health Services program promotes access to quality and affordable health care for the uninsured, underinsured, and tribes.

Community Health Services provides health care access for over 161,000 patients who are at or below 200% Federal Income Guidelines (FIG) with no insurance by:

- Working with communities and clinics to maintain and expand access for the uninsured and underinsured
- Conducting technical site visits to monitor contract compliance and to provide assistance as needed
- Partnering with private organizations, governmental agencies, and others to minimize health care barriers and enhance quality of health care for all

Community Health Services coordinates and manages relationships among HCA and tribes by:

- Working with the Governor's Office of Indian Affairs, tribal entities, and tribal organizations to minimize health care barriers and enhance quality of health care
- Collaborating with tribes and tribal entities to identify opportunities for partnerships in HCA program areas

Services Available to Tribes: CHS provides funding to the Seattle Indian Health Board and the Port Gamble S'Klallam Tribe to provide primary health care services. Technical assistance is available to tribes on the grant application process and other clinical areas.

Funding Method Currently Available to Tribes: Tribal organizations may compete for grant funding. General funding is distributed by the following formulae: 40% shared equally among grantees and 60% distributed according to CHS sliding fee productivity (see definitions).

Consultation Processes and Procedures: Varying degrees of consultation and coordination can be initiated by contacting the operational staff, the Tribal Liaison, or through communication with the Executive Director and/or the Administrator. The American Indian Health Commission for Washington State will be used as a venue for on-going communication and coordination. Consultation will be held in accordance with the HCA Consultation Policy (see Attachment A).

Dispute Resolution Processes: As outlined in the grant award contracts.

PUBLIC EMPLOYEES BENEFIT BOARD (PEBB) http://www.pebb.hca.wa.gov/
Statutory Authority RCW 41.05.050.197
http://www.leg.wa.gov/RCW/index.cfm?fuseaction=section&section=41.05.050

WAC Chapters 182-08 http://www.leg.wa.gov/wac/index.cfm?fuseaction=chapterdigest&chapter=182-08**and 182-12** http://www.leg.wa.gov/wac/index.cfm?fuseaction=chapterdigest&chapter=182-12.

The State of Washington provides health benefits and related insurance coverage to all eligible state and higher-education employees as a benefit of employment. In addition, K-12 school districts and local government entities (such as ports, cities, and water districts) also may choose to join PEBB plans.

The Public Employees Benefits Board, created within HCA, establishes eligibility requirements and approves plan benefits of all participating health care organizations. PEBB administers medical, dental, basic life, and long-term disability insurance coverage for eligible employees. Most coverage is available on a self-paid basis to eligible retirees, former employees, and employees who are temporarily not in pay status.

Services Available to Tribes: Tribes currently do not receive services under PEBB.

Funding Method Currently Available to Tribes: Tribes currently are not eligible for PEBB funding.

Consultation Processes and Procedures: Consultation and coordination can be initiated by contacting the Tribal Liaison or through communication with the Assistant Administrator and/or the Administrator. The American Indian Health Commission for Washington State will be used as a venue for on-going communication and coordination. Consultation will be held in accordance with the HCA Consultation Policy (see Attachment A).

Dispute resolution processes: Not applicable.

UNIFORM MEDICAL PLAN (UMP) http://www.ump.hca.wa.gov/
Statutory Authority RCW 41.05.140
http://www.leg.wa.gov/RCW/index.cfm?fuseaction=section&section=41.05.140

The UMP is a self-insured preferred provider health insurance plan available to public employees, both active and retired, and their dependents. It is administered by HCA, and is offered only to those covered through PEBB. Coverage is available worldwide.

Services Available to Tribes: Tribes currently do not receive services under PEBB.

Funding Method Currently Available to Tribes: Tribes currently are not eligible for PEBB funding.

Consultation Processes and Procedures: Consultation and coordination can be initiated by contacting the Tribal Liaison or through communication with the Assistant Administrator and/or the Administrator. The American Indian Health Commission for Washington State will be used as a venue for on-going communication and coordination. Consultation will be held in accordance with the HCA Consultation Policy (See Attachment A).

Dispute resolution processes: Not applicable.

Prescription Drug Project (PDP) http://rx.wa.gov/
Senate Bill 6088
http://www.leg.wa.gov/pub/billinfo/2003-04/Senate/6075-6099/6088_pl_06052003.txt

As a result of the passage of SB 6088 during the 2003 Legislative session, HCA is developing a senior prescription drug discount program. The PDP will be responsible for negotiating prescription drug price discounts for state agencies and must negotiate similar discounts for any eligible Washington resident. Those eligible are residents (who are at least 50 or between 19-49 and disabled, whose family income does not exceed 300 percent of the federal poverty guidelines) and whose existing prescription drug need is not covered by insurance. Participants are charged an enrollment fee.

A Pharmacy Connection program also will be established through which health care providers and members of the public can obtain information about and help in accessing manufacturer-sponsored prescription drug assistance programs.

Notice regarding the program is to initially target seniors, but the program must be available to anyone, and is to include a toll-free number that may be used to obtain information.

This plan is in the early stages of development.

Services Available to Tribes: Not specific to tribes, but they may be indirectly affected.

Funding Method Currently Available to Tribes: Funding not specific to tribes.

Consultation Processes and Procedures: Consultation and coordination can be initiated by contacting the Tribal Liaison or through communication with the Assistant Administrator and/or the Administrator. The American Indian Health Commission for Washington State will be used as a venue for on-going communication and coordination. Consultation will be held in accordance with the HCA Consultation Policy (See Attachment A).

Dispute resolution processes: Not applicable.

Agency Activities

ACCOMPLISHMENTS

The HCA:

- Formalized the Tribal Liaison position in Community Health Services with direct responsibility for identifying opportunities for improving relationships between the HCA and Washington tribes to promote quality affordable health care to American Indians and Alaska Natives.
- Established the Tribal Liaison function in the CHS strategic business plan.
- Conducted internal stakeholder work to establish the Tribal Liaison's agencywide role.
- Coordinated an onsite tribal government-to-government training through the Governor's Office of Indian Affairs for all staff, who either work directly with tribes or who requires a more in-depth awareness of tribal issues and/or American Indian culture, due to their roles within the agency.
- Visited the Port Gamble S'Klallam Tribe for the purpose of collaboration. Those attending included the Administrator, BH Assistant Administrator, CHS Executive Director, and Tribal Liaison.
- Visited the Jamestown S'Klallam Tribe for the purpose of collaboration. Those attending included the Administrator, BH Assistant Administrator, CHS Executive Director, and Tribal Liaison.
- The Acting Administrator participated in the May 16, 2003 American Indian Health Commission Meeting for the purpose of becoming acquainted with the tribes and AIHC.
- Drafted the HCA Centennial Accord Plan and Consultation Policy.

Basic Health (BH)

- Revised tribal sponsor contract language to allow 3rd party verification of income, where tribal sponsors are considered a third party for the purposes of verifying income of tribal sponsored enrollees.
- Maintained exemption for existing tribal sponsors from the freeze on new applications.
- Appointed a tribal representative to the Basic Health Advisory Board.
- Provided on-going quarterly joint meetings with the tribal sponsors and BH staff.

Community Health Services (CHS)

- Entered into a contract with the Port Gamble S'Klallam tribal clinic, the first tribal clinic to

receive Washington State Community Health Service grant funds.

- Transitioned the lead contract management role to HCA's Tribal Liaison for the Port Gamble S'Klallam and the Seattle Indian Health Board clinics.
- Conducted site visit/review of the Seattle Indian Health Board clinic.
- Conducted site visit/review of the Port Gamble S'Klallam clinic.

GOALS FOR 2003-05

- Ensure communication and collaboration with tribes to help provide access to HCA program areas.
- Establish method for tracking and monitoring issues and accomplishments.
- Establish relationships with tribal clinics that are not current contractors.
- Refer appropriate staff to the Tribal government-to-government training as roles within the agency dictate.

Basic Health (BH)

- Collaborate with tribes to establish new tribal sponsors (when enrollment permits).
- Establish early consultation on BH policy changes.
- Conduct site reviews of tribal sponsor programs.
- Provide quarterly joint meetings with the tribal sponsors and BH staff.

Public Employee Benefits Board (PEBB)

- Work with tribes to examine the policy issue of extending access to PEBB coverage to tribal governments for their employees, as a benefit of employment. This reflects what is extended to local governmental entities. A legislative change would be required.

Uniform Medical Plan (UMP)/ Prescription Drug Project (PDP)

- Explore the interest and impact of the PDP on tribes.

Health Care Authority Definitions

American Indian Health Commission for Washington State (AIHC): The Commission consists of federally-recognized tribes and urban Indian programs authorized under Title V of the Indian Health Care Improvement Act located in Washington State. The Commission seeks consensus and guides the state of Washington regarding the collective needs of the tribal governments and other individual American Indian people to assure quality and comprehensive heath care to all American Indians and Alaska Natives in Washington State. The Commission does not circumvent the sovereign authority of the tribal governments; rather its objective is to seek unity among American Indian/Alaska Native health care providers.

BH—Basic Health: A state-sponsored program administered by HCA that provides affordable health care coverage to low-income Washington residents through eight private health plans.

Basic Health Advisory Board: As provided for in RCW 70.47.040(3), the Basic Health Advisory Board is appointed by the HCA Administrator. The board consists of representation from health care professionals, health care providers, and those directly involved in the purchase, provision, or delivery of health care services, as well as consumers, and those knowledgeable of the ethical issues involved with health care public policy. Committee members are reimbursed for travel expenses pursuant to RCW 43.03.050. The current Basic Health Advisory Board tribal representative is Cindy Lowe, Jamestown S'Klallam Tribe. Ms. Lowe also serves as Vice Chair of the American Indian Health Commission for Washington State.

CHC—Community Health Clinic: Specific to CHS, Community Health Clinic means a public or private nonprofit tax exempt corporation with the mission of providing primary health care to low income individuals at a charge based upon ability to pay.

CHS—Community Health Services: A state program that promotes access to quality and affordable health care for the uninsured, underinsured, and tribes. This program is not related to federal Contract Health Service (CHS) dollars, which are appropriated through the Indian Health Service.

Financial Sponsor: Individuals, organizations, or agencies that help an individual or family apply for Basic Health and pay all or a portion of the premium.

Government-to-Government: The relationship between tribes and the federal government. It is also used to describe other relationships and protocols between tribes and other governments like states.

HSA—Health Services Account: The health services account is created in the state treasury. Moneys in the account may be expended only for maintaining and expanding health services access for low-income residents, maintaining and expanding the public health system, maintaining and improving the capacity of the health care system, containing health care costs, and the regulation, planning, and administration of the health care system.

PEBB—Public Employees Benefits Board: The PEBB establishes eligibility requirements and approves plan benefits of all participating health care organizations. The board has nine members

appointed by the Governor, seven of who are voting members. The two non-voting members will become voting members when school district enrollment in PEBB plans exceeds 12,000 subscribers.

PEBB plans—Public Employees Benefit Board plans: The PEBB plan is administered through HCA to provide health benefits and related insurance coverage to all eligible state and higher-education employees as a benefit of employment. In addition, K-12 school districts and employer groups may also choose to join PEBB plans.

PPP—Preferred Provider Plan: A health care plan that makes available to its members either comprehensive health care services or a limited range of health care services performed by providers selected by the plan. It allows members to use providers outside the network but enrollees may be liable for a significant portion of these claims.

(CHS) Sliding Fee Productivity: The CHS sliding fee productivity has two parts determined by: 1) The number of unduplicated sliding fee users (people at or below 200% of FIG that have no other coverage. 2) Medical determined by the number of unduplicated sliding fee user visits. Dental determined by the number of sliding fee relative value units (RVUs). See WAC 182-20-200.

Tribal Sponsor: Tribes that sponsor tribal enrollees by helping to apply for Basic Health and pay for the BH premium.

Trust Responsibility: This references the unique legal status of American Indians to the United States. Trust responsibility is a legally enforceable obligation of the United States to protect tribal self-determination, tribal lands, assets, resources, and treaty rights, as well as carry out the directions of federal statutes and court cases.

Tribal Sovereignty: American Indian Tribes are recognized in federal law as possessing sovereignty over their members and their territory. Sovereignty means that tribes have the power to make and enforce laws, and to establish courts and other forums for resolution disputes. The sovereignty that American Indian Tribes possesses is inherent, which means that it comes from within the tribe itself and existed before the founding of the United States. Tribal sovereignty is not absolute, but rather is subject to certain limits resulting from the unique relationship of the tribes to the United States. Under federal law, tribes are said to retain all those aspects of the original sovereignty except aspects that have been given up in a treaty, taken away by an act of Congress, or divested by implication as a result of their dependent status. In addition to inherent sovereignty, tribal governments may also exercise authority delegated to them by Congress.

Key principles of sovereignty include:

- Tribal Sovereignty is the right of tribes, as "domestic dependent nations," to exercise self-determination and the right to self-government, unless these powers have been modified by treaty or by an act of Congress. Sovereignty ensures control over the future of the tribes and encourages preservation of tribal culture, religions, and traditional practices.

- Tribes have the authority to, among other things, govern their people and their land; define their own tribal membership criteria; create tribal legislation law enforcement, and court systems; and to impose taxes in certain situations.

Membership in a sovereign tribe is what distinguishes American Indians as a political group rather than solely an ethnic minority.

UMP – Uniform Medical Plan: A self-insured preferred provider health insurance plan administered by HCA and designed by PEBB, available to public employees, and retirees, and their dependents.

American Indian Health Care Delivery Plan Executive Summary

Working Together To Build A Healthy Future

The 2003 American Indian Health Care Delivery Plan

Executive Summary

American Indian Health Commission for Washington State

Washington State Department of Health

In collaboration with

The Northwest Portland Area Indian Health Board

Introduction

In recognition of the health disparities facing AI/ANs, Washington in 1995 enacted legislation requiring the Department of Health (DOH) to develop an American Indian Health Care Delivery Plan (AIHCDP).

Since its first publication in 1997, the AIHCDP and its subsequent updates have been the result of active collaboration between tribes, tribal organizations, and DOH. Through the auspices of the American Indian Health Commission for Washington State (AIHC), tribes have been the driving force in the report's contents and scope. The 2003 report**, Working Together To Build A Healthy Future**, is the latest such collaborative effort.

The AIHCDP must be viewed as an evolving framework to address health care issues affecting Washington's AI/AN population, and should be used as a starting point for continued dialogue with tribes and urban Indian health programs regarding their priorities and goals.

The AIHCDP has three main objectives. It is designed to:

- Show the health status of AI/ANs in Washington State using data to benchmark progress and identify areas in need of improvement
- Highlight successful tribal-state strategies for addressing health disparities in AI/AN populations
- Provide policy recommendations and objectives developed by tribes

Health Status of AI/ANs in Washington State

The 2003 AIHCDP focuses on three main areas in its report on the health status of AI/ANs in Washington State – population characteristics, health outcome measures, and other factors contributing to health status. Key findings are summarized below.

<u>Population Characteristics</u>

- The total AI/AN population in Washington is 112,006, making it the smallest racial group in the state (less than 2% of the population).
- The AI/AN population grew 27.4% between 1990 and 2000, 7.5% faster than the state population as a whole.
- The AI/AN population is forecasted to increase by 20% by 2005, to 134,000.
- Most AI/ANs live in Western Washington (72.4%), with 1/3 of the entire AI/AN population in King and Pierce counties.
- The gender split among AI/ANs in Washington is relatively equal, but there are more men than women in the 30- and younger groups and more women than men in the 31- and older groups.
- The AI/AN population is much younger than the rest of Washington's population.
- Families living on reservations are larger and more likely to be headed by single women.
- The median and per capita income of AI/ANs in Washington are lower, while poverty and unemployment are higher.
- The formal education attainment of AI/ANs in Washington is lower than the statewide population.
- Housing for AI/ANs living in Washington is more crowded, and there is a higher percentage of AI/AN homes without phone service.

Cover Photo: Spokane Family – Four Generations. Lewis, Richard T. 1940. University of Washington American Indians of the Pacific Northwest Digital Collection

- AI/ANs have the lowest insured rate of any racial and ethnic group in Washington.

Health Outcome Measures

- AI/ANs in Washington experience a disproportionately high mortality and morbidity burden compared to the general population, and the gap in the total age-adjusted death rate is not closing.
- Between 1999 and 2001, the average life expectancy of AI/ANs in Washington was 74.4 years, 3.9 years less than the statewide population.
- The age-adjusted mortality rates for AI/ANs due to stroke, chronic liver disease, diabetes, violence, suicide, and injury are higher than for the state as a whole.
- The AI/AN population has higher rates of several infectious diseases.
- Although infant mortality has improved in the past decade, pregnant AI/AN women delay prenatal care longer, are younger, and are more likely to smoke, which results in poorer birth outcomes.
- AI/AN children have poorer oral health than the state population as a whole.
- AI/ANs have a higher rate of obesity, and the obesity rate for AI/AN youth is increasing.
- Tobacco use among AI/ANs is high and likely increasing.
- Alcohol and substance abuse is a significant problem among AI/AN men, women, and youth, with death rates due to causes related to alcoholism substantially higher among AI/ANs than for the general population.

Other Factors

Limited access and funding gaps are contributing causes of the disproportionately poorer health status of AI/ANs in Washington State. Specific access issues include:

- Inability to pay for care and lack of insurance coverage
- Lack of geographically available services
- Not having a regular doctor
- Inadequate transportation
- Chronic underfunding of Indian Health Service (IHS) programs
- Lack of properly trained, culturally competent providers

Policy Priorities

The AIHCDP discusses priorities identified at the 2002 Tribal Leaders Health Care Summit and endorsed through issue papers approved by the American Indian Health Commission for Washington State. It gives background information, specific policy recommendations, current status, and additional steps needed to achieve desired outcomes. Critical issue areas and key policy recommendations are highlighted below.

Government-to-Government Relations

- AIHC will work with agencies without Centennial Accord Plans to identify issues of mutual concern and to develop a Centennial Accord Plan.

- AIHC will review the Department of Social and Health Services' (DSHS) Centennial Accord Plan and Administrative Policy 7.01 relative to health programs to identify areas of mutual concern and to develop a workplan that includes quality assurance standards.

- AIHC will draft and seek enactment of legislation codifying the intent, process, and plans of the Centennial Accord for state programs and agencies responsible for health programs and policies.

- AIHC will work with tribes and the Association of Washington Tribes to include in each Centennial Accord Plan provisions to address a comprehensive educational effort promoting a better understanding of the government-to-government relationship and to develop quality assurance standards, and will work with the state to conduct such educational efforts.

- AIHC will work with tribes and the Association of Washington Tribes to encourage the development of tribal Centennial Accord Plans.

- Tribes will work with the state on a government-to-government basis to develop a list of legislative, administrative, and other barriers to full implementation of Centennial Accord Plans.

Behavioral Health

- AIHC, in partnership with DSHS and the Northwest Portland Area Indian Health Board (NPAIHB), will locate funding to establish a workgroup on behavioral health issues.

- AIHC will encourage the development and implementation of a statewide policy to address the comprehensive health care needs of AI/ANs in a systematic manner.

- AIHC will work to ensure that comprehensive state and federal behavioral health funding continues to be available to tribes in a manner that acknowledges the government-to-government relationship.

- AIHC will work to ensure that Regional Support Network (RSN) board composition reflects the patient population served by the DSHS Mental Health Division and will work to increase AI/AN representation on RSN boards.

- AIHC will work to ensure that federal and state guidelines and regulations authorize reimbursement of traditional treatment approaches.

- AIHC will work to ensure that the Office of the Superintendent of Public Instruction participates in a government-to-government relationship with tribes to address the behavioral health needs of AI/AN students, parents, and tribal communities.

- AIHC will work to ensure that tribes have direct, equitable access to all state-funded behavioral health services, especially for in-patient treatment.

- AIHC will work with the Office of the Insurance Commissioner to ensure third-party coverage of mental health services.

- AIHC will work with relevant state agencies to assist tribes in enhancing local prevention activities.

Public Health Capacity

- AIHC should work to ensure that tribes have funding for community health assessments.

- AIHC should renew discussions with DOH to develop a strategy or workplan to define tribal health jurisdiction and to build tribal health capacity.

- AIHC should develop model environmental health agreements for tribal/local health departments.
- AIHC should develop model tribal codes for environmental health and communicable diseases.
- AIHC will request that the state actively include tribes in electronic public health discussion groups and other communications, especially related to infectious disease outbreaks.
- AIHC will work to provide state resources for connectivity at a comparable level to local health departments and other health agencies.

Medicaid Funding and Access

- AIHC opposes Medicaid cuts affecting AI/ANs.
- AIHC will work to ensure that S-CHIP is implemented in a way that is accessible for AI/AN children and families.
- AIHC should review, comment, and follow the Medicaid waiver submitted by DSHS in 2002.
- AIHC should pursue discussions with the Medical Assistance Administration (MAA) about defining a consistent benefit package for AI/ANs.
- DSHS should create a tribal workgroup on Medicaid issues.

Uniform Benefits Package

- AIHC should work with MAA and the Centers for Medicare and Medicaid Services (CMS) to research possible avenues to preserve current Medicaid services for AI/ANs that maintain budget neutrality and provide a more stable financial environment for tribal health programs.
- AIHC should work with the State Board of Health and other groups to identify a uniform benefits package that is a list of effective, basic services that AI/ANs need to access in order to maintain personal health and preserve the public health.

Dental Health

- AIHC should work to improve access to and funding for dental care.
- AIHC should work to identify and inform tribes about state-level dental resources not currently accessed by tribes.

Managed Care

- AIHC supports a feasibility study on developing a Washington State AI/AN Health Plan.
- AIHC will work to seek full implementation of the Patient Bill of Rights to ensure that plans pay Indian health programs for services provided to their AI/AN enrollees.

Data Collection and Use

- AIHC will promote the NPAIHB EpiCenter as the clearinghouse for AI/AN research in Washington.
- AIHC will request that the state work with the EpiCenter to establish data sharing agreements with tribes for health and social service data.
- AIHC will request that the state provide information and technical assistance on the types of health data it has and how tribes may access it.

- AIHC will work to identify current issues and develop model tribal ordinances on AI/AN research and the IRB process.

Tobacco

The 2003 AIHCDP provides an update on statewide tobacco cessation efforts and the distribution of settlement funds to tribes. It also describes the new DOH tribal tobacco training and technical assistance program subcontracted through the NPAIHB with the support of AIHC.

Workforce Development

- DOH, in consultation with tribes, should conduct an assessment of health care workers needed for tribal health programs in the next ten years.
- AIHC and NPAIHB should collaborate with Washington health agencies and organizations to identify existing programs and opportunities that encourage workforce diversity and invite AI/ANs to explore health careers.
- AIHC and NPAIHB will work with tribes to foster the desire for tribal members to pursue health careers and to better link tribes with DOH efforts on this front.
- AIHC will work with tribes and Indian health organizations to support increased funding for existing health career pipeline programs for AI/AN youth.
- AIHC will work with tribes and the Washington Health Foundation on AI/AN health care workforce development and the promotion of cultural competency.

Organizational Development of the American Indian Health Commission for Washington State

- Continued work on the AIHCDP should be funded.
- AIHC relations with the Board of Health, Governor's Office of Indian Affairs, Health Care Authority, Department of Health, Department of Social and Health Services, WA State Association of Local Public Health Officials, Office of the Insurance Commissioner, Region X DHHS, and Centers for Medicare and Medicaid Services should be expanded.
- DOH will work with NPAIHB and DOH to draft and distribute the 2003 AIHCDP.

Federal Issues

The 2003 AIHCDP also touches on federal policies which determine the parameters under which several key state-administered health programs – particularly Medicaid and S-CHIP – operate. AIHC members, largely through the NPAIHB, are active in a number of areas that influence these federal policies.

Success Stories

Interspersed throughout the 2003 AIHCDP are several success stories demonstrating innovations in the delivery of health care services to AI/ANs in Washington.

- The Port Gamble S'Klallam Tribe received the first IHS Director's award given to a tribal health care program.
- Colville tribal member Mel Tonasket was given Lifetime Achievement Award by the Washington Health Foundation.
- WACs implementing the Patient Bill of Rights ensure that private health plans reimburse Indian health programs for services they provide to insured AI/AN enrollees.

- Washington was the first state to implement contracts with federally recognized tribes to provide them with reimbursement through Medicaid Administrative Match (MAM), federal funding that supports the costs of assisting potential Medicaid beneficiaries to enroll and access Medicaid services.

- The Jamestown S'Klallam Tribe was given the Washington Health Foundation Innovations in Health Programs Award for its new approach to providing 100% access to health care for tribal members.

- As a result of discussions with tribes and tribal organizations, DOH adopted a tobacco settlement funding formula and distribution process that has helped to provide adequate base funding for both small and large tribes and that has produced a wide variety of successful local programs.

Appendices

The 2003 AIHCDP also contains the following resources designed to serve as education and communication tools for state and tribal officials:

- 2002 Tribal Leaders Health Summit Issue Papers

    - ✓ Behavioral Health
    - ✓ Centennial Accord Plans Related To Health Care
    - ✓ Uniform Benefits
    - ✓ Workforce Development

- Tribal Contacts

    - ✓ Tribal Leaders
    - ✓ Tribal and Urban Indian Health Programs

- Tribal Health System Profiles

    - ✓ Tribal
    - ✓ Urban Indian Health Systems
    - ✓ Indian Organizations

Copies of the 2003 American Indian Health Care Delivery Plan

The complete 127-page AIHCP can be downloaded through AIHC's website at http://www.aihc-wa.org/Issues/Issues.htm#delivery. CD-ROM and paper copies may be requested by contacting AIHC via e-mail (aihc@aihc-wa.org) or postal mail (American Indian Health Commission for Washington State, 1752 NW Market Street, Box 104, Seattle, WA 98107).

AIHC By-Laws

BYLAWS
OF THE
AMERICAN INDIAN HEALTH COMMISSION
FOR WASHINGTON STATE

(Membership Corporation)

We, the federally-recognized Indian Tribes, urban Indian programs authorized under Title V of the Indian Health Care Improvement Act, and individual Indian people of Washington territory, invoking the divine blessings of the Creator in order to preserve for the federally-recognized Indian Tribes, all rights secured under Treaties and agreements, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the welfare of the Indian people, do hereby establish this organization (the "Corporation" or "Commission") and solemnly pledge our devotion to and adoption of the following By-Laws.

ARTICLE 1. OFFICES

The principal office of the corporation shall be located at its principal place of business or such other place as the Board of Directors ("Board") may designate. The corporation may have such other offices, either within or without the State of Washington, as the Board may designate or as the business of the corporation may require from time to time.

ARTICLE 2. MEMBERSHIP

2.1 Classes of Members

The corporation shall initially have one class of members. Additional classes of members, the manner of election or appointment of each class of members, and the qualifications and rights of each class of members may be established by amendment to these Bylaws.

2.2 Qualifications for Membership

Membership with full voting rights shall include the federally recognized Tribes in Washington State, urban Indian programs authorized under Title V of the Indian Health Care Improvement Act, and up to four At-Large positions to provide for representation for individual American Indian and Alaska Native people within Washington State. At-Large positions are to be accepted by majority vote of the tribal delegates. Members may have such other qualifications as the Board may prescribe by amendment to these Bylaws.

2.3 Voting Rights

2.3.1 Voting rights of the members shall be exercised by their voting delegates (the "Delegates").

2.3.2 Eligibility of Delegates must be credentialed through a Tribal or organizational resolution or acceptance as an At-Large delegate by a majority vote of the Tribal Delegates. A Delegate is defined to mean the delegate or the alternate(s), assigned by a resolution or another authorizing document.

2.3.3 Each member of this Commission shall, at every meeting of the members, be entitled to one vote in person or by proxy upon each subject properly submitted to vote.

2.3.4 No proxy shall be deemed operative unless and until signed by the authorized member delegate and filed with the Commission. In the absence of limitation to the contrary contained in the proxy, the same shall extend to all meetings of the members and shall remain in force three years from its date or until sooner revoked.

2.3.5 Commission: Each member shall have one delegate and as many alternates as it chooses, but is entitled to only one (1) vote on each issue or matter calling for a vote. The intent of the Commission is to achieve consensus. All matters regarding the sovereign rights of Tribes must be determined by consensus among the Tribal delegates. In the absence of consensus, matters regarding policy shall be determined by a minimum of seventy-five (75%) percent of delegates present and voting. All other matters regarding organizational actions shall be determined by a majority vote of delegates present and voting, unless otherwise stipulated by the Commission.

2.3.6 Board: Each member of the Board shall have one (1) vote. All matters shall be determined by a majority vote, unless otherwise stipulated by the Commission.

2.4 Number and Term of Commission Delegates

The business, property and affairs of this organization shall be managed by a Commission composed of delegates, one from each eligible Tribe, and the Seattle Indian Health Board who shall be members of this Commission, together with the At-Large delegates accepted by a majority vote of the Tribal delegates.

2.5 Verification of Delegates

Each delegate shall be certified by resolution or other authorizing documents from each of the member Tribes and the Seattle Indian Health Board. The documentation shall identify the name of the delegate(s) and alternate(s).

2.6 Vacancies of Delegates

Vacancies in the Commission shall be filled by appointment made by the authorizing tribal government or organization. In the case of At-Large delegates, vacancies shall be filled by a majority vote of the tribal delegates. Each person so selected to fill a vacancy shall remain a delegate until his successor has been appointed by the member Tribe(s) or recognized urban program.

2.7 Annual Membership Meeting

The annual membership meetings of the Commission shall be held during the month of November on a date established by the Board. Election of Directors and officers will take place every odd numbered year, at the Annual Meeting. Delegates shall receive a minimum of thirty (30) calendar days' notice of the date for the Annual Meeting. This date may not be changed unless consented to in writing, or by a resolution adopted at a meeting, by all Delegates entitled to vote at the meeting.

The annual meeting of the members shall be held for the purpose of electing Directors and transacting such other business as may properly come before the meeting. If the annual meeting is not held on the date designated therefore, the Board shall cause the meeting to be held as soon thereafter as may be convenient.

2.8 Special Membership Meetings

The President, the Board, or not less than a majority of the members entitled to vote at such meeting, may call special meetings of the members for any purpose.

2.9 Place of Meetings

Any or all meetings of the Commission shall be held at a place established by the Board of the Commission.

2.10 Notice of Regular and Special Meetings

2.10.1 Regular meetings of the members shall be determined by the President or at the call of three (3) or more of the Board members. Regular meetings of the Commission shall convene for the purpose of transacting business properly brought before it, provided, that the Commission meeting was called and a minimum of twenty (20) calendar days of notice was provided to the Commission delegates.

2.10.2 Special meetings of the members shall be determined by the President or at the call of three (3) or more of the Board members. Special meetings of the Commission shall convene for the purpose of transacting business properly brought before it, provided, that the Commission meeting was called and a minimum of ten (10) calendar days' notice was provided to the Commission delegates.

2.10.3 At any time, upon the written request or not less than a majority of the members entitled to vote at the meeting, it shall be the duty of the Secretary to give notice of a special meeting of members to be held at such date, time and place as the Secretary may fix, not less than ten (10) nor more than thirty-five (35) days after receipt of such written request, and if the Secretary shall neglect or refuse to issue such notice, the person or persons making the request may do so and may fix the date, time and place for such meeting. If such notice is mailed, it shall be deemed delivered when deposited in the official government mail properly addressed to the member at his or her address as it appears on the records of the corporation with postage thereon prepaid.

2.10.4 The President, the Secretary or the Board shall cause to be delivered to each member entitled to notice of or to vote at the meeting, either personally or by mail, written notice stating the place, date and time of the meeting and, in the case of a special meeting, the purpose or purposes for which the meeting is called. All notices required to be given by any provision of these By-Laws shall state the authority pursuant to which they are issued ("by order of the President," or "by order of the Commission" as the case may be) and shall bear the written, stamped, typewritten or printed signature of the President, Secretary or Treasurer.

2.11 Waiver of Notice

Whenever any notice is required to be given to any member under the provisions of these Bylaws, the Articles of Incorporation or applicable Washington law, a waiver thereof in writing, signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice. Notice of the time, place and purpose of any meeting of the Commission, waived for emergency purposes by telecommunication or other writing must be authorized by the Board of Directors. The attendance of a Member at a meeting shall constitute a waiver of notice of such meeting, except where a Member attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.

2.12 Quorum

A quorum of the membership of the Commission shall be a minimum of thirty percent (30%) of the Delegates.

2.13 Manner of Acting

The vote of a majority of the votes entitled to be cast by the members represented in person at a meeting at which a quorum is present shall be necessary for the adoption of any matter voted upon by the

members, unless a greater proportion is required by applicable Washington law, the Articles of Incorporation or these Bylaws.

2.14 Order of Business at Meetings

2.14.1 In the absence of any objection, the presiding officer may vary the order of business at his/her discretion. Otherwise, the order of business at the meetings of the members shall be as follows:

2.14.1.1 Roll call and determination of quorum
2.14.1.2 Reading and approval of minutes of last meeting
2.14.1.3 Reports of Officers, if any
2.14.1.4 Reports of Committees and/or Task Forces, if any
2.14.1.5 Old Business
2.14.1.6 New Business
2.14.1.7 Unscheduled Business
2.14.1.8 Schedule next meeting(s)
2.14.1.9 Adjournment

2.14.2 The minutes of each meeting shall be mailed to each Tribe and organization for review and comment, approved by a majority vote at a subsequent meeting and certified by the Secretary or authorized officer.

2.15 Action by Members Without a Meeting

Any action which could be taken at a meeting of the members may be taken without a meeting if a written consent setting forth the action so taken is signed by all members entitled to vote with respect to the subject matter thereof. Such written consents may be signed in two or more counterparts, each of which shall be deemed an original and all of which, taken together, shall constitute one and the same document. Any such written consent shall be inserted in the minute book as if it were the minutes of a meeting of the members.

2.16 Meetings by Telephone

Members of the corporation may participate in a meeting of members by means of a conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other at the same time. Participation by such means shall constitute presence in person at a meeting.

2.17 Powers to Make Bylaws

The Commission shall have the power to make and alter the Bylaws in accordance with Article 6.

2.18 Power to Elect Board of Directors

The Commission shall have power to elect a Board of Directors. The Commission shall select a Chair, a Vice-Chair, a Secretary, and a Treasurer to serve on the Board of Directors.

2.19 Power to Establish Organizational Policies and Procedures

2.19.1 The Commission shall have the power to establish an Organizational Policies and Procedures Manual to guide the staff and organizational operations.

2.19.2 The Policies and Procedures of this organization shall require that the organization maintain a balanced budget and shall not incur any debts, unless approved by three-fourths (3/4) of the voting membership.

2.20 Power to Establish Committees and Task Forces

The Commission shall have the authority to establish Standing Committees and Task Forces as necessary. The Commission shall establish the mission, objectives, membership, and rules that guide the Committee or Task Force.

ARTICLE 3. BOARD OF DIRECTORS

3.1 General Powers

The affairs of the corporation shall be managed by a Board of Directors (the "Board").

3.2 Number

The Commission shall have power to elect a Board of Directors composed of five (5) delegates, of which four (4) shall be tribal delegates. The Board of Directors shall include the officers, who shall have and exercise the authority of the Commission in the management of the business between meetings of the Commission. The number of Directors may be changed from time to time by amendment to these bylaws, provided that no decrease in the number shall have the effect of shortening the term of any incumbent Director.

3.3 Qualifications

Directors shall be members of the corporation. Directors may have such other qualifications as the Board may prescribe by amendment to these Bylaws.

3.4 Election of Directors

3.4.1 Initial Directors. The initial Directors shall be named in the Articles of Incorporation and shall serve until the next election.

3.4.2 Successor Directors. Successor Directors shall be elected at the annual meeting of members pursuant to Section 2.7.

3.5 Term of Office

Each member of the Board of Directors shall serve a two (2) year term, unless a Director dies, resigns or is removed.

3.6 Annual Meeting

The annual meeting of the Board shall be held without notice at the same time and at the same place as the annual meeting of members for the purposes of electing officers and transacting such business as may properly come before the meeting.

3.7 Regular Meetings

Regular meetings of the Board shall be held without notice at the same time and at the same place as the regular meeting of members for the purposes of transacting such business as may properly come before the meeting.

3.8 Special Meetings

Special meetings of the Board shall be held without notice at the same time and at the same place as any special meeting of members for the purposes of transacting such business as may properly come before the meeting. The person or persons authorized to call special meetings may fix any place either within or without the State of Washington as the place for holding any special Board or committee meeting called by them.

3.9 Meetings by Telephone

Members of the Board or any committee designated by the Board may participate in a meeting of such Board or committee by means of a conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other at the same time. Participation by such means shall constitute presence in person at a meeting.

3.10 Place of Meetings

All meetings shall be held at the principal office of the corporation or at such other place within or without the State of Washington designated by the Board, by any persons entitled to call a meeting or by a waiver of notice signed by all Directors.

3.11 Waiver of Notice

3.11.1 In Writing

Whenever any notice is required to be given to any Director under the provisions of these Bylaws, the Articles of Incorporation or applicable Washington law, a Waiver thereof in writing, signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board need be specified in the waiver of notice of such meeting.

3.11.2 By Attendance

The attendance of a Director at a meeting shall constitute a waiver of notice of such meeting, except where a Director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.

3.12 Quorum

Three of the number of Directors in office shall constitute a quorum for the transaction of business at any Board meeting. If a quorum is not present at a meeting, a majority of the Directors present may adjourn the meeting from time to time without further notice.

3.13 Manner of Acting

The act of the majority of the Directors present at a meeting at which there is a quorum shall be the act of the Board, unless the vote of a greater number is required by these Bylaws, the Articles of Incorporation or applicable Washington law.

3.14 Presumption of Assent

A Director of the corporation present at a Board meeting at which action on any corporate matter is taken shall be presumed to have assented to the action taken unless his or her dissent or abstention is entered in the minutes of the meeting, or unless such Director files a written dissent or abstention to such action with the person acting as secretary of the meeting before the adjournment thereof, or forwards such dissent or abstention by registered mail to the Secretary of the corporation immediately after the adjournment of the meeting. Such right to dissent or abstain shall not apply to a Director who voted in favor of such action.

3.15 Action by Board Without a Meeting

Any action which could be taken at a meeting of the Board may be taken without a meeting if a written consent setting forth the action so taken is signed by each of the Directors. Such written consents may be signed in two or more counterparts, each of which shall be deemed an original and all of which, taken together, shall constitute one and the same document. Any such written consent shall be inserted in the minute book as if it were the minutes of a Board meeting.

3.16 Resignation

Any Director may resign at any time by delivering written notice to the President or the Secretary at the registered office of the corporation, or by giving oral or written notice at any meeting of the Directors. Any such resignation shall take effect at the time specified therein, or if the time is not specified, upon delivery thereof and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

3.17 Removal

At a meeting of members called expressly for that purpose, one or more Directors (including the entire Board) may be removed from office, with or without cause, by two-thirds of the votes cast by members then entitled to vote on the election of Directors represented in person or by proxy at a meeting of members at which a quorum is present.

3.18 Vacancies

3.18.1 Vacancy(s) shall be replaced in the same procedures as they were elected and shall serve the remainder of the authorized term unless otherwise determined by the member Tribe.

3.18.2 If one of the Board Member's positions is replaced then the Commission shall hold an election for the vacant position on the Board within 60 calendar days of removal.

3.19 Board Committees

3.19.1 Committees or Task Forces

The Board, by resolution adopted by a majority of the Directors in office, may designate and appoint one or more Committees or Task Forces, each of which shall consist of two or more Directors. Such Committees or Task Forces shall have and exercise the authority of the Directors in the management of the corporation, subject to such limitations as may be prescribed by the Board; except that no Committee or Task Force shall have the authority to: (a) amend, alter or repeal these Bylaws; (b) elect, appoint or remove any member of any other committee or any Director or officer of the corporation; (c) amend the Articles of Incorporation; (d) adopt a plan of merger or consolidation with another corporation; (e) authorize the sale, lease or exchange of all or substantially all of the property and assets of the corporation

not in the ordinary course of business; (f) authorize the voluntary dissolution of the corporation or revoke proceedings therefore; (g) adopt a plan for the distribution of the assets of the corporation; or (h) amend, alter or repeal any resolution of the Board which by its terms provides that it shall not be amended, altered or repealed by a Committee or Task Force. The designation and appointment of any such Committee or Task Force and the delegation thereto of authority shall not operate to relieve the Board or any individual Director of any responsibility imposed upon it, him or her by law.

3.19.2 Quorum; Manner of Acting

A majority of the number of Directors composing any committee shall constitute a quorum, and the act of a majority of the members of a committee present at a meeting at which a quorum is present shall be the act of the committee.

3.19.3 Resignation

Any member of any committee may resign at any time by delivering written notice thereof to the President, the Secretary or the chairperson of such committee, or by giving oral or written notice at any meeting of such committee. Any such resignation shall take effect at the time specified therein, or if the time is not specified, upon delivery thereof and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

3.19.4 Removal of Committee Member

The Board, by resolution adopted by a majority of the Directors in office, may remove form office any member of any committee elected or appointed by it.

3.20 Compensation

The Directors shall receive no compensation for their service as Directors but may receive reimbursement for expenditures incurred on behalf of the corporation.

ARTICLE 4. OFFICERS

4.1 Number and Qualifications

The officers of the corporation shall be a President, one or more Vice Presidents, a Secretary and a Treasurer, each of whom shall be elected by the Board. Other officers and assistant officers may be elected or appointed by the Board, such officers and assistant officers to hold office for such period, have such authority and perform such duties as are provided in these Bylaws or as may be provided by resolution of the Board. Any officer may be assigned by the Board any additional title that the Board deems appropriate. Any two or more offices may be held by the same person, except the offices of President and Secretary.

4.2 Election and Term of Office

Each officer shall serve a two (2) year term, unless an officer dies, resigns or is removed.

4.3 Resignation

Any officer may resign at any time by delivering written notice to the President, a Vice President, the Secretary or the Board, or by giving oral or written notice at any meeting of the Board. Any such resignation shall take effect at the time specified therein, or if the time is not specified, upon delivery thereof and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

4.4 Removal

Any officer or agent elected or appointed by the Board may be removed from office by the Board whenever in its judgment the best interests of the corporation would be served thereby, but such removal shall be without prejudice to the contract rights, if any, of the person so removed.

4.5 Vacancies

Vacancy(s) shall be replaced in the same procedures as they were elected and shall serve the remainder of the authorized term unless otherwise determined by the members.

4.6 President

The President shall be selected by, and from, the membership of the Commission and shall be the chief executive officer of the corporation, and, subject to the Board's control, shall supervise and control all of the assets, business and affairs of the corporation. The President shall preside over meetings of the members and the Board. The President shall have general and active management of the business of the corporation and shall see that all orders and resolutions of the board are carried into effect. The President shall be a member of all standing committees, task forces, and shall have the general powers and duties of supervision and management usually vested in the office of the president of an organization. As a member of any standing committee or task force, the President shall vote only if recognized as an authorized voter for an associated Tribe. The President may sign deeds, mortgages, bonds, contracts, or other instruments, except when the signing and execution thereof have been expressly delegated by the Board or by these Bylaws to some other officer or agent of the corporation or are required by law to be otherwise signed or executed by some other officer or in some other manner. In general, the President shall perform all duties incident to the office of President and such other duties as are assigned to him or her by the Board from time to time.

4.7 Vice President

A Vice-President shall be a Tribal delegate chosen from the membership of the Commission. He/she shall perform the duties and exercise the powers of the President during the absence or disability of the President.

4.8 Secretary/ Treasurer

The Secretary/Treasurer shall attend all meetings of the members and of the Board of Directors, and shall preserve in books of the corporation true minutes of the proceedings of all such meetings. All notices required by By-Law or resolution shall be given by the Secretary/Treasurer. The Secretary/ Treasurer shall perform such other duties as may be delegated by the Commission or the Board of Directors. The Secretary/Treasurer shall provide for reports of the use of funds made available to the organization to advance the purpose of the Commission. The Secretary/Treasurer shall in general perform all duties incident to the office of Secretary/Treasurer and such other duties as from time to time may be assigned to him or her by the President or the Board.

ARTICLE 5. ADMINISTRATIVE PROVISIONS

5.1 Books and Records

The corporation shall keep at its principal or registered office copies of its current Articles of Incorporation and Bylaws; correct and adequate records of accounts and finances; minutes of the proceedings of its members and Board, and any minutes which may be maintained by committees of the Board; records of the name and address and class, if applicable of each member and Director, and of the name and post office address of each officer; and such other records as may be necessary or advisable. All

books and records of the corporation shall be open at any reasonable time to inspection by any member of three months standing or to a representative of more than five percent of the membership.

5.2 Accounting Year

The accounting year of the corporation shall be the twelve months ending December.

5.3 Rules of Procedure

The rules of procedure at meetings of the Board and committees of the Board shall be rules contained in Roberts' Rules of Order on Parliamentary Procedure, newly revised, so far as applicable and when not inconsistent with these Bylaws, the Articles of Incorporation or any resolution of the Board.

ARTICLE 6. AMENDMENTS

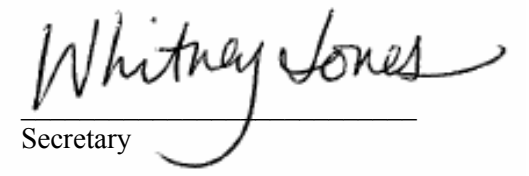
These by-laws may be amended by the affirmative vote of two-thirds (66.7%) of the voting delegates at any regular meeting of the Commission if notice of possible amendment was stated in the notice for the meeting. When prior notice is not given, the Amendments may be proposed at a regular or special meeting of the Commission and adopted at a subsequent regular meeting.

ARTICLE 7. DICLAIMER CLAUSE

This organization does not have the authority or power to infringe or jeopardize the sovereignty of any member Tribe. Nothing herein shall constitute or evidence recognition as an Indian Tribe of any presently unrecognized group.

CERTIFICATION

The foregoing Bylaws were adopted by the Board of Directors on June 12, 2003.



Secretary

AIHC Membership and Executive Committee

American Indian Health Commission for Washington State

Members

Chehalis Tribe • Colville Confederated Tribes • Cowlitz Indian Tribe • Kalispel Tribe of Indians • Lower Elwha Klallam Tribe • Lummi Tribe • Jamestown S'Klallam Tribe • Makah Tribe • Muckleshoot Tribe • The N.A.T.I.V.E. Project • Nooksack Tribe • Port Gamble S'Klallam Tribe • Puyallup Tribe • Quinault Nation • Quileute Tribe • Samish Nation • Sauk-Suiattle Indian Tribe • Seattle Indian Health Board • Shoalwater Bay Tribe • Skokomish Tribe • Small Tribes of Western Washington • Spokane Tribe • Squaxin Island Tribe • Stillaguamish Tribe • Suquamish Tribe • Swinomish Tribe • Tulalip Tribes • Upper Skagit Tribe

Executive Committee (2003-2005)

Chair
Marilyn Scott (Chairwoman, Upper Skagit Tribe)

Vice Chair
Cindy Lowe (Clinic Manager, Jamestown S'Klallam Tribe)

Secretary
Whitney Jones (Health Director, Squaxin Island Tribe)

Treasurer
Rod Smith (Director, Puyallup Tribal Health Authority)

Member-At-Large
Crystal Tetrick (Operations Coordinator, Seattle Indian Health Board)

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AIHC 2003 – 2004 Meeting Agendas

American Indian Health Commission for Washington State

QUARTERLY MEETING
MARCH 14, 2003
SEATTLE INDIAN HEALTH BOARD
AGENDA

10:00	**Welcome/Invocation/Introductions** Marilyn Scott, AIHC Chair
10:15	**Roll Call** Whitney Jones, AIHC Secretary
10:20	**Review of December 12, 2002 Minutes**
10:30	**Review of Agenda** Marilyn Scott
10:35	**Centennial Accord Plans Related to AI/AN Health** Andrea Alexander, Acting Director Governor's Office of Indian Affairs
11:00	**Tobacco Program Update/Increasing Assessment & Technical Assistance Support to AI/AN** David Harrelson, Tobacco Prevention Specialist DOH Office of Community Wellness & Prevention
11:15	**DSHS Update/7.01 Plan Reviews** Doug North, Regional Manager – Region Four DSHS Indian Policy & Support Services
11:30	**Overview of Proposed Budget Cuts** Becky Donovan Johnston, AIHC Director
11:45	**Northwest Portland Area Indian Health Board Update** Jim Roberts, NPAIHB Policy Analyst
12:00	**Working Lunch**
	DOH Update Maria Gardipee, Tribal Liaison & Agency Multicultural Coordinator DOH Office of Policy, Legislative, & Constituent Relations
	MAA Update Rick Arnold, AI-AN Liaison Medical Assistance Administration Division of Policy & Analysis
1:00	**Social Security Administration Training and Outreach** Dan Ferrell, Regional Communication Director, and Mary Ann Traynor, Public Affairs Specialist Social Security Administration
1:30	**Review of Bylaws/Application for Non-Profit Status** Lee Shannon, Attorney Hobbs, Straus, Dean & Walker, LLP
1:55	**Set Next Meeting Date and Location**
2:00	**Adjourn**

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American Indian Health Commission for Washington State

May 16, 2003
Seattle Indian Health Board
Agenda

10:00 **Welcome/Invocation/Introductions**
Marilyn Scott, AIHC Chair

10:15 **Roll Call**
Whitney Jones, AIHC Secretary

10:20 **Review of March 14, 2003 Minutes**

10:30 **Review of Agenda**
Marilyn Scott

10:35 **Health Care Authority Update**
Pete Cutler, Acting Administrator
Washington Health Care Authority

11:00 **Proposed By-Laws/Articles of Incorporation**
Marilyn Scott

11:30 **Director's Update**
Becky Johnston, AIHC Director

11:45 **Medical Assistance Administration Update**
Roger Gantz, Director
Rick Arnold, Indian Health Program Manager
MAA Office of Policy and Analysis

1:00 **Proposed WAC on Medicaid Estate Recovery**
Tony Mauhar, Supervisor, Medicaid Estate Recovery
DSHS Financial Services Administration

1:15 **Title X Funding Outreach**
Sharon McAllister, Section Manager
DOH Office of Family Planning and Reproductive Health

1:45 **NPAIHB Update**
Jim Roberts, NPAIHB Policy Analyst

1:55 **Set Next Meeting Date and Location**

2:00 **Adjourn**

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American Indian Health Commission for Washington State

July 11, 2003
Seattle Indian Health Board
Agenda

10:00 **Welcome/Invocation/Introductions**
Marilyn Scott, AIHC Chair

10:15 **Roll Call**
Whitney Jones, AIHC Secretary

10:20 **Review of May 16, 2003 Minutes**

10:30 **Review of Agenda**
Marilyn Scott

10:35 **Review of American Indian Health Care Delivery Plan**
Becky Johnston, AIHC Director

Kris Sparks, Director
DOH Office of Community and Rural Health

11:15 **Medical Assistance Administration Update**
Rick Arnold, Indian Program Manager
Medical Assistance Administration Division of Policy & Analysis

11:45 **Director's Update**
Becky Johnston

12:00 **Homeland Security/Public Health Emergency Response Issues**
John Erickson, Director, Public Health Preparedness & Response Program
Department of Health

Suzanne Swadener, Assistant Director, NW Center for Public Health Practice
U-WA School of Public Health & Community Medicine

1:15 **Proposed Changes to the Patient Requiring Regulation Program**
Bernice Lawson, Program Manager
Medical Assistance Administration Division of Customer Support

Shauna Owen, Program Manager
Medical Assistance Administration Division of Customer Support

1:45 **NPAIHB Update**
Jim Roberts, NPAIHB Policy Analyst

1:55 **Set Next Meeting Date and Location**

2:00 **Adjourn**

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American Indian Health Commission for Washington State

September 12, 2003
Seattle Indian Health Board
Agenda

Welcome/Invocation/Introductions

10:00 Marilyn Scott, Chair, AIHC

10:15 **Roll Call**
Whitney Jones, Secretary, AIHC

10:20 **Review of July 11, 2003 Minutes**

10:30 **Review of Agenda**
Marilyn Scott

10:35 **Sue Crystal Bill Discussion**
Becky Johnston, Director, AIHC

11:00 **Health Care Authority Centennial Accord Plan Update**
Jan Olmstead, Tribal Liaison, Health Care Authority

11:30 **NPAIHB Update**
Jim Roberts, Policy Analyst, NPAIHB

11:40 **Uniform Benefits Update**
Rod Smith, Director, Puyallup Tribal Health Authority
Kris Locke, Consultant, AIHC

12:00 **Medicaid Eligibility Changes Overview Training**
Wendy Forslin, Division of Customer Support, MAA

1:00 **DOH Centennial Accord Plan Update**
Maria Gardipee, DOH

1:15 **"Let's Get Washington Covered"**
Bill Daley, Deputy Commissioner for Policy and Legislation, Office of the Insurance Commissioner

1:45 **AIHC-IPAC Conference Update**
Marilyn Scott, Becky Johnston

1:55 **Set Next Meeting Date and Location**

2:00 **Adjourn**

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"Coming Together"

Tribal Mental Health Summit
Indian Policy Advisory Committee/American Indian Health Commission Summit

November 6 – 7, 2003
Skagit Valley Casino Resort
Bow, Washington

Thursday, November 6, 2003

8:30 – 10:30	General Assembly 8:30 Invocation – *Upper Skagit Elder* 8:40 Welcome *Liz Mueller, Chair, IPAC* *Marilyn Scott, Chair AIHC* *Karl Brimner, Director, DSHS Mental Health Division* 9:10 Roll Call *AIHC – Whitney Jones, Secretary* *IPAC – Nancy Dufraine, Secretary* 9:20 Panel – A Multi-Tiered Approach to Addressing Tribal Mental Health Issues Dr. *Connie Hunt, Indian Health Service – Portland Area Office* *Karl Brimner, DSHS Mental Health Division* *Dr. Charlene Matheson, Puyallup Tribe* *Jean Robertson, King County RSN*		
10:30 – 11:00	Break		
11:00 – 12:30	IPAC Meeting • *7.01 Policy* • *By-Laws* • *Strategic Plan*	AIHC Meeting • *Elections* • *Sue Crystal Bill* • *HCA Cent. Accord*	Tribal Mental Health Summit • *Facilitated Go-Around* • *Barriers* • *What's Needed*
12:30 – 2:00	Lunch		
2:00 – 3:00	Joint IPAC-AIHC Meeting *Prep for Budget Meeting with Secretary Braddock*		Tribal Mental Health Summit • *Hot Policy Issues* • *Defining/Writing Policy*
3:00 – 5:00	Joint IPAC-AIHC Meeting *Secretary Braddock – 2005-2007 Budget Priorities and TANF Proposal*		

Friday, November 7, 2003

9:00 – 10:00	DHHS Region X Issues/Update on Consultations *Elizabeth Healy, Executive Officer, DHHS Region X* *Ed Fox, Executive Director, NW Portland Area Indian Health Board*	Tribal Mental Health Summit • *Best Practices*
10:00 – 11:00	Medical Assistance Administration Strategic Plan *Doug Porter, Assistant Secretary, MAA*	
11:00 – 11:30	Tribal Mental Health Summit Report *Avreayl Jacobson, Program Administrator, DSHS Mental Health Division*	
11:30 – 1:00	Lunch – Keynote Address – "Working with Tribal Leaders To Improve Health" *Brian Cladoosby, Chairman, Swinomish Tribe*	
1:00 – 1:30	Division of Alcohol and Substance Abuse Tribal Gathering Report *Fred Garcia, Chief, DASA Office of Program Services* *Sandra Mena, Special Programs Manager, DASA*	
1:30 – 2:30	Next Steps	

Meeting Rooms	
Monday Morning General Assembly	Pacific Showroom – 2nd Floor
AIHC Meeting	Northwest Ballroom B
IPAC Meeting	Northwest Ballroom A
Monday Afternoon Joint IPAC-AIHC Meeting	Northwest Ballroom A&B
Friday Joint IPAC-AIHC Meeting	Northwest Ballroom A&B
Friday Luncheon	Pacific Showroom – 2nd Floor
Mental Health Summit	Cascade Court Ballroom

Special Thanks To:

Washington State Department of Social & Health Services

Washington HEALTH FOUNDATION

Northwest Portland Area Indian Health Board

American Indian Health Commission for Washington State

November 6, 2003
Upper Skagit Casino Resort
Agenda

11:00 **Welcome/Introductions**
Marilyn Scott, Chair, AIHC

11:10 **Review September 12, 2003 Minutes**

11:15 **Review Agenda**
Marilyn Scott

11:20 **Sue Crystal Bill Update/Centennial Accord Meeting Update**
Marilyn Scott and Becky Johnston

11:30 **AIHC Elections**

11:50 **State Board of Health Vacancy Issue**
Becky Johnston, Director, AIHC

12:00 **Health Care Authority Centennial Accord Plan Discussion**
Jan Olmstead, HCA Tribal Liaison

12:15 **NPAIHB Update**
Ed Fox, NPAIHB Executive Director

12:25 **Set Next Meeting Date**

12:30 **Adjourn**

Note: Roll Call will be conducted at 9:00 during the joint AIHC-IPAC general assembly. This is necessary to ensure a quorum, due to the number of delegates and alternates who serve on both AIHC and IPAC.

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American Indian Health Commission for Washington State

January 9, 2004
Seattle Indian Health Board
Agenda

10:00 **Welcome/Introductions**
Marilyn Scott, Chair, AIHC

10:10 **Roll Call**
Whitney Jones, Secretary, AIHC

10:15 **Review September 12, 2003 and November 6, 2003 Minutes**

10:25 **Review Agenda**
Marilyn Scott

10:30 **Election of At-Large Executive Committee Member**

10:40 **Governor's Office of Indian Affairs Update**
Kyle Taylor Lucas, Executive Director

11:00 **TB Outbreak in AI/ANs**
Dr. Masa Narita, TB Control Officer, Seattle & King County Public Health
Linda Lake, TB Program Manager, Seattle & King County Public Health

11:30 **Emergency Preparedness Funding and Assessments**
John Erickson, Director, DOH Public Health Preparedness & Response
Joe Finkbonner, Director, Northwest Tribal EpiCenter

12:00 **Working Lunch – MAA Issue Update**
Roger Gantz, Policy Director, MAA
Deb Sosa, Indian Program Manager, MAA

1:15 **Public Health Issues Related To Water Conservation Rulemaking**
Denise Addotta Clifford, Constituent Relations Manager
DOH Office of Drinking Water

1:45 **Sue Crystal Bill Update and Discussion**
Sen. Pat Thibaudeau (Invited)
Becky Johnston, AIHC Director

2:00 **Uniform Benefits Update**
Marilyn Scott
Kris Locke, AIHC Consultant

2:30 **NPAIHB Update**
Ed Fox, NPAIHB Executive Director
Jim Roberts

2:55 **Set Next Meeting Date**

3:00 **Adjourn**

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American Indian Health Commission for Washington State

March 5, 2004
Seattle Indian Health Board
Agenda

10:00 **Welcome/Introductions**
Marilyn Scott, Chair, AIHC

10:10 **Roll Call**
Whitney Jones, Secretary, AIHC

10:15 **Review January 9, 2004 Minutes**

10:25 **Review Agenda**
Marilyn Scott

10:30 **Emergency Preparedness Funding and Assessments**
Joe Finkbonner, Director, Northwest Tribal EpiCenter
Jack Thompson or Suzanne Swadener

11:00 **Medicaid Integration Project**
Brett Lawton, Department of Social and Health Services

11:45 **Sue Crystal Bill Update and Discussion**
Becky Johnston, AIHC Director

12:00 **Healthy Youth Survey**
David Harrelson, DOH Tobacco Program
Susan Richardson, DOH Tobacco Program
Linda Becker, DSHS Division of Alcohol and Substance Abuse

1:15 **Health Care Authority – PEBB Issues**
Sandi Lakey, PEBB Outreach and Training Manager
Jan Olmstead, Tribal Liaison

2:00 **NPAIHB Tobacco Project Update**
Nichole Hildebrant, CIRCLE Project, NPAIHB
Stephanie Craig, Western Tobacco Prevention Project, NPAIHB

2:15 **Uniform Benefits Update**
Kris Locke, AIHC Consultant

2:30 **NPAIHB Update**
Jim Roberts, NPAIHB Policy Analyst

2:55 **Set Next Meeting Date**

3:00 **Adjourn**

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