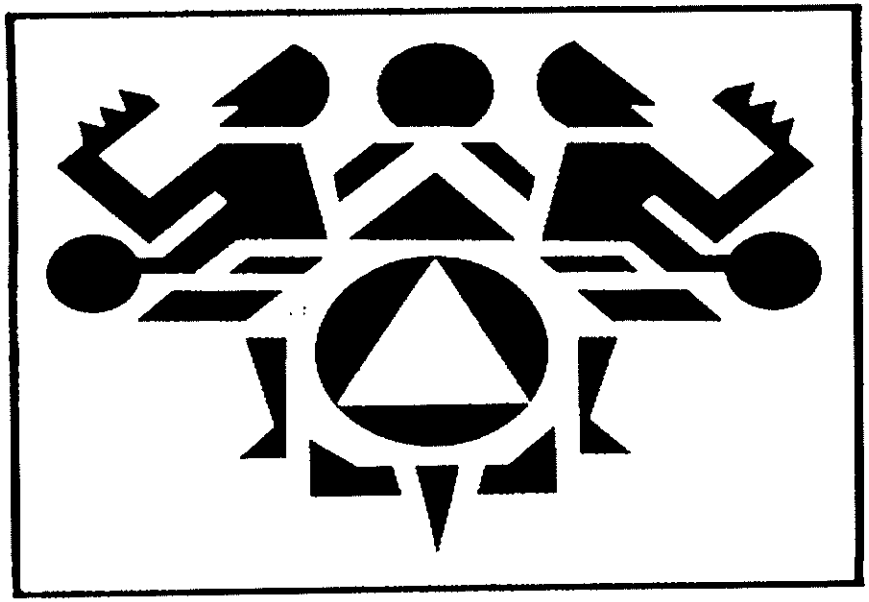
SUMMARY OF MINUTES



QUARTERLY BOARD MEETING

JANUARY 20-22, 2015

GREAT WOLF LODGE

CENTRALIA WA

January 2015 Quarterly Board Meeting
Summary of Minutes

Issue	Summary	Action	Follow-Up
Area Director Report	Dr. Roubideaux mentioned during last listening session that she would be conducting another listening session in all 12 Areas. Portland Area is in the process of being scheduled	Please watch for your DTL letter confirming the dates.	
Area Director Report	Previous quarterly board meetings I have been reporting on Regional Youth Treatment funds – there is about $827,000 in alcohol and drug funds that were recurring & approximately $300,000 contract support costs. On 4/28/14 sent out DTL letter and not much feedback. Another call in December and had some good feedback.	Anticipate mid to late February I will make a decision on how we will move forward with that. **Motion by Cheryl Sanders, Lummi Nation; 2nd by Cassandra Sellards-Reck, Cowlitz Tribe that this money is allocated by the second quarter of this year, if not sooner, to the tribes. Motion Carried**	
Area Director Report	Certified 2014 EHR came from Headquarters and went to 24 sites; there were 758 applications. There are 2 sites yet that need to be installed in February and 1 site has requested a delay.	The EHR now compliant with Meaningful Use.	
Area Director Report	42 of the 43 tribes have left their IT shares with the Area Office & Headquarters.	Installed new RPMS serves at Tulalip & Inchelium. Vista Imaging cluster servers were installed at Lummi & Colville. Vista Imaging was installed at Nooksack, Nisqually & Squaxin Island.	
Area Director Report	Public Health Emergency Management update; Region 10 Office for FEMA has been charged by the Agency to develop a plan on how to implore in their role of working with tribes throughout the US on disasters. IHS is involved & CMD Celeste Davis has been representing the Agency.	We hope to get feedback from the tribes that will be taken to the next meeting to help finalize the document. As soon as a clear draft version is available it will be shared with all.	
Area Director Report	Chronic Pain & Management update: Dr. Karol, Chief Medical Officer for the Agency is the Chair of the National PMD Committee and has made a requirement for all federal opiate prescribes to go	This includes all federal employees; either subservice or commissioned officers who are either IPA or MOA for the tribes.	

	through this training. Some of the work products that the group has been working on are a national IHS policy on chronic non-cancer pain management, launching an IHS webpage on pain management to give guidance within the Agency.	Most recently developing a 5-hour educational course for providers on chronic pain management that will be a requirement for those prescribes to go through. This will be shared with all Medical Directors so that they are aware that this is available for tribal clinicians who may choose to participate. The federal programs, it will be a requirement for them to participate.	
Area Director Report	Portland Area Facilities Advisory Committee met on 12/3/14; we gave them some charges to work on. Formed 2 workgroups to take a look at the next step of developing a business plan. The first workgroup objective is: the Regional Specialty Referral Centers benefit all IHS eligible AI/AN in the Portland Area by expanding access to health care. Those members are Andy Joseph, Sharon Stanphill, Frank Mesplie, Devon Boyer & John Stephens. The second workgroup objective is: combine a core group of tribes & a project site; that is going to be important in move forward. Those members are Mark Johnston, Steve Kutz, Pearl Capoeman-Baller, Dan Gleason & Marcus Martinez	I did commit $110,000 towards developing a business plan. The next steps is when we see the objectives we will be able to proceed with a more detailed business plan and move that forward to Headquarters. Once we have this we will report back to you more detail. The intent and it always will be is to move forward to get approval for all three, knowing that we can only build one at a time.	
Area Director Report	Staff Updates: Two new permanent full time CEOS; Colleen Cawston at Colville Service Unit and CDR Laura Herbison at the Western Oregon Service Unit. Steven Poitra has retired, who had many duties,		

January 2015 Quarterly Board Meeting
Summary of Minutes

	one of which was the Statistical Officer. Mary Brickell is now the Area Statistical Officer. Dr. Donnie Lee, Diabetes and other duties has retired.		
Area Director Report	User Population; they have not been finalized by Headquarters; but expect that any time. I heard back from a couple of tribes and there were some final adjustments made.	The final numbers for the Portland Area is 110,000 for FY14.	
Area Director Report	Contract Support Costs settlement – the Portland Area is one of the larger Area with large CSC claims.	There are 163 claims that have been settled so far; 85 claims are in negotiation phase and 3 claims are in analysis.	
Election of Officers: VICE CHAIRMAN	Pearl Capoeman-Baller, Quinault Nation nominated Cheryle Kennedy. Rhonda Metcalf, Sauk-Suiattle Tribe nominated Cassandra Sellards-Reck. Cheryle Kennedy: 22 Cassandra Sellards-Reck: 11	Cheryle Kennedy was elected Vice Chairman.	
Election of Officers: SERGEANT-AT-ARMS	Shawna Gavin nominated Pearl Capoeman-Baller.	Pearl Capoeman-Baller elected by acclamation.	
Elections	According to our by-laws any vacancy shall be filled by vote at the following quarterly meeting.	The Secretary position will be voted on at the April 2015 board meeting	
Third Party Collection Requirements	In November 2014 the Office of Inspector General from HHS issued an alert. In the alert they raised concerns about tribes and tribal organization misspending third party revenues under self-determination contracts and agreements.	It was not intended to scare people but they had run into more frequently circumstances which they think that tribes really do not understand what their rights are with respect to third party revenues. The alert is worded very generically and generally and really what they were trying to do is be helpful by issuing this kind of alert.	
Elders Committee	Report attached		
Veterans Committee	Report attached		
Public Health	Report attached		

January 2015 Quarterly Board Meeting
Summary of Minutes

Behavioral Health	Report attached		
Personnel Committee	Report attached		
Legislative/Resolution	Report attached		
Legislative Report	Discussion about the loss of the All Tribes meetings we were held that followed the budget formulation meetings.	Need to bring them back; possibly having it the first day (Monday) of the April board meeting or even a half day during the HHS Region 10 tribal consultation	Joe will talk with Dean Seyler and make sure that that also works with the Area Office schedule.
Finance Report	The financials through September 30, 2014 were discussed.		
MOTION - Minutes	**Motion by Dan Gleason, Chehalis Tribe; 2nd by Cassandra Sellards-Reck, Cowlitz Tribe to approve the October 2014 minutes.**	**MOTION CARRIED**	
RESOLUTION #15-02-01	**Washington State University School of Medicine**	**Motion by Andy Joseph, Colville Tribe; 2nd by Cassandra Sellards-Reck, Cowlitz Tribe to approve the resolution. MOTION CARRIED**	
RESOLUTION #15-02-02	**Oregon Tribal Tobacco Cessation Project**	**Motion by Cassandra Sellards-Reck, Cowlitz Tribe; 2nd by Cheryle Kennedy, Grand Ronde Tribe to approve the resolution. MOTION CARRIED**	
Personnel Committee	The 2015 proposed Program Operations Manual revisions that were passed in the Personnel Committee needs to be voted on.	**Motion by Rhonda Metcalf, Sauk-Suiattle Tribe; 2nd by Cheryl Sanders, Lummi Nation to approve the Personnel Committee report. MOTION CARRIED**	
Future Meetings	Andy Joseph: The tribe is building new hotel in Omak and am proposing an August 2016 meeting in place of our June 2016 meeting; the week that Colville Tribe has their Omak Stampede. Sam Penney: Nez Perce would like to host the April 19-21, 2016 board meeting at the Clearwater River Casino in Lewiston ID	**Motion by Dan Gleason, Chehalis Tribe; 2nd by Janice Clements, Warm Springs Tribe to approve those 2 future meeting dates. MOTION CARRIED**	

Resolution #15-02-01
Washington State University School of Medicine

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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

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Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.npaihb.org

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

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

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

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

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

WHEREAS, access to primary care in tribal communities across the Northwest is being compromised by an aging population and a retiring physician workforce; and

WHEREAS, according to 2011 Association of American Medical Colleges (AAMC) data, the most recent data available, approximately 1 percent of matriculated medical students are tribal; and

WHEREAS, recruitment and retention of medical professionals to rural and tribal areas is crucial for addressing health disparities and the loan repayment program is paramount in the effort of bringing health care providers to underserved locations and all efforts must be exercised to maintain this program; and

WHEREAS, access to medical school in the Northwest for aspiring doctors is among the worst in the United States, with capacity growing only marginally over the past four decades; and

WHEREAS, Washington State University is proposing a new medical school for the specific purpose of producing more primary care doctors for underserved communities to specifically include tribal communities around Washington State; and

WHEREAS, Washington State University will promote this by targeting pipeline and bridge programs for Native American students as early as middle school; and

WHEREAS, Washington State University will use its own admissions process to favor qualified applicants who hail from underserved communities, specifically including the tribal communities, even above applicants with better test scores from urban areas.

NOW THEREFORE BE IT RESOLVED that the NPAIHB does hereby support a new Washington State University School of Medicine and urges members of the Washington State Legislature to authorize it.

CERTIFICATION

NO. 15-02-01

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 35 **for, _____ against, _____ abstain on** January 22, 2015.

Andrew C. Joseph Jr.
Chairman

1-22-15
Date

Cheryle A. Kennedy
Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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

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Resolution #15-02-02
"Oregon Tribal Tobacco Cessation Project"

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

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

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

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

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

WHEREAS, in furtherance of this goal in 1997, NPAIHB established the Northwest Tribal Epidemiology Center (*EpiCenter*) in an effort to improve the quality of American Indian and Alaska Native (AI/AN) epidemiology data; and

WHEREAS, The *EpiCenter* has gained national recognition for developing and implementing many useful and innovative projects to improve the health and quality of life of Northwest tribes and has served as a national model for other Indian Health Service (IHS) areas to emulate in establishing their *EpiCenter* programs; and

WHEREAS, AI/AN in Oregon have the highest tobacco use rate (44%),

WHEREAS, the Knight Cancer Institute has invited proposals that aim to address the cancer continuum from prevention to early detection and treatment through survivorship with focus on cancer-related health disparities; and

WHEREAS, a successful proposal for this Knight Cancer Institute Community Partnership Program would provide the support to implement a tobacco cessation campaign for tribal communities; and

WHEREAS, the goals of this initiative are consistent with the goals and objectives of both the NPAIHB and the *EpiCenter*.

THEREFORE BE IT RESOLVED that the NPAIHB endorses and supports an effort by the staff of the *EpiCenter,* under guidance of the Executive Director, to submit a grant application to the Knight Cancer Institute requesting funding for the Community Partnership Program entitled "Oregon Tribal Tobacco Cessation Project".

CERTIFICATION

NO. 15-02-02

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 35 **for,** _____ **against,** _____ **abstain on** January 22 **, 2015.**

Andrew C. Joseph Jr.
Chairman

1-22-15
Date

Cheryle A. Kennedy
Secretary

Elders Committee

Tuesday January 20, 2015
Great Wolf Lodge, Centralia WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Violet Tolbert	CTCR	971-218-3752
2	Gladys Hobbs	CTCR	971-241-8486
3	DAN GLEASON	CHEHALIS	360-273-5911
4	Wanda Johnson	Burns Paiute	541-573-1820
5	Janice Clements	Warm Springs	541-553-1196 ex cassie
6	Andy Joseph	Colville	
7	Gloria Ingle	Siletz	541-994-5953
8	Bridget Cunniff	NPAIHB	
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NPAIHB Quarterly Board Meeting
Elders Committee
Tuesday, January 20, 2015
Great Wolf Lodge, Grand Mound, WA – Chehalis

Attendees: Violet Folden (Grand Ronde), Gladys Hobbs (Grand Ronde), Dan Gleason (Chehalis), Wanda Johnson (Burns Paiute), Janice Clements (Warm Springs), Andy Joseph (Colville), Gloria Ingle (Siletz)

NPAIHB Staff: Bridget Canniff

The meeting opened with introductions and a prayer, particularly for our friend and colleague Clarice Charging.

Each tribe gave updates on their activities. There was general discussion of the need to support our elders who are taking care of grandchildren or great-grandchildren, and the challenges they face. There was also talk about Elder Honor Days sponsored by various tribes, and how much the elders and staff enjoy traveling to different events.

Grand Ronde: They have 2 members of their social services committee at this meeting. The committee has been around for 5 years but now has 4 new members and is much more cohesive and active. Grand Ronde has 3 units that provide adult foster care, one of which will house the community health program. The program provides transport, visits to the sick and other services, and having it close to the elder community will be a huge benefit.

Chehalis: There has been a lot of illness and flus, which have hit the community hard, especially the elders.

Burns Paiute: While they don't have an elder committee, there is an active women's elder group, which provides support especially for grandmothers taking care of grandkids. They recognize how stressful this can be, and the group has been a great place to release tension and tears, talk about struggles with child care, and sometimes having their adult children in the home.

Warm Springs: There are lots of grandparents raising grandkids, who need support. The Elder program will meet soon, and we'll know more about the 2015 agenda then.

Colville: There are a lot of working elders who had been receiving low pay, some of whom are veterans. Colville is very proud that it has passed policies for a higher minimum wage for Tribal government employees, to catch up with the cost of living and provide workers, including elders, with a living wage.

Siletz: Each tribal community has separate elder programs, but once a month there is a gathering of the Elders Council, drawing participants from across the tribe, in Lincoln City. The Elder programs support healthcare services like providing immunizations during events.

Veterans Committee

Tuesday January 20, 2015
Great Wolf Lodge, Centralia WA

	Name and Title	Organization	Phone/FAX/E-mail
1	DON HEAD	NPAIHB	dhead@npaihb.org
2	Ronda Metcalf	Sauk Suiattle	rmetcalf@sauk-suiattle.com
3	JoMarie Tessman	CTUIR Health Comm.	541-215-2184 jomarietessman@yahoo.com
4	Victor Johnson	Burns Paiute Tribe	victorjohnson874@msn.com
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Veteran's Committee Meeting, January 20, 2015

In attendance:
Ronda Metcalf, Sauk-Suiattle Tribe
Jo Marie Tessman, Conf. Tribes of Umatilla Health Commission
Victor Johnson, Burns-Paiute Tribe
Don Head, NPAIHB Staffer

The minutes of the October 2014 meeting were read to the committee.

Ronda Metcalf asked that Don Head makes sure that Joe Finkbonner, Executive Director, sends an invitation letter to Terry Bentley from the Office of Intergovernmental Affairs - VA, to invite Secretary Birdwell to the Joint NPAIHB/CRIHB meeting in July. This Joint Meeting between NPAIHB and CRIHB will allow an opportunity for Secretary Birdwell to address a large group of tribes within her region. Once the dates are set, the letter will be sent to Terry.

Ronda asked about the flier for the Veteran's Summit that is going to be held in Swinomish in February. Don Head told her the flier was passed out to all the delegates, and the remainder was placed on the materials table in the back of the room.

Since the QBM in October is going to be held at the Wildhorse Casino in Umatilla, Ronda asked Jo Marie Tessman if she could request speakers from the VA hospital in Walla Walla, WA, or if she had access to other resources within the tribe or nearby VA facilities. Jo Marie indicated that she could ask some people if they would like to present at the QBM in October. The staffer, Don Head, will follow up with Jo Marie Tessman regarding possible presenters for that QBM.

Public Health Committee

Tuesday January 20, 2015
Great Wolf Lodge, Centralia WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Jessica Marcinkevage EISO	NPAIHB / IDC	503-416-3293 jmarcinkevage@npaihb.org
2	Kelle Little Health Administrator	Coquille Indian Tribe	541-888-9494
3	Andrew Shogren Health Director	Chehalis Nation	360 379-4318
4	Karen Hanson Health Director	Kootenai Tribe	208-267-5223
5	MARIA C. GARDIPE WA DOH Tribal Liaison	WASH. DOH	360-236-4021
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Public Health Committee
January 20, 2015
Great Wolf Lodge

Dental Data: The State of Washington is seeking dental data to inform the DHAT. Maria was provided with Kathy Phipps name for the best source of data, as the NWTEC Dental Epidemiologist. Washington is specifically seeking information on the dental gap. This is difficult information even if we are able to identify gaps, how much funding is available to fund dentists. The group spent time discussing dental disparities and gaps.

The State Community Health Profiles are now available on line for OR, WA, and ID.
http://www.npaihb.org/epicenter/project/reports
Oregon Tribes will be sent a hard copy of the State Community Health Profile.

Public health agenda topics:
The Public Health Committee recommended that Autism screening be provided as a meeting topic. There are now useful screening tools. Kids should be screened at 9 months, to decrease disability. It takes 6 months to get into a program. It was stated that 1:42 boys are on the spectrum of autism. The Northwest Tribal Epicenter has been speaking about needed expansion in the area of children with special health care needs. Autism screening might be an area for development. Basic screening tool kit is $200 to $300 dollars. Addressing the issue early may save general education costs due to early intervention.

The committee requests that an update on adult immunization recommendations was requested from Dr. Weiser. (Attached is the adult immunization schedule). Measles – shots for those that were 40 years ago are not effective. Adult immunizations – QI improvement project. This topic should focus on an update on immunization status.

The Cross Boarders Emergency Preparedness Conference is in Victoria, BC. Need more tribal involvement. Dates: April 28th through 30th, 2015. Last year successful planning was undertaken around the Canoe Journey to Bella Bella. Additional work will be undertaken this year. The US Tribal Chair is Betsy Buckingham. Dr. Evan Adams continues to chair for British Columbia.

Maria stated that the hemispheric consultation report should be out from WHO soon. This report was the result of 14 country attendance at the conference.

The Washington State Pharmacy Board would like to provide the health directors an update on the pharmaceutical tracking system. Update Narcotic distribution. Volunteer participation. Client safety. Chris Baumgardner requests agenda time.

Recommended Adult Immunization Schedule—United States - 2014

Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

Figure 1. Recommended adult immunization schedule, by vaccine and age group[1]

VACCINE ▼ AGE GROUP ►	19-21 years	22-26 years	27-49 years	50-59 years	60-64 years	≥ 65 years
Influenza [2,*]	1 dose annually					
Tetanus, diphtheria, pertussis (Td/Tdap) [3,*]	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs					
Varicella [4,*]	2 doses					
Human papillomavirus (HPV) Female [5,*]	3 doses					
Human papillomavirus (HPV) Male [5,*]	3 doses					
Zoster [6]					1 dose	
Measles, mumps, rubella (MMR) [7,*]	1 or 2 doses					
Pneumococcal 13-valent conjugate (PCV13) [8,*]	1 dose					
Pneumococcal polysaccharide (PPSV23) [9,10]	1 or 2 doses					1 dose
Meningococcal [11,*]	1 or more doses					
Hepatitis A [12,*]	2 doses					
Hepatitis B [13,*]	3 doses					
Haemophilus influenzae type b (Hib) [14,*]	1 or 3 doses					

*Covered by the Vaccine Injury Compensation Program

For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indication)

No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382 To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m. - 8:00 p.m. Eastern Time, Monday - Friday, excluding holidays.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), American College of Obstetricians and Gynecologists (ACOG) and American College of Nurse-Midwives (ACNM).

Figure 2. Vaccines that might be indicated for adults based on medical and other indications[1]

VACCINE ▼ INDICATION ►	Pregnancy	Immunocompromising conditions (excluding human immunodeficiency virus [HIV])[4,6,7,8,15]	HIV infection CD4+ T lymphocyte count[4,6,7,8,15] < 200 cells/μL	HIV infection CD4+ T lymphocyte count[4,6,7,8,15] ≥ 200 cells/μL	Men who have sex with men (MSM)	Kidney failure, end-stage renal disease, receipt of hemodialysis	Heart disease, chronic lung disease, chronic alcoholism	Asplenia (including elective splenectomy and persistent complement component deficiencies)[8,14]	Chronic liver disease	Diabetes	Healthcare personnel
Influenza [2,*]	1 dose IIV annually				1 dose IIV or LAIV annually	1 dose IIV annually					1 dose IIV or LAIV annually
Tetanus, diphtheria, pertussis (Td/Tdap) [3,*]	1 dose Tdap each pregnancy	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs									
Varicella [4,*]	Contraindicated			2 doses							
Human papillomavirus (HPV) Female [5,*]		3 doses through age 26 yrs				3 doses through age 26 yrs					
Human papillomavirus (HPV) Male [5,*]		3 doses through age 26 yrs				3 doses through age 21 yrs					
Zoster [6]	Contraindicated				1 dose						
Measles, mumps, rubella (MMR) [7,*]	Contraindicated			1 or 2 doses							
Pneumococcal 13-valent conjugate (PCV13) [8,*]					1 dose						
Pneumococcal polysaccharide (PPSV23) [9,10]					1 or 2 doses						
Meningococcal [11,*]	1 or more doses										
Hepatitis A [12,*]	2 doses										
Hepatitis B [13,*]	3 doses										
Haemophilus influenzae type b (Hib) [14,*]		post-HSCT recipients only			1 or 3 doses						

*Covered by the Vaccine Injury Compensation Program

For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

No recommendation

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly indicated for adults ages 19 years and older, as of February 1, 2014. For all vaccines being recommended on the Adult Immunization Schedule a vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/hcp/acip-recs/index.html). Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

Footnotes
Recommended Immunization Schedule for Adults Aged 19 Years or Older: United States, 2014

1. **Additional information**
   - Additional guidance for the use of the vaccines described in this supplement is available at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
   - Information on vaccination recommendations when vaccination status is unknown and other general immunization information can be found in the General Recommendations on Immunization at www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm.
   - Information on travel vaccine requirements and recommendations (e.g., for hepatitis A and B, meningococcal, and other vaccines) is available at http://wwwnc.cdc.gov/travel/destinations/list.
   - Additional information and resources regarding vaccination of pregnant women can be found at http://www.cdc.gov/vaccines/adults/rec-vac/pregnant.html.
2. **Influenza vaccination**
   - Annual vaccination against influenza is recommended for all persons aged 6 months or older.
   - Persons aged 6 months or older, including pregnant women and persons with hives-only allergy to eggs, can receive the inactivated influenza vaccine (IIV). An age-appropriate IIV formulation should be used.
   - Adults aged 18 to 49 years can receive the recombinant influenza vaccine (RIV) (FluBlok). RIV does not contain any egg protein.
   - Healthy, nonpregnant persons aged 2 to 49 years without high-risk medical conditions can receive either intranasally administered live, attenuated influenza vaccine (LAIV) (FluMist), or IIV. Health care personnel who care for severely immunocompromised persons (i.e., those who require care in a protected environment) should receive IIV or RIV rather than LAIV.
   - The intramuscularly or intradermally administered IIV are options for adults aged 18 to 64 years.
   - Adults aged 65 years or older can receive the standard-dose IIV or the high-dose IIV (Fluzone High-Dose).
3. **Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination**
   - Administer 1 dose of Tdap vaccine to pregnant women during each pregnancy (preferred during 27 to 36 weeks' gestation) regardless of interval since prior Td or Tdap vaccination.
   - Persons aged 11 years or older who have not received Tdap vaccine or for whom vaccine status is unknown should receive a dose of Tdap followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter. Tdap can be administered regardless of interval since the most recent tetanus or diphtheria-toxoid containing vaccine.
   - Adults with an unknown or incomplete history of completing a 3-dose primary vaccination series with Td-containing vaccines should begin or complete a primary vaccination series including a Tdap dose.
   - For unvaccinated adults, administer the first 2 doses at least 4 weeks apart and the third dose 6 to 12 months after the second.
   - For incompletely vaccinated (i.e., less than 3 doses) adults, administer remaining doses.
   - Refer to the ACIP statement for recommendations for administering Td/Tdap as prophylaxis in wound management (see footnote 1).
4. **Varicella vaccination**
   - All adults without evidence of immunity to varicella (as defined below) should receive 2 doses of single-antigen varicella vaccine or a second dose if they have received only 1 dose.
   - Vaccination should be emphasized for those who have close contact with persons at high risk for severe disease (e.g., health care personnel and family contacts of persons with immunocompromising conditions) or are at high risk for exposure or transmission (e.g., teachers; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).
   - Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health care facility. The second dose should be administered 4 to 8 weeks after the first dose.
   - Evidence of immunity to varicella in adults includes any of the following:
     — documentation of 2 doses of varicella vaccine at least 4 weeks apart;
     —U.S.-born before 1980, except health care personnel and pregnant women;
     — history of varicella based on diagnosis or verification of varicella disease by a health care provider;
     — history of herpes zoster based on diagnosis or verification of herpes zoster disease by a health care provider; or
     — laboratory evidence of immunity or laboratory confirmation of disease.
5. **Human papillomavirus (HPV) vaccination**
   - Two vaccines are licensed for use in females, bivalent HPV vaccine (HPV2) and quadrivalent HPV vaccine (HPV4), and one HPV vaccine for use in males (HPV4).
   - For females, either HPV4 or HPV2 is recommended in a 3-dose series for routine vaccination at age 11 or 12 years and for those aged 13 through 26 years, if not previously vaccinated.
   - For males, HPV4 is recommended in a 3-dose series for routine vaccination at age 11 or 12 years and for those aged 13 through 21 years, if not previously vaccinated. Males aged 22 through 26 years may be vaccinated.
5. **Human papillomavirus (HPV) vaccination (cont'd)**
   - HPV4 is recommended for men who have sex with men through age 26 years for those who did not get any or all doses when they were younger.
   - Vaccination is recommended for immunocompromised persons (including those with HIV infection) through age 26 years for those who did not get any or all doses when they were younger.
   - A complete series for either HPV4 or HPV2 consists of 3 doses. The second dose should be administered 4 to 8 weeks (minimum interval of 4 weeks) after the first dose; the third dose should be administered 24 weeks after the first dose and 16 weeks after the second dose (minimum interval of at least 12 weeks).
   - HPV vaccines are not recommended for use in pregnant women. However, pregnancy testing is not needed before vaccination. If a woman is found to be pregnant after initiating the vaccination series, no intervention is needed; the remainder of the 3-dose series should be delayed until completion of pregnancy.
6. **Zoster vaccination**
   - A single dose of zoster vaccine is recommended for adults aged 60 years or older regardless of whether they report a prior episode of herpes zoster. Although the vaccine is licensed by the U.S. Food and Drug Administration for use among and can be administered to persons aged 50 years or older, ACIP recommends that vaccination begin at age 60 years.
   - Persons aged 60 years or older with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication, such as pregnancy or severe immunodeficiency.
7. **Measles, mumps, rubella (MMR) vaccination**
   - Adults born before 1957 are generally considered immune to measles and mumps. All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine or laboratory evidence of immunity to each of the three diseases. Documentation of provider-diagnosed disease is not considered acceptable evidence of immunity for measles, mumps, or rubella.

   Measles component:
   - A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who:
     — are students in postsecondary educational institutions;
     — work in a health care facility; or
     — plan to travel internationally.
   - Persons who received inactivated (killed) measles vaccine or measles vaccine of unknown type during 1963–1967 should be revaccinated with 2 doses of MMR vaccine.

   Mumps component:
   - A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who:
     — are students in a postsecondary educational institution;
     — work in a health care facility; or
     — plan to travel internationally.
   - Persons vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type who are at high risk for mumps infection (e.g., persons who are working in a health care facility) should be considered for revaccination with 2 doses of MMR vaccine.

   Rubella component:
   - For women of childbearing age, regardless of birth year, rubella immunity should be determined. If there is no evidence of immunity, women who are not pregnant should be vaccinated. Pregnant women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the health care facility.

   Health care personnel born before 1957:
   - For unvaccinated health care personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval for measles and mumps or 1 dose of MMR vaccine for rubella.
8. **Pneumococcal conjugate (PCV13) vaccination**
   - Adults aged 19 years or older with immunocompromising conditions (including chronic renal failure and nephrotic syndrome), functional or anatomic asplenia, cerebrospinal fluid leaks, or cochlear implants who have not previously received PCV13 or PPSV23 should receive a single dose of PCV13 followed by a dose of PPSV23 at least 8 weeks later.
   - Adults aged 19 years or older with the aforementioned conditions who have previously received 1 or more doses of PPSV23 should receive a dose of PCV13 one or more years after the last PPSV23 dose was received. For adults who require additional doses of PPSV23, the first such dose should be given no sooner than 8 weeks after PCV13 and at least 5 years after the most recent dose of PPSV23.
   - When indicated, PCV13 should be administered to patients who are uncertain of their vaccination status history and have no record of previous vaccination.
   - Although PCV13 is licensed by the U.S. Food and Drug Administration for use among and can be administered to persons aged 50 years or older, ACIP recommends PCV13 for adults aged 19 years or older with the specific medical conditions noted above.

9. **Pneumococcal polysaccharide (PPSV23) vaccination**
   - When PCV13 is also indicated, PCV13 should be given first (see footnote 8).
   - Vaccinate all persons with the following indications:
     - — all adults aged 65 years or older;
     - — adults younger than 65 years with chronic lung disease (including chronic obstructive pulmonary disease, emphysema, and asthma), chronic cardiovascular diseases, diabetes mellitus, chronic renal failure, nephrotic syndrome, chronic liver disease (including cirrhosis), alcoholism, cochlear implants, cerebrospinal fluid leaks, immunocompromising conditions, and functional or anatomic asplenia (e.g., sickle cell disease and other hemoglobinopathies, congenital or acquired asplenia, splenic dysfunction, or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]);
     - — residents of nursing homes or long-term care facilities; and
     - — adults who smoke cigarettes.
   - Persons with immunocompromising conditions and other selected conditions are recommended to receive PCV13 and PPSV23 vaccines. See footnote 8 for information on timing of PCV13 and PPSV23 vaccinations.
   - Persons with asymptomatic or symptomatic HIV infection should be vaccinated as soon as possible after their diagnosis.
   - When cancer chemotherapy or other immunosuppressive therapy is being considered, the interval between vaccination and initiation of immunosuppressive therapy should be at least 2 weeks. Vaccination during chemotherapy or radiation therapy should be avoided.
   - Routine use of PPSV23 vaccine is not recommended for American Indians/Alaska Natives or other persons younger than 65 years unless they have underlying medical conditions that are PPSV23 indications. However, public health authorities may consider recommending PPSV23 for American Indians/Alaska Natives who are living in areas where the risk for invasive pneumococcal disease is increased.
   - When indicated, PPSV23 vaccine should be administered to patients who are uncertain of their vaccination status and have no record of vaccination.
10. **Revaccination with PPSV23**
   - One-time revaccination 5 years after the first dose of PPSV23 is recommended for persons aged 19 through 64 years with chronic renal failure or nephrotic syndrome, functional or anatomic asplenia (e.g., sickle cell disease or splenectomy), or immunocompromising conditions.
   - Persons who received 1 or 2 doses of PPSV23 before age 65 years for any indication should receive another dose of the vaccine at age 65 years or later if at least 5 years have passed since their previous dose.
   - No further doses of PPSV23 are needed for persons vaccinated with PPSV23 at or after age 65 years.
11. **Meningococcal vaccination**
   - Administer 2 doses of quadrivalent meningococcal conjugate vaccine (MenACWY [Menactra, Menveo]) at least 2 months apart to adults of all ages with functional asplenia or persistent complement component deficiencies. HIV infection is not an indication for routine vaccination with MenACWY. If an HIV-infected person of any age is vaccinated, 2 doses of MenACWY should be administered at least 2 months apart.
   - Administer a single dose of meningococcal vaccine to microbiologists routinely exposed to isolates of *Neisseria meningitidis*, military recruits, persons at risk during an outbreak attributable to a vaccine serogroup, and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic.
   - First-year college students up through age 21 years who are living in residence halls should be vaccinated if they have not received a dose on or after their 16th birthday.
   - MenACWY is preferred for adults with any of the preceding indications who are aged 55 years or younger as well as for adults aged 56 years or older who a) were vaccinated previously with MenACWY and are recommended for revaccination, or b) for whom multiple doses are anticipated. Meningococcal polysaccharide vaccine (MPSV4 [Menomune]) is preferred for adults aged 56 years or older who have not received MenACWY previously and who require a single dose only (e.g., travelers).
   - Revaccination with MenACWY every 5 years is recommended for adults previously vaccinated with MenACWY or MPSV4 who remain at increased risk for infection (e.g., adults with anatomic or functional asplenia, persistent complement component deficiencies, or microbiologists).
12. **Hepatitis A vaccination**
   - Vaccinate any person seeking protection from hepatitis A virus (HAV) infection and persons with any of the following indications:
     - — men who have sex with men and persons who use injection or non-injection illicit drugs;
     - — persons working with HAV-infected primates or with HAV in a research laboratory setting;
     - — persons with chronic liver disease and persons who receive clotting factor concentrates;
     - — persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A; and

12. **Hepatitis A vaccination (cont'd)**
     - — unvaccinated persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. (See footnote 1 for more information on travel recommendations.) The first dose of the 2-dose hepatitis A vaccine series should be administered as soon as adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.
   - Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6 to 12 months (Havrix), or 0 and 6 to 18 months (Vaqta). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule may be used, administered on days 0, 7, and 21 to 30 followed by a booster dose at month 12.
13. **Hepatitis B vaccination**
   - Vaccinate persons with any of the following indications and any person seeking protection from hepatitis B virus (HBV) infection:
     - — sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than 1 sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexually transmitted disease (STD); current or recent injection drug users; and men who have sex with men;
     - — health care personnel and public safety workers who are potentially exposed to blood or other infectious body fluids;
     - — persons with diabetes who are younger than age 60 years as soon as feasible after diagnosis; persons with diabetes who are age 60 years or older at the discretion of the treating clinician based on the likelihood of acquiring HBV infection, including the risk posed by an increased need for assisted blood glucose monitoring in long-term care facilities, the likelihood of experiencing chronic sequelae if infected with HBV, and the likelihood of immune response to vaccination;
     - — persons with end-stage renal disease, including patients receiving hemodialysis, persons with HIV infection, and persons with chronic liver disease;
     - — household contacts and sex partners of hepatitis B surface antigen–positive persons, clients and staff members of institutions for persons with developmental disabilities, and international travelers to countries with high or intermediate prevalence of chronic HBV infection; and
     - — all adults in the following settings: STD treatment facilities, HIV testing and treatment facilities, facilities providing drug abuse treatment and prevention services, health care settings targeting services to injection drug users or men who have sex with men, correctional facilities, end-stage renal disease programs and facilities for chronic hemodialysis patients, and institutions and nonresidential day care facilities for persons with developmental disabilities.
   - Administer missing doses to complete a 3-dose series of hepatitis B vaccine to those persons not vaccinated or not completely vaccinated. The second dose should be administered 1 month after the first dose; the third dose should be given at least 2 months after the second dose (and at least 4 months after the first dose). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, give 3 doses at 0, 1, and 6 months; alternatively, a 4-dose Twinrix schedule, administered on days 0, 7, and 21 to 30 followed by a booster dose at month 12 may be used.
   - Adult patients receiving hemodialysis or with other immunocompromising conditions should receive 1 dose of 40 mcg/mL (Recombivax HB) administered on a 3-dose schedule at 0, 1, and 6 months or 2 doses of 20 mcg/mL (Engerix-B) administered simultaneously on a 4-dose schedule at 0, 1, 2, and 6 months.
14. ***Haemophilus influenzae type b*** **(Hib) vaccination**
   - One dose of Hib vaccine should be administered to persons who have functional or anatomic asplenia or sickle cell disease or are undergoing elective splenectomy if they have not previously received Hib vaccine. Hib vaccination 14 or more days before splenectomy is suggested.
   - Recipients of a hematopoietic stem cell transplant should be vaccinated with a 3-dose regimen 6 to 12 months after a successful transplant, regardless of vaccination history; at least 4 weeks should separate doses.
   - Hib vaccine is not recommended for adults with HIV infection since their risk for Hib infection is low.
15. **Immunocompromising conditions**
   - Inactivated vaccines generally are acceptable (e.g., pneumococcal, meningococcal, and inactivated influenza vaccine) and live vaccines generally are avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

Behavioral Health Committee

Tuesday January 20, 2015
Great Wolf Lodge, Centralia WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Colenn McCray THRIVE-Proj. Assistant	NPAIHB	503-416-3270 cmccray@npaihb.org
2	Mitch Lykins HSS Director	Sauk-Suiattle	360-436-2832 mlykins@sauk-suiattle.com
3	Caroline M. Cruz HEHS Tribal Health	Confederated Tribes of Warm Springs	541-553-0497 caroline.cruz@wstribes.org
4	Shawna Gavin Health Com. Chair	CTUIR	541 429 7378 shawnagavin@ctuir.org
5	Marie Zackuse Tribal Council	Tulalip Tribe	360 926 4284 360.716-4444
6	Alan Ham MAH, MSW retired	Grand Ronde tribe	alanham1951@hotmail.com 503-949-2721
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Behavioral Health Committee

Quarterly Board Meeting, January 20, 2015

Grand Mound, WA

Attendees: Alan Ham, Grand Ronde; Celena McCray, THRIVE Project Assistant; Mitch Lykins, Sauk-Suiattle; Caroline Cruz, Warm Springs; Shawna Gavin, Umatilla; Marie Zackuse, Tulalip; Cheryl Saunders, Lummi.

Committee Report: Marilyn Scott

Meeting Minutes:

- ***What are the goals of the Behavioral Health Committee?***
    - Draft resolutions for the Executive Committee / Board Delegates that make recommendations to IHS, States, and HHS Agencies related to behavioral health.

- For example, ***we would like to draft a resolution to IHS***, asking that the FY2014 funds (amounting to 1.9 Million) be earmarked and budgeted for the youth residential treatment program by April 2015. It is also important that IHS better communicate with NPAIHB delegates about the source and history of those funds, to support the decision-making process.
    - Caroline Cruz provided a useful background on the history of those funds: The funding was originally a carve-out from the State of Oregon and IHS, to start a youth residential treatment program for tribal youth in OR. The contract was originally fulfilled by Grand Ronde (Nanish Sahallie), and then later by Klamath (Wembly House... both programs closed because there wasn't sufficient funding to cover the cost of the program.
    - OR State is willing to put in money for 5 beds at the facility, if the contract were fulfilled in OR. Is Washington State also willing/interested in contributing funds to support beds for WA AI/AN youth?
    - Caroline recommended that the funds <u>not be divided;</u> that they remain combined to re-open a youth residential treatment program in Oregon. NARA could house the project.
    - IHS will have to put it out for bid, but the OR Tribes supports NARA's application.
    - Mitch Lykins: IHS issued a "Request for Information" letter... A lot of time and energy went into formulating that response, but our response might have been different if we had known the full story.

- Another recommendation/suggestion was also shared by Caroline Cruz: Their staff regularly participate in ***trainings offered by the NPAIHB***, and they always come back energized, but it's sometimes difficult for them to follow-through and implement new practices.
    - Are there things that NPAIHB projects can do to better support implementation back home?
        - Booster classes
        - Refreshers (there's a lot of staff turnover at tribal health departments)

        - In Oregon, the *9-Tribes Prevention Meetings* help support idea sharing and networking between tribes.

- Tulalip is still recovering from the shooting tragedy, and has brought in trainers from the *International Trauma Center*, to support healing and crisis response. WA's DOH is helping to support the training.

- **Drug Addiction**
    - Heroin –Tulalip can't afford to send everyone who needs treatment to treatment;
    - Opioids – OR State is planning on hosting regional Opioid Addictions Conferences in OR... ***Do Tribes have a seat at the table for that?***
        - Jason Yarmer will be here tomorrow to talk about their plans.
    - Marijuana – Emerging challenges related to the legalization of marijuana in WA and OR.
    - How do we keep people from relapsing?

Personnel Committee

Tuesday January 20, 2015
Great Wolf Lodge, Centralia WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Cassandra Sharp	Coquitz	360-513-1243
2	Bonnie Sanchez	Squaxin Island	bsanchez@squaxin.us
3	Andra Wagner	NPAIHB	awagner@npaihb.org
4	Shawn Gavin	CTUIR	Shawngavin@ctuir.org
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Northwest Portland Area Indian Health Board
Quarterly Board Meeting
Personnel Committee Meeting Minutes

January 21, 2015

Start Time: 12:30 pm

Members Present: Cassandra Sellards-Reck, Shawna Gavin, Bonnie Sanchez

Members Absent: Rose Purser

Staff Present: Andra Wagner

- Personnel update was read by Andra Wagner
    - 7 new hires
    - 3 promotions
    - 1 separation of employment
- Training on the Worker's Compensation Claims Process was given to staff
- Suggestion was made for suspicion training to be given to supervisors to better identify the signs of drug use
- Revisions to the Program Operations Manual were discussed and copies were distributed to the delegates for review and vote
- Suggestion was made to move personnel committee meeting to the second day of the QBM in order to allow delegates to participate in other committee meetings

2015 Proposed Program Operations Manual Revisions

POM Section C, Hiring Policies, pg.7

In order to provide equal employment and advancement opportunities to all individuals, employment decisions by the Board will be based on merit, qualifications, and abilities. Other than Indian preference in hiring, the Board's policy is to ensure that all employees are treated equally and that no employee or job applicant shall be discriminated against in employment on the basis of race, color, religion, age, sex, national origin, ~~physical handicap~~ disability, sexual orientation, marital status or any other characteristic protected by law.

POM Section C, Payroll Policies, pg.16

Time Reports: The Accounting Department is responsible for the preparation of the NPAIHB payroll. Payroll checks will not be issued without a Time Distribution Report ~~or time card, which includes a signature of the employee, approved by their supervisor, and signed by the Executive Director.~~ which must be approved by the supervisor and the Executive Director. Total hours will be reported for each day worked for each employee. Annual Leave, Sick Leave, Holiday Leave, Overtime, must be reported in appropriate categories of the Time Distribution report. A statement of gross earnings, an itemization of all deduction, and net earnings will accompany each paycheck.

POM Section C, Payroll Policies, pg.16

Pay Days: Pay days are on the 5th and 20th of each month. Time reports cover the periods of the 1st through the 15th, and the 16th through the last day of each month. The payroll week runs from 12:00 am Monday through 11:59 pm Sunday. Time reports are due, in the Accounting Department, on the 16th and 1st day of the following month.

Legislative/Resolution Committee

Tuesday January 20, 2015
Great Wolf Lodge, Centralia WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Joe Finkbonner	NPAIHB	
2	Cheryle Kennedy	NPAIHB	503 879 5211 cheryle.kennedy@grandronde.org
3	CHERYL RASAR	SWINOMISH	
4	Kim Zellmer	Swinomish	
5	PEARL		
6	Jeff Lorenz Exec. Director	CTGR	5038792079 jeff.lorenz@grandronde.org
7	Joanne LiAntonio	Samish Nation	jliantonio@SamishTribe.NSN.us 360-899-5454
8	Leslie Wozniak	Suquamish Tribe	
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Legislative/Resolution Committee minutes;

Attendees – Cheryle Kennedy, Cheryl Rasar, Kim Zillyett, Pearl Capoeman-Baller, Jeff Lorenz, Joanne Liantonio, Leslie Wosnig, Joe Finkbonner, Jim Roberts (telephonically).

Review of resolution to support the establishment of a Medical School at Washington State University. Discussion about adding verbiage to include the discussion from the earlier presentation related to loan repayment. Motion to approve as amended– Pearl Capoeman-Baller. Seconded by Cheryl Rasar. Motion passed unanimously.

Jim began discussing elements of the legislative plan priorities, that includes;

- Budget analysis
- Permanent funding of EpiCenters
- Funding current services
- Substance abuse/mental health services
- Facilities, specifically Regional Referral Center
- Indian definition fix
- Medicaid administrative costs due to ACA expansion
- Permanent reauthorization of SDPI
- Advance appropriations
- Long Term Care Elder issues
- Youth treatment program
- Resource for implementation of IHCIA
- Emergency Preparedness in Indian Country
- UCC
- Expand S. Gov. Vet Health Issues

Discussion of reconstituting the All Tribes Meeting to get input from tribes about Federal budget. The discussion reviewed previous objectives of the ATM and identifying potential dates to possibly plan an ATM.