

A Best Practice  
Health Organizations in the Pacific Northwest

Submitted by:  
Colleen F. Cawston,  
Masters in Public Administration Candidate

Health care and health services are the federal responsibility for the provision to American Indian and Alaska Natives through the established treaties, executive orders, legislation and court decisions. Within Washington State all of these mechanisms are in place among the 29 Federally recognized tribes. Repeatedly identified in various reports including the Indian Health Service budget formulation process and the Level of Need workgroup have identified that there is a disparity of about \$8-9 billion to meet the true need of health care for Indian people.

A question arises when seeing such disparity, and that is how does one this get the attention of the lawmakers? Specifically how can the tribes have this message be delivered and heard by the United States Congress? Within the Northwest there has been great success in this by the formation of boards that focus on the health and health care systems of tribes. Three such organizations will be the focus of this paper; the Northwest Portland Area Indian Health Board, the Indian Policy Advisory Committee and the American Indian Health Commission. The later two are specific to the state of Washington and the former is a regional organization of the tribes in Idaho, Oregon and Washington.

The Northwest Portland Area Indian Health Board (NPAIHB) was formed in 1972. The creation of the board stemmed from a recognized necessity to have one unified voice when addressing decision makers of Indian Health Care. The era of formation was at the end of the Federal Termination era. And was a time in which tribes needed to speak in a unified manner, so as to avoid the tactic of “divide and concur”. Tribes in the Northwest

were fortunate to have leaders of health like; Shirley M. Palmer, Colville Business Council, James SiJohn, Spokane Business Committee and Bernice Mitchell, Warm Springs Business Council to name a few<sup>1</sup>. These leaders saw the need to form themselves and to identify issues, strategize approaches to the issues, and form a mechanism of credibility. To fully understand the area of health and to be able to articulate the service delivery, access and overall concerns, not only for their individual tribes, but for all Northwest tribes.

Therefore in 1972 these and many other tribal leaders came together and developed by-laws for what is now nationally known as the best health board in Indian country. Some of the characteristics that make the by-laws so representative of the region include the following sections.

The preamble clearly identifies that the objective for the board will be within the area of Indian health legislation, regulation, policy and programs. Specifically the NPAIHB on an annual basis will review the appropriations language of Health and Human Services and from this review develop a legislative packet for the Executive Board to lobby the Congressional delegates with. There is also the development of testimony for the appropriations committee that is completed. These documents are not limited to the Executive Committee members; rather they are broadly distributed to the member tribes for them to also utilize in their congressional visits. This process clearly meets the original intentions of speaking with an organized voice. The NPAIHB will make

---

<sup>1</sup> Presentation of Mel Tonasket to the 30<sup>th</sup> anniversary of the Northwest Portland Area Indian Health Board, Muckleshoot Casino, Auburn Washington, October 2002.

recommendations to the Portland Area Indian Health Services and the Headquarters of Indian Health Services for membership to any workgroups established to either review existing policies or for new policy considerations. This provides for the unique concerns of the tribes in the Portland Area (Idaho, Oregon and Washington) to be heard. As an example, for most other regions of the country Indian Health Services not only has Ambulatory Health Care facilities (service units) but also operate hospitals. This is not the case for Portland Area tribes.

One facet of the by-laws for the NPAIHB was the inclusion of the local area boards and the representation of the delegates to the NPAIHB itself. During the early years of the NPAIHB there were many tribes that were clustered into “Service Units”. That is the Indian Health Services had centralized many small tribes into a service unit for administrative and providers. To assure that all the tribes had opportunity to contribute to the unified voice, these local service units were identified in the by-laws as to the regularity meetings expected of them. This proved most useful in the early years. However, with the advent of the Indian Self-Determination Act, and more tribe either contracting or compacting the services these types of service units have all but disappeared.

It is important to note that the NPAIHB contains language specific to the limitation of the board. In Article II Section 2. states<sup>2</sup>:

*Membership on the Service Unit Board or the NPAIHB is not intended to affect or abridge any rights or powers of the Indian tribes recognized by the Constitution of the United States, by treaties, federal or state laws, or otherwise. The Board*

---

<sup>2</sup> [http://www.npaihb.org/npaihb/const\\_bylaws/const\\_bylaws\\_toc.htm](http://www.npaihb.org/npaihb/const_bylaws/const_bylaws_toc.htm)

*recognizes that tribes retain all rights powers possessed by them, or subsequently vested in them to act, confer or negotiate directly with the United States Public Health Service or any other governmental body or agency on any matter directly affecting their respective tribes or members thereof.*

Development of voting rights within the NPAIHB was identified during the 30<sup>th</sup> anniversary of the NPAIHB as one area of great discussion. The language included in the by-laws is clearly defined in Article III<sup>3</sup>.

*Each member of the NPAIHB shall have one vote on all matters. Members, or their alternates, must be present to vote. **No proxies will be permitted.***

In Washington State there are two organized boards that provide for Tribal leadership to meet to discuss and address health and social issues with regard to Tribal – State relations.

In the late 1970's the Department of Social and Health Services formed an advisory committee to the Secretary, which became recognized as the Indian Policy Advisory Committee (IPAC). As with the NPAIHB it was evident to the tribes that there needed to be an established venue for the Tribes to discuss issues of concern, as well as develop a mechanism for preparing a unified statement in regards to policy, legislation and appropriations in Washington State with regards to health and social services. In the development of IPAC, it was essential on the part of some of the tribes not to exclude the non-federally recognized tribes. In the early years many of these tribes were represented by the Small Tribes of Western Washington. Additionally, the tribes also recognized that federal policies such as the relocation act had created some large urban populations that were impacted by state regulations, and had no mechanism for having their voice included. There was also a need to identify those who are recognized by the tribes and

---

<sup>3</sup> [http://www.npaihb.org/npaihb/const\\_bylaws/const\\_bylaws\\_toc.htm](http://www.npaihb.org/npaihb/const_bylaws/const_bylaws_toc.htm)

those who are not. Therefore in the creation of the IPAC by-laws the membership was designed to address these populations. In the 2004 revision of the by-laws the delegates voted to change two critical areas in an effort to bring clarity to the membership.

Article IV states<sup>4</sup>:

*Section 1. Tribal*

*Each Federally Recognized Tribe of Washington State is entitled to determine one delegate by tribal resolution; each Tribe has the option to determine any amount of alternates they desire.*

*Section 2. Other*

*Recognized American Indian Organizations the recognized American Indian Organizations will be legally established such as chartered and organized under IRS 501(c)(3) ruling. Acceptance to IPAC as a member will be by a majority vote of the Tribal Delegates.*

This change maintains the desire of the founders of IPAC to afford a voice to the urban centers and to the non-federally recognized tribes. However, it removed any perception that tribes who were members of recognized organizations had more voice than the tribes themselves.

The second critical change was in Article VII.

*Section 1. Who is Entitled to vote*

*Each member of this Committee shall, at every meeting of the members, be entitled to one vote in person*

This change was from the original language that did provide for proxy voting. In discussion of the leadership, this was not desired. Rather that in person voting was what should be the expectation, and therefore the by-laws were amended accordingly. The final change to the by-laws, was the staggered terms for the officers. It was discussed

---

<sup>4</sup> Washington State Department of Social and Health Services; Indian Policy Advisory Committee By-laws, February 2004.

and believed that for the continuity of IPAC to have some of the officers remain would carry the business of IPAC forward.

The newest formed group for addressing health issues and concerns for the Tribes in Washington state is: The American Indian Health Commission for Washington (AIHC) which was created in 1994 by federally recognized tribes, urban Indian health programs, and Indian organizations to provide a forum for tribal-state health issues.

Membership is open to the Twenty-nine (29) federally recognized tribes in Washington State, the Seattle Indian Health Board, and certain Indian organizations. Delegates are officially appointed by each tribe through a tribal council resolution, and representatives from Indian organizations are elected to at-large positions.

The American Indian Health Commission during the six monthly meetings (they schedule meetings every two months) work to achieve unity and guide the collective needs of tribal governments and Indian Organizations in providing high-quality, comprehensive health care to American Indians and Alaska Natives. An overarching goal from the beginning of the commission has been the promotion of increased tribal-state collaboration is to improve the health status of American Indians and Alaska Natives by influencing state health policy and resource allocation.

While these meetings may appear to be the key activity of the commission there are other activities which include the following:

- Identifying health policy issues and advocating strategies to address tribal concerns
- Coordinating policy analysis
- Soliciting and collecting information from the state for tribal review and response
- Disseminating information to tribal health programs and leaders
- Promoting the government-to-government relationship between tribes and state health agencies

These remain to be the focus of the Health Summit coordinated by the commission and held every other year. These areas and other pressing health matters are discussed with elected tribal leadership, and state representatives from across the three departments that impact or influence health services. These state agencies include: the Department of Health, Department of Social and Health Services and the Health Care Authority.

Unlike the Northwest Portland Area Indian Health Board and the Indian Policy Advisory Committee the American Indian Health Commission does allow for the following in their By-laws<sup>5</sup>:

### 2.3 *Voting Rights*

#### 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 limitations to the contrary contained in the proxy, the same extend to all meetings of the members shall remain in force for three years from its date or until sooner revoked.*

### 2.12 *Quorum*

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

## Article 7 *Disclaimer Clause*

---

<sup>5</sup> <http://www.aihc-wa.org/About/about.htm#about>

*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.*

In conclusion what the review of these three active health committees provides is that there has been extreme success in local, regional and national issues as a result of their work(s).

There continues to be development of high profile materials for the Indian Health Services from the NPAIHB delegates work. Many times the work done at one of the regular meetings of the AIHC or IPAC will stem further discussion at this more regional forum. Be this in addressing fiscal impacts, or budget development, or national policy review and input. All the organizations contribute to one another and share the information from their respective meetings.

While many of the delegates from the tribes are the same for all three there is also the recognition that this is not 100 percent. Therefore to assure all tribes are included in the discussion and information sharing, all materials are shared to all tribes. To avoid a duplication of agenda time the American Indian Health Commission and Indian Policy Advisory Committee Executive Committee's met in October 2002 to address this. Liz Mueller Chair for IPAC indicated the following; "we need to assure that the information is complete but not repetitive, therefore there will be an understanding that our committees will share information back and forth to give comprehensive covering of the full health spectrum."<sup>6</sup>

---

<sup>6</sup> Joint minute IPAC-AIHC Executive Committee; Puyallup Tribal Health Authority, October 2002.

It is worth noting that the overarching success with all three has been the acknowledgement of the individual tribal sovereignty that the Tribes have. All three organizations clearly identify that they do not in any way waive, infringe or jeopardize this right.