RESOLUTION # 19-04-02
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 334-08-19
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

A CALL TO CONGRESS TO SUPPORT ADVANCE APPROPRIATIONS FOR THE INDIAN HEALTH SERVICE

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

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

WHEREAS, the United States has a unique and special relationship with AI/ANs to provide health care as established through the U.S. Constitution, treaties, U.S. Supreme Court decisions and federal legislation; **AND**

WHEREAS, although the trust relationship requires the federal government to provide for the health and welfare of Tribal nations, the Indian Health Service (IHS) remains chronically underfunded and AI/ANs suffer from among the lowest health status nationally; **AND**

WHEREAS, IHS, an agency within the Department of Health and Human Services, administers health care to 2.6 million AI/ANs residing in Tribal communities in 35 states, directly, or through contracts or compacts with Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act; **AND**

WHEREAS, in recent years, federal appropriation bills have not been enacted in a timely manner, thus hampering Tribal and IHS health care providers' budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts; **AND**

WHEREAS, since Fiscal Year 1998, there has only been one year (FY2006) in which the Interior, Environment and Related Agencies Appropriations bill has been enacted before the beginning of the new fiscal year; **AND**

WHEREAS, the budgetary solution to this failure to uphold the federal trust responsibility, and the one which does not require the Congressional appropriations committees to count Advance Appropriations against their spending cap is Advance Appropriations; **AND**

WHEREAS, the NPAIHB and CRIHB believe that moving to the Advance Appropriations process protects Tribes and Tribal organizations and the IHS direct service units from cash flow problems that regularly occur at the start of the federal fiscal year due to delays in enactment of annual appropriations legislation; **AND**

WHEREAS, Congress has recognized the difficulties inherent in the provision of direct health care that relies on the appropriations process and traditional funding cycle through enactment of the Veterans Health Care Budget Reform and Transparency Act of 2009 (PL 111-81), which authorized Advance Appropriations for Veterans Administration (VA) medical care programs; **AND**

WHEREAS, the IHS should be afforded the same budgetary certainty and protections extended to the VA, which is also a federally-funded provider of direct health care.

THEREFORE BE IT RESOLVED that the NPAIHB and CRIHB request that Congress amend the Indian Health Care Improvement Act to authorize Advance Appropriations for the IHS; **AND**

BE IT FURTHER RESOLVED, that the NPAIHB and CRIHB request that Congress include our recommendation for Advance Appropriations for IHS in the Budget Resolution; **AND**

BE IT FURTHER RESOLVED, that the NPAIHB and CRIHB request that Congress include in the enacted appropriations bill Advance Appropriations for IHS.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest

RESOLUTION # 19-04-03
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 335-08-19
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

FULL FUNDING FOR THE INDIAN HEALTH SERVICE

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

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

WHEREAS, Indian Nations and the United States (US) government have a sovereign-to-sovereign relationship established by treaties, agreements, acts of Congress, and court decisions; **AND**

WHEREAS, this relationship has resulted in the federal trust responsibility to Indian Nations and it is a legally enforceable fiduciary obligation on the part of the US to protect Tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of federal law with respect to AI/AN Tribes and villages; **AND**

WHEREAS, in several cases discussing the trust responsibility, the US Supreme Court has used language detailing the legal duties, moral obligations, and fulfillment of understandings and expectations that have been established by law between the US and the Indian Nations; **AND**

WHEREAS, the US Court of Appeals for the Ninth Circuit declared that the system used by the Indian Health Service (IHS) for the allocation of its funds violated the California Indians' constitutional right to equal protection. Furthermore, in a subsequent clarification of that judgment, the district court declared that, "(i)n accordance with this conclusion, defendants are obligated to adopt a program for providing health services to Indians in California which is comparable to those offered [to] Indians elsewhere in the United States"; **AND**

WHEREAS, as stated in treaties and other federal issuances with Indian Nations, health care is guaranteed to AI/ANs in perpetuity in exchange for the millions of acres of Indian lands that now make up the US; **AND**

WHEREAS, IHS, an agency within the Department of Health and Human Services, administers health care to 2.6 million AI/ANs residing in Tribal communities across the US, directly, or through contracts or compacts with Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act; **AND**

WHEREAS, Tribal leaders representing the 12 IHS Areas sit on the National Tribal Budget Formulation Workgroup and make recommendations to the administration annually on IHS funding; **AND**

WHEREAS, the National Tribal Budget Formulation Workgroup recommended that the amount necessary to fully fund IHS was $32 billion in Fiscal Year 2019, and the IHS only received a $5.8 billion appropriation in Fiscal Year 2019; **AND**

WHEREAS, in Fiscal Year 2017, the IHS per capita expenditures for patient health services were just $3,332[1], compared to $9,207 per person for health care spending nationally[2], and $12,744 for Medicare spending per capita[3]; **AND**

WHEREAS, for Fiscal Year 2021, the National Tribal Budget Formulation Workgroup, in an updated recommendation, suggests that IHS be fully funded at $37.61 billion; **AND**

WHEREAS, AI/ANs continue to suffer some of the worst health disparities of all Americans, and according to the Center for Disease Control and Prevention, include, but are not limited to:

- An overall life expectancy that is 5.5 years less than the national average;
- The second highest age-adjusted mortality rate of any demographic nationwide at 800.3 deaths per 100,000 people;
- The highest Hepatitis C mortality rates nationwide (10.8 per 100,000) and higher rates of chronic liver disease and cirrhosis deaths (2.3 times that of Whites);
- A suicide rate that is more than 3.5 times higher than other racial/ethnic groups;

---

[1] The figure on congressional appropriations for IHS includes funding for health care delivery as well as sanitation, facilities and environmental health. Per capita IHS appropriation was calculated from $4,957,856,000 in total appropriations divided by 1,638,687 Active Users. Source: *2017 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita*," February 26, 2018, available at: https://www.ihs.gov/ihcif/includes/themes/responsive2017/display_objects/documents/2018/2017_IHS_Expenditures.pdf, last accessed 10/15/2018.

[2] NHE Projections 2016-2025 –Tables, Table 5 Personal Health Care Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2016-2025; Per Capita Amount; Projected; available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

[3] Honoring The Federal Trust Responsibility: A New Partnership to Provide Quality Healthcare to America's First Citizens: The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2019 Budget, March 2017, p. 14, https://www.nihb.org/docs/04032017/TBFWG%20Testimony%20FY%202019%20FINAL.pdf

- A significant increase in cancer rates, while overall cancer rates for Whites declined from 1990 to 2009;
- A lower prevalence of having a personal doctor or health care provider (63.1%) compared to Whites (72.8%); **AND**

WHEREAS, all of these determinants of health and poor health status could be dramatically improved with adequate investment into the health, public health, and health delivery systems in Indian Country**.**

NOW THEREFORE BE IT RESOLVED, that the CRIHB and NPAIHB recommend Congress fully fund the IHS at $37.61 billion pursuant to the recommendation of the National Tribal Budget Formulation Workgroup for Fiscal Year 2021 and ensure the Portland and California Areas receive their fair share of the resources.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest

RESOLUTION # 19-04-04
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 336-08-19
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

A CALL TO CONGRESS TO SUPPORT MANDATORY APPROPRIATIONS FOR THE INDIAN HEALTH SERVICE

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

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

WHEREAS, Indian Nations and the United States (US) government have a sovereign-to-sovereign relationship established by treaties, agreements, acts of Congress, and court decisions; **AND**

WHEREAS, this relationship has resulted in the federal trust responsibility to Indian Nations and it is a legally enforceable fiduciary obligation on the part of the US to protect Tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of federal law with respect to AI/AN Tribes and villages; **AND**

WHEREAS, in several cases discussing the trust responsibility, the Supreme Court has used language detailing the legal duties, moral obligations, and fulfillment of understandings and expectations that have been established by law between the US and the Indian Nations; **AND**

WHEREAS, as stated in treaties and other federal issuances with Indian Nations, health care is guaranteed to AI/ANs in perpetuity in exchange for the millions of acres of Indian lands that now make up the US; **AND**

WHEREAS, in 2010, the US Congress declared, “It is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians… to ensure the highest possible health status for Indians and to provide all resources necessary to effect that policy”; **AND**

WHEREAS, the Indian Health Service (IHS), an agency within the Department of Health and Human Services, administers health care to 2.6 million AI/ANs residing in Tribal communities across the US, directly, or through contracts or compacts with Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act; **AND**

WHEREAS, the IHS received a $5.8 billion appropriation in Fiscal Year (FY) 2019, yet the National Tribal Budget Formulation Workgroup recommends that the amount necessary to fully fund IHS is $37.61 billion pursuant to their FY 2021 recommendation; **AND**

WHEREAS, in FY 2017, the IHS per capita expenditures for patient health services were just $3,332, compared to $9,207 per person for health care spending nationally; **AND**

WHEREAS, Tribes and Tribal Health Programs cannot properly establish proper planning procedures due to current fluctuation of funding each FY in conjunction with congressionally approved budgets and recent government shutdowns; **AND**

WHEREAS, Tribes and Tribal Health Programs cannot recruit, maintain, and sustain staff for their clinics due to funding uncertainties; **AND**

WHEREAS, AI/ANs continue to suffer some of the worst health disparities of all Americans and according to IHS data, they die at higher rates than other Americans from alcoholism (552% higher), diabetes (182% higher), unintentional injuries (138% higher), homicide (83% higher), and suicide (74% higher); **AND**

WHEREAS, AI/ANs suffer from higher mortality rates from cervical cancer (1.2 times higher), pneumonia/influenza (1.4 times higher), and maternal deaths (1.4 times higher) compared to the larger US population; **AND**

WHEREAS, the instability of the current discretionary funding process for IHS continues to put the lives of AI/ANs at risk; **AND**

WHEREAS, moving IHS to the mandatory side of the federal budget would stabilize the IHS budget and ensure that the care that AI/ANs need is always guaranteed; **AND**

WHEREAS, making spending for IHS mandatory would exempt IHS form broad-based cuts in discretionary spending, and budget rescissions **AND**

WHEREAS, other direct health programs like the Veterans Health Administration have a mandatory spending designation; **AND**

WHEREAS, IHS should be treated like the obligation it is, and the Congress should move IHS funding to the mandatory side of the federal budget; **AND**

NOW THEREFORE BE IT RESOLVED, that the CRIHB and NPAIHB urge Congress to enact mandatory appropriations for the IHS, in order to provide the highest level of health care service for all AI/ANs, as is the government’s duty to fulfill this obligation under the federal trust responsibility.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest

RESOLUTION # 19-04-05
NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

RESOLUTION # 337-08-19
CALIFORNIA RURAL INDIAN HEALTH BOARD

JOINT RESOLUTION

A CALL TO CONGRESS TO FULLY FUND SECTION 105(l) INDIAN SELF-DETERIMINATION AND EDUCATION ASSISTANCE ACT (ISDEAA) LEASE OBLIGATIONS TO TRIBES AND TRIBAL ORGANIZATIONS

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

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

WHEREAS, the United States (U.S.) has a unique and special relationship with AI/ANs to provide health care as established through the U.S. Constitution, treaties, U.S. Supreme Court decisions and federal legislation; **AND**

WHEREAS, Section 105(l) of ISDEAA requires IHS, upon Tribal request, to enter into a lease for a facility owned or leased by the Tribe or Tribal organization and used to carry out its ISDEAA agreement; **AND**

WHEREAS, as established in *Maniilaq*, IHS must compensate the Tribe or Tribal organization fully for its reasonable facility expenses under Section 105(l); **AND**

WHEREAS, on July 10, 2018, IHS sent a Dear Tribal Leader Letter (DTLL) proposing to fund a $13 million Fiscal Year (FY) 2018 shortfall of Section 105(l) ISDEAA lease costs by reprogramming funding from IHS unallocated inflation increases; **AND**

WHEREAS, on July 25, 2018, NPAIHB sent a letter to IHS asking it to seek and obtain a supplemental appropriation of $13 million from Congress; and

WHEREAS, on September 14, 2018, IHS sent a follow-up DTLL informing Tribes that it had decided that in order to meet FY 2018 105(l) lease funding requirements it had reprogrammed $25 million from the $70.4 million increase identified for inflation; **AND**

WHEREAS, on March 2, 2019, IHS issued an additional DTLL that stated:

- IHS has received 100 105(l) lease proposals from Tribes and Tribal organizations, totaling approximately $39 million, for FY 2019; and
- In addition to an initial $5 million that the IHS identified in the base services appropriation, Congress provided IHS an increase of $25 million for Tribal clinic operational costs in FY 2019; and
- Base IHS appropriation increases IHS's capacity to address the anticipated FY 2019 funding need, but full FY 2019 need remains unknown; and
- FY 2018 reprogramming was done on a one-time basis in the hopes that other options might become available in FY 2019; and
- Due to the continued need for resources beyond those identified for Tribal clinic operational costs in FY 2019, IHS is legally required to use a portion of the funds included in the IHS appropriation to fund 105(l) leases; **AND**

WHEREAS, it is anticipated that 105(l) lease costs will far exceed appropriations for FY2020; **AND**

WHEREAS, Tribes and Tribal organizations rely on program increases to keep pace with the cost of living; **AND**

WHEREAS, unless additional funding is provided for IHS appropriations, the additional funds required for 105(l) leases will come at the expense of the overall health program and result in cuts in services for both direct service and self-governance tribes as 105(l) lease costs increase; **AND**

WHEREAS, the National Tribal Budget Formulation Workgroup's recommendations for FY 2021 requested that IHS take adequate steps to fully address 105(l) leasing obligations and work proactively with Congress to ensure its full payment as an indefinite appropriation.

THEREFORE BE IT RESOLVED that the NPAIHB and CRIHB call on Congress to fully fund Section 105(l) ISDEAA lease obligations to Tribes and Tribal organizations as an indefinite discretionary appropriation for such sums as are necessary.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest

RESOLUTION # 19-04-06
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 338-08-19
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

A CALL TO CONGRESS TO ENACT MANDATORY APPROPRIATIONS IN SUPPORT OF THE NATIONAL CHILD TRAUMATIC STRESS INITIATIVE

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest**; AND**

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California**; AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people**; AND**

WHEREAS, the National Center for Child Traumatic Stress (NCCTS), is part of the National Child Traumatic Stress Initiative (NCTSI), under the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the Department of Health and Human Services (HHS)**; AND**

WHEREAS, the purpose of NCTSI is to improve the quality of trauma treatment and services in communities for children, adolescents, and their families who experience or witness traumatic events, and to increase access to effective trauma-focused treatment and services for children and adolescents throughout the nation**; AND**

WHEREAS, the initiative is designed to address child trauma issues by creating a national network of grantees—the National Child Traumatic Stress Network that works collaboratively to develop and promote effective trauma treatment and services for children, adolescents, and their families exposed to a wide array of traumatic events**; AND**

WHEREAS, NCCTS awards grants and block grants to federally-recognized AI/AN Tribes and Tribal organizations through an extremely detailed application process with unrealistic time frames, submission of two separate budget proposals with budget justifications and extensive supporting documents**; AND**

WHEREAS, Tribes and Tribal health clinics, especially small Tribes, face barriers such as limited access to broadband wireless, computers, and unfamiliarity with the grant application process, putting them at a disadvantage to be awarded grants through NCCTS**; AND**

WHEREAS, grants, if awarded, may not exceed $6 million per year**; AND**

WHEREAS, in November 2014, according to the Attorney General's Advisory Committee on AI/AN Children Exposed to Violence: Ending Violence so Children Can Thrive [the Committee] found,

- AI/AN children suffer exposure to violence at rates higher than any other in the United States**;** and
- Immediate and long-term effects of this exposure to violence includes increased rates of altered neurological development, poor physical and mental health, poor school performance, substance abuse, and overrepresentation in the juvenile justice system**;** and
- Chronic exposure to violence often leads to toxic stress reactions and severe trauma, which is compounded by historical trauma**;** and
- AI/AN children experience post-traumatic stress disorder at the same rate as veterans returning from Iraq and Afghanistan and triple the rate of the general population**;** and
- With the convergence of exceptionally high crime rates, jurisdictional limitations, vastly under-resourced programs, and poverty, it is likely that *all* AI/AN children have been exposed to violence**; AND**

WHEREAS, according to SAMHSA's 2012 National Survey on Drug Use and Health (NSDUH),

- 5.2% of AI/AN youth had a major depressive episode (MDE) and 2.6% had an MDE with severe impairment**;** and
- 11% of AI/AN youth had specialty mental health services during the past year with services provided in a range of settings from education and juvenile justice settings to general and specialty health settings**; AND**

WHEREAS, according to the SAMHSA and the Center for Disease Control and Prevention, AI/AN youth are disproportionally impacted by suicide**; AND**

WHEREAS, according to the Committee, critical Tribal funding has been cut for housing, law enforcement, child welfare, juvenile justice, health care and education, negatively impacting the children in Tribal communities**; AND**

WHEREAS, according to the Committee, a routine lack of funding, in violation of the trust obligations to AI/ANs and their children, negatively impacts AI/AN children in Tribal communities**; AND**

NOW THEREFORE BE IT RESOLVED, the CRIHB and NPAIHB urge Congress to enact mandatory appropriations for programs that provide critical services and care to AI/AN children and youth.

BE IT FURTHER RESOLVED, the CRIHB and NPAIHB also urge Congress and the Executive Branch to uphold treaties and existing law and trust responsibilities by directing sufficient funds to AI/AN Nations to bring funding into parity with the rest of the United States in order to effectively address violence in their communities, prevent children from being exposed to violence, and respond to those children who need to heal.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest

RESOLUTION # 19-04-07
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 339-08-19
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

SUPPORT OF ENACTING LEGISLATION TO ENSURE MEDICAID FULFILLS FEDERAL TRUST RESPONSIBILITY TO AMERICAN INDIANS/ALASKA NATIVES

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

WHEREAS, the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member tribes; **AND**

WHEREAS, Tribes have a unique government-to-government relationship with the federal government, and it is required that the federal government consult with Tribes on any policy or action that will significantly impact Tribal governments; **AND**

WHEREAS, Tribal Nations are political, sovereign entities whose status stems from the inherent sovereignty they possess as self-governing people predating the founding of the United States (U.S.), and since its founding, the U.S. has recognized Tribal Nations as such and have entered into treaties with them on that basis; **AND**

WHEREAS, Executive Order 13175 sets forth clear definitions and frameworks for consultation, policymaking, and accountability to ensure that consultation with Indian Tribes is regular, meaningful, and collaborative; **AND**

WHEREAS, in 24 U.S.C. § 1602(a)(1) Congress declared that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians…to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy"; **AND**

WHEREAS, in 1955, Congress created the Indian Health Service (IHS) in order to help fulfill its trust responsibility for health care to Tribes; **AND**

WHEREAS, the unmet health needs of AI/ANs are severe and the health status of AI/ANs is far below that of the general population of the U.S., resulting in an average life expectancy for AI/ANs to be 4.5 years less than that for the U.S. population; **AND**

WHEREAS, in 1976, Congress noted that Medicaid payments were a "needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian" (H.R. Rep. No. 94-1026-Part III); **AND**

WHEREAS, in 1976, Congress established the authority for the IHS, Tribal Nations, and Tribal health organizations, to seek reimbursement under the federal Medicaid program in order to help fulfill its trust responsibility for health care to the Tribes; **AND**

WHEREAS, in Fiscal Year 2017, the congressional appropriations for IHS was only $3,332 per person,[4] as compared to average per capita spending nationally for personal health care services of $9,207[5] and $12,744 for Medicare spending per capita[6]; **AND**

WHEREAS, the IHS continues to be significantly underfunded by Congress—even when considering government health insurance resources—leading to rationed care and worse health outcomes for AI/ANs;[7] **AND**

WHEREAS, the federal Medicaid program generates significant resources that are critical to the ability of Tribal Nations to meet the health care needs of Tribal citizens, but there are significant gaps in access to quality health care services under the federal Medicaid program for low and moderate-income AI/ANs, depending upon state of residence; **AND**

WHEREAS, AI/ANs across the U.S. have substantially different eligibility and access to services under the federal Medicaid program based on their state of residence; **AND**

WHEREAS, state governments are not reimbursed for the costs of care provided by urban Indian health care providers to AI/ANs to the same degree that state governments are reimbursed for care to AI/ANs provided by IHS and Tribal health care providers; **AND**

WHEREAS, Tribal Nations have developed a legislative proposal to address these gaps in access to quality health care services which will create authority for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level;

---

[4] The figure on congressional appropriations for IHS includes funding for health care delivery as well as sanitation, facilities and environmental health. Per capita IHS appropriation was calculated from $4,957,856,000 in total appropriations divided by 1,638,687 Active Users. Source: *2017 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita*," February 26, 2018, available at: https://www.ihs.gov/ihcif/includes/themes/responsive2017/display_objects/documents/2018/2017_IHS_Expenditures.pdf, last accessed 10/15/2018.

[5] NHE Projections 2016-2025 –Tables, Table 5 Personal Health Care Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2016-2025; Per Capita Amount; Projected; available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

[6] Honoring The Federal Trust Responsibility: A New Partnership to Provide Quality Healthcare to America's First Citizens: The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2019 Budget, March 2017, p. 14, https://www.nihb.org/docs/04032017/TBFWG%20Testimony%20FY%202019%20FINAL.pdf

[7] "FY2017 Indian Health Service Level of Need Funded (LNF) Calculation" (shown at https://www.ihs.gov/ihcif/includes/themes/responsive2017/display_objects/documents/2018/FY_2017_LevelofNeedFunded_(LNF)_Table.pdf) indicates an LNF funding percentage of 46.6%. A preliminary LNF figure for FY 2018 of 48.6% was calculated by IHS, which includes consideration of third-party coverage made available through the Affordable Care Act.

authorize Indian Health Care Providers in all states to receive Medicaid reimbursement for mandatory and optional health care services authorized under federal Medicaid law, as well as select services authorized under the Indian Health Care Improvement Act when delivered to Medicaid-eligible AI/ANs; extend full federal funding (through 100% FMAP) to states for Medicaid services furnished by urban Indian providers to AI/ANs, in addition to services furnished by IHS/Tribal providers to AI/ANs; clarify that state Medicaid programs are not permitted to override Indian-specific Medicaid provisions in federal law through state waivers; and removes the limitation on billing by Indian health care providers for services provided outside the four walls of a clinic facility; **AND**

WHEREAS, these provisions, if enacted, will improve access to quality health care services for AI/ANs across all states, and thereby advance the Federal government's trust responsibility to AI/ANs and Tribal governments.

THEREFORE BE IT RESOLVED, that the NPAIHB and CRIHB support the enactment of legislation to ensure Medicaid advances the federal government's trust responsibility to AI/AN Tribal governments, including:

- Creates authority for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level;
- Authorizes Indian Health Care Providers in all states to receive Medicaid reimbursement for mandatory and optional health care services authorized under federal Medicaid law, as well as select services authorized under the Indian Health Care Improvement Act when delivered to Medicaid-eligible AI/ANs;
- Extends full federal funding (through 100% FMAP) to states for Medicaid services furnished by urban Indian providers to AI/ANs, in addition to services furnished by IHS/Tribal providers to AI/ANs;
- Clarifies that state Medicaid programs are not permitted to override Indian-specific Medicaid provisions in federal law through state waivers;
- Removes the limitation on billing by Indian health care providers for services provided outside the four walls of a clinic facility.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest

RESOLUTION # 19-04-08
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 340-08-19
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF MINORITY HEALTH AMERICAN INDIAN/ALASKA NATIVE HEALTH RESEARCH ADVISORY COMMITTEE

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

WHEREAS, the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member tribes; **AND**

WHEREAS, the Department of Health and Human Resources (HHS) Office of Minority Health established the AI/AN Health Research Advisory Council (HRAC) in 2006 to serve as an advisory body to HHS; **AND**

WHEREAS, the purpose of the HRAC was to help ensure that federally recognized Tribes and AI/AN people have meaningful and timely input in the development of relevant HHS policies, programs, and priorities specific to AI/AN research; **AND**

WHEREAS, for more than a decade, the HRAC was instrumental in developing research priorities that served as a foundation for several public health initiatives to improve the health status of AI/AN communities; **AND**

WHEREAS, on or about December 24, 2018, the Acting Director, Division of Policy and Data, Office of Minority Health, sent a memorandum to the Acting Director, Office of Minority Health, recommending that HRAC be decommissioned and cease to convene as an HHS FACA exempt advisory committee effective December 31, 2018; **AND**

WHEREAS, the memorandum stated that "[Office of Minority Health] identified many overlapping priorities between HRAC and NIH TAC [National Institutes of Health Tribal Advisory Committee]," and that "NIH TAC is poised to assume the leadership role in guiding research for Tribal Nations;" **AND**

WHEREAS, NIH TAC sent a strong letter of opposition to the decommissioning of HRAC and proposal for NIH TAC to take over HRAC responsibilities, **AND**

WHEREAS, the duties of the HRAC and NIH TAC are separate and distinct; **AND**

WHEREAS, pursuant to Presidential Executive Order No.13175, November 6, 2000, executive departments and agencies are charged with engaging in regular and meaningful consultation; **AND**

WHEREAS, HHS has adopted a Tribal Consultation Policy that applies to all HHS Operating and Staff Divisions, including Office of Minority Health; **AND**

WHEREAS, Tribal consultation under the HHS Tribal Consultation Policy is required when there is a critical event affecting one or more Indian Tribe(s); **AND**

WHEREAS, decommissioning the HRAC without notice is such a critical event and Tribal consultation was required; **AND**

WHEREAS, no Tribal consultation was conducted prior to the decommissioning of the HRAC.

THEREFORE BE IT RESOLVED that NPAIHB and CRIHB request Tribal consultation on whether the HRAC should continue under the HHS Office of Minority Health or whether its focus can be accomplished by other HHS tribal advisory committees.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest

RESOLUTION # 19-04-09
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 341-08-19
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

SUPPORT FOR INCREASED FUNDING FOR THE SPECIAL BEHAVIORAL HEALTH PILOT PROGRAM AND OPTION FOR FUNDING THROUGH TITLE I AND TITLE V FUNDING AGREEMENTS

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

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

WHEREAS, as stated in treaties and other federal issuances with Indian Nations, health care is guaranteed to AI/ANs in perpetuity in exchange for the millions of acres of Indian lands that now make up the United States; **AND**

WHEREAS, the Indian Health Service (IHS), an agency within the Department of Health and Human Services, administers health care to 2.6 million AI/ANs residing in Tribal communities across the United States, directly, or through the Indian Self-Determination and Education Assistance Act (ISDEAA), Title I and Title V contracts, or compacts with Tribes and Tribal organizations; **AND**

WHEREAS, since 1997, Northwest AI/AN people have had consistently higher drug and opioid overdose mortality rates compared to non-Hispanic Whites (NHW) in the Northwest region; **AND**

WHEREAS, from 2006-2012, AI/AN age-adjusted death rates for drug and prescription opioid overdoses were nearly twice the rate for NHW in the region; **AND**

WHEREAS, the Center for Disease Control (CDC) National Center for Health Statistics (NCHS), reported in 2016 that California had the second highest number of total deaths due to overdose and age-adjusted death rate for drug overdose in the United States with 4,654 total deaths; **AND**

WHEREAS, AI/ANs continue to suffer some of the worst health disparities of all Americans and according to the CDC include, but are not limited to:

- Nationally, the AI/AN population has experienced the largest increases in drug and opioid-involved overdose mortality rates compared with any other racial/ethnic groups;
- Misclassification of AI/AN race is known to underestimate AI/AN mortality rates;
- Mortality rates among AI/ANs were 2.7 and 4.1 times higher than rates among NHW for total drug and opioid-related overdoses and heroin-related overdoses, respectively;
- AI/AN communities experience high rates of physical, emotional, and historical trauma and significant socioeconomic disparities, all of which may contribute to higher rates of drug use in these communities; and
- AI/AN face barriers to receiving quality medical and behavioral health care, resulting in part from longstanding underfunding of the IHS, Tribal, and urban Indian clinics, as well as stigma associated with accessing behavioral health care in some communities; **AND**

WHEREAS, according to the SAMHSA 2012 National Survey on Drug Use and Health (NSDUH),

- The rate of substance dependence or abuse among people aged 12 and up was higher among the AI/AN population (21.8%) than among other groups; and
- AI/AN individuals have the highest rate of binge alcohol use (30.2%) compared with other groups; **AND**

WHEREAS, the Consolidated Appropriations Act, 2019 (Public Law 116-6), provided a $10 million increase to the IHS in the Alcohol and Substance Abuse Program budget line to better combat the opioid epidemic by creating the Special Behavioral Health Pilot Program (SBHPP), modeled after the Special Diabetes Program for Indians; **AND**

WHEREAS, $10 million is not enough for Tribes to establish pilot programs, however the fully funded amount of $150 million annually with medical inflation increases after year one is enough to establish pilot programs; **AND**

WHEREAS, while California Area Tribes and Portland Area Tribes have had successful SDPI programs, it is critical that SBHPP funding provide the option for Tribes to receive funding through ISDEAA Title I and Title V funding agreements.

THEREFORE BE IT RESOLVED that the NPAIHB and CRIHB request that Congress fund the IHS SBHPP at $150 million in FY 2021 with medical inflation rate increases annually thereafter; **AND**

BE IT FURTHER RESOLVED that NPAIHB and CRIHB request that Tribes have the option to receive IHS SBHPP funding through ISDEAA Title I and Title V funding agreements.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0

Against and 2 Abstain) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest

RESOLUTION # 19-04-10
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 342-08-19
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

A CALL TO INDIAN HEALTH SERVICE TO MOVE THE PURCHASED/REFERRED CARE (PRC) DEPENDENT FACTOR IN THE PRC FUNDING FORMULA TO THE ANNUAL ADJUSTMENT CATEGORY

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

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

WHEREAS, the Indian Health Service (IHS), an agency within the Department of Health and Human Services, administers health care to 2.6 million AI/ANs residing in Tribal communities across the United States, directly or through contracts or compacts with Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act; **AND**

WHEREAS, the IHS received a $5.8 billion appropriation in Fiscal Year (FY) 2019, yet the National Tribal Budget Formulation Workgroup recommends that the amount necessary to fully fund IHS is $37.61 billion pursuant to their FY 2021 recommendation; **AND**

WHEREAS, of the 12 IHS Areas, four are formally designated PRC Dependent (California, Portland, Bemidji, and Nashville) because they have limited or no access to IHS/Tribal hospitals; **AND**

WHEREAS, the Tribal health clinics in PRC Dependent Areas must use their extremely limited PRC funding to cover the costs of placing patients in non-IHS/Tribal hospitals and/or buying other specialty care services; **AND**

WHEREAS, the extremely limited PRC funding is often depleted before the end of each fiscal year, leading to the denial or rationing of inpatient and other specialty care; **AND**

WHEREAS, the remaining eight IHS areas have IHS/Tribal hospitals funded through the IHS and also receive PRC funding which further assists these areas in strengthening the system of care they provide; **AND**

WHEREAS, the June 2012 Government Accountability Office Report entitled, *Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program* (PRC), notes that the distribution of PRC funding varies widely across IHS Areas and recommends IHS "improve the equity of how it allocates program increase funds to Areas through improvements in its implementation of the PRC Allocation Formula [by refining, among other factors,]…the access to care factor to account for differences in available health care services at IHS and Tribally operated facilities"; **AND**

WHEREAS, a critically important need exists to move the PRC Dependent/Access to Care Factor from the Program Increases category to the Annual Adjustment category in the PRC Funding Distribution Formula to assist in eliminating inequities in funding for PRC programs; **AND**

WHEREAS, 40 House lawmakers issued a letter to IHS on June 17, 2019, outlining this issue for the agency and inquiring if IHS will implement this change; **AND**

NOW THEREFORE BE IT RESOLVED, that the CRIHB and NPAIHB urge IHS to move the PRC Dependent/Access to Care Factor in the PRC Funding Distribution Formula to the Annual Adjustment category in FY 2020.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest

RESOLUTION # 19-04-11
NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

RESOLUTION # 343-08-19
CALIFORNIA RURAL INDIAN HEALTH BOARD

JOINT RESOLUTION

SUPPORT FOR LEGISLATION THAT ESTABLISHES A DEPARTMENT OF VETERANS AFFAIRS' (VA) TRIBAL ADVISORY COMMITTEE (TAC)

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

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

WHEREAS, the United States (U.S.) has a unique and special relationship with AI/ANs to provide health care as established through the U.S. Constitution, treaties, U.S. Supreme Court decisions and federal legislation; **AND**

WHEREAS, AI/AN Veterans have played a vital role in the U.S. military for over two hundred years in all of the U.S.' wars since the Revolutionary War and have served in several wars before they were even recognized as American citizens; **AND**

WHEREAS, AI/AN Veterans have distinctive cultural values that drive them to serve their country; **AND**

WHEREAS, AI/ANs serve in the U.S. Armed Forces at higher rates per capita, are younger as a cohort and have a higher concentration of female Service members compared to all other Service members, yet they are underrepresented among Veterans who access the services and benefits they have earned; **AND**

WHEREAS, in Fiscal Year (FY) 2016, the National Center for Veterans Analysis and Statistics estimated 1,766 AI/AN Veterans in Idaho, 2,979 in Oregon, and 6,315 in Washington; **AND**

WHEREAS, in FY 2016, the National Center for Veterans Analysis and Statistics estimated 13,518 AI/AN Veterans in California; **AND**

WHEREAS, the VA must take into consideration that AI/AN Veterans are more likely to lack health insurance and to have a disability, service-connected or otherwise, than Veterans of other races; **AND**

WHEREAS, in FY 2016, the National Center for Veterans Analysis and Statistics highlighted about 19 percent of AI/AN Veterans had a service-connected disability rating in 2010; **AND**

WHEREAS, the National Center for Veterans Analysis and Statistics also reported that AI/AN Veterans have lower incomes, lower educational attainment, and higher unemployment than Veterans of other races; **AND**

WHEREAS, for the VA to better serve AI/AN Veterans after their service to this country, the VA must create a Tribal Advisory Committee (TAC) to address inequities of AI/AN Veterans and to fulfill the federal trust responsibility; **AND**

WHEREAS, the creation of a VA TAC is critical to ensuring that the VA, in partnership with Tribes, provides improved comprehensive, culturally responsive care and benefits to better serve our AI/AN Veterans; **AND**

WHEREAS, a VA TAC would supplement meaningful Tribal consultation and provide deliberation on issues and proposals that pertain to the need of AI/AN Veterans and the complex and varying infrastructure of IHS and Tribal health care facilities for the 573 federally-recognized Tribes in the U.S.; **AND**

WHEREAS, a VA TAC is needed to ensure that pertinent issues are brought to the attention of Tribes in a timely manner for Tribal feedback to be obtained; **AND**

WHEREAS, a VA TAC is needed to develop effective collaboration and informed decision-making with Tribes prior to, during, and after the development of VA policy decisions and opportunities for our AI/AN Veterans; **AND**

WHEREAS, a VA TAC should be comprised of designated Tribal representatives from the IHS Areas to ensure ongoing communications with the leadership of the VA regarding policy decisions that significantly impact the health care and well-being of AI/AN Veterans.

THEREFORE BE IT RESOLVED that the NPAIHB and CRIHB supports legislation that establishes a VA TAC with these provisions:

- Tribes must be able to select their own representatives to participate on the VA TAC, and such representatives may or may not be elected Tribal leaders;
- Be comprised of 17 voting members;
- Include 12 representatives from the Indian Health Service (IHS) Areas;
- Incorporate five “National At Large Member (NALM)” positions and two “Alternate NALM” positions;
- Include Alternate Representatives and two Technical Advisors for each Area;

- No term limits on TAC membership except that a TAC member may be replaced if the TAC member is unable to attend two of four meetings per year;
- Membership must include non-voting representatives from the VA Office of Tribal Government Relations and IHS; and
- Quarterly meetings must be held, along with monthly calls, as necessary; and
- Submission of an annual report and recommendations to Tribes.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest

RESOLUTION # 19-04-12
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 344-08-19
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

SUPPORT FOR PERMANENT REAUTHORIZATION OF THE SPECIAL DIABETES PROGRAM FOR INDIANS AND CHANGE TO INDIAN SELF-DETERMINATION EDUCATION ASSISTANCE ACT (ISDEAA) TO SUPPORT SDPI FUNDING THROUGH TITLE I AND TITLE V FUNDING AGREEMENTS

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

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

WHEREAS, the United States (U.S.) has a unique and special relationship with AI/ANs to provide health care as established through the U.S. Constitution, treaties, U.S. Supreme Court decisions, and federal legislation; **AND**

WHEREAS, AI/AN adults are 2.3 times more likely to have diagnosed diabetes compared with non-Hispanic whites; **AND**

WHEREAS, the death rate due to diabetes for AI/ANs is 1.8 times higher than the general U.S. population; **AND**

WHEREAS, the Balanced Budget Act of 1997 established the Special Diabetes Program for Indians (SDPI) for “the prevention and treatment of diabetes in American Indians and Alaska Natives (AI/AN) for five years; **AND**

WHEREAS, Congress reauthorized SDPI for one to three year periods from 2002 to 2019; **AND**

WHEREAS, the current renewal of SDPI expires in September, 2019; **AND**

WHEREAS, SDPI provides grants for diabetes treatment and prevention services to 301 IHS, Tribal, and Urban Indian health programs in 35 states and funds Community Directed Grant Programs; **AND**

WHEREAS, SDPI has had positive clinical and community outcomes, including the incident rate of end-stage renal disease (ESRD) due to diabetes in AI/AN people fell by 54% between 1999 and 2003 - a greater decline than for any other racial or ethnic group; the average blood sugar level (A1c) decreased from 9.0% in 1996 to 8.1% in 2014; and the average LDL ("bad" cholesterol) declined from 118 mg/dL in 1998 to 92 mg/dL in 2014; **AND**

WHEREAS, California Area Tribes and Portland Area Tribes have successful SDPI programs, 39 in California Area and 40 in the Portland Area, with consistent positive clinical and community outcomes; **AND**

WHEREAS, SDPI funding has been at $150 million since 2004 and does not include medical inflation; **AND**

WHEREAS, SDPI grant application and reporting requirements are burdensome and California Area Tribes and Portland Area Tribes have successful ISDEAA Title I or Title V funding agreements and could manage SDPI funds through such funding agreements.

THEREFORE BE IT RESOLVED that the NPAIHB and CRIHB support permanent reauthorization of SDPI at $200 million per year with medical inflation rate increases annually; **AND**

BE IT FURTHER RESOLVED, that the NPAIHB and CRIHB request an amendment to Section 505(b) of the ISDEAA (25 U.S.C. 458aaa-4(b)) to add the following new subparagraph (3):

(3) At the option of an Indian Tribe grant for special diabetes programs for Indians awarded to Indian tribes under Section 330C(b)(2) of the Public Health Service Act (42 U.S.C. 254c-3(b)(2)) shall, after award, be added to the Title I or Title V funding agreements of any Indian Tribe under this Act, and shall be administered and implemented in accordance with the provisions of this Act rather than the Secretary's grant regulations (including the regulation).

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest

RESOLUTION # 19-04-13
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 345-08-19
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

URGING THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICE ADMINISTRATION (SAMHSA)TO REMOVE UNNECESSARY GOVERNMENT PERFORMANCE AND RESULTS MODERNIZATION ACT REPORTING REQUIREMENTS FOR OPIOID TREATMENT SERVICES PROVIDED BY TRIBES AND URGING CONGRESS TO INCREASE FUNDING FOR THESE SERVICES

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest**; AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people**; AND**

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

WHEREAS, Indian Nations and the United States (US) government have a sovereign-to-sovereign relationship established by treaties, agreements, Acts of Congress, and court decisions**; AND**

WHEREAS, this relationship has resulted in the federal trust responsibility to Indian Nations and it is a legally enforceable fiduciary obligation on the part of the US to protect Tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of federal law with respect to AI/AN Tribes and villages**; AND**

WHEREAS, in several cases discussing the trust responsibility, the Supreme Court has used language detailing the legal duties, moral obligations, and fulfillment of understandings and expectations that have been established by law between the US and the Indian Nations**; AND**

WHEREAS, as stated in treaties and other federal issuances with Indian Nations, health care is guaranteed to AI/ANs in perpetuity in exchange for the millions of acres of Indian lands that now make up the US**; AND**

WHEREAS, AI/ANs continue to suffer some of the worst health disparities of all Americans and according to the Center for Disease Control and Prevention (CDC) include, but are not limited to, the largest increases in drug and opioid-involved overdose mortality rates compared with any other racial/ethnic group and mortality rates 2.7 - 4.1 times higher than rates among whites for total drug and opioid-related overdoses and heroin-related overdoses**; AND**

WHEREAS, vital statistics and surveillance systems contain racial misclassification and according to multiple reports, including *Accuracy of Race Coding On American Indian Death Certificates* and *Self-Reported vs. Administrative Race/Ethnicity Data And Study Results,* AI/ANs are identified as another racial population, causing underestimated morbidity and mortality measures; **AND**

WHEREAS, the Tribal Epidemiology Centers have devoted extensive work to accurately identify effects of opioid abuse in AI/AN communities and have issued *The Opioid Crisis Impact on Native American Communities* report showing the opioid overdose death rate among AI/AN males significantly exceeds the rate among AI/AN females (10.0 per 100,000 vs. 7.0 per 100,000, respectively), and more than 1 in 10 AI/AN high school students in a state (11%) used a prescription pain medication without a doctor's order in the past 30 days, and 22 % of AI/AN high school students who used a prescription pain medication also used heroin in the past 30 days**; AND**

WHEREAS, Tribes have consistently advocated Congress and the federal administration provide additional funding to prevent and treat opioid abuse and addiction among AI/ANs, **AND**

WHEREAS, the 115th US Congress passed the Department of Defense, Labor, Health and Human Services (HHS) and Education Appropriations Act of 2019, and Continuing Appropriations Act of 2019 in Fiscal Year (FY) 2019, which became law**; AND**

WHEREAS, through the HHS, $50 million of $1.5 billion was allocated to Indian Tribes or Tribal organizations for the purpose of combating opioid abuse, with 15% of the remaining amount for the states with the highest mortality rate related to opioid use disorders**; AND**

WHEREAS, the amounts provided for State Opioid Response (SOR) Grants in California is $36 million, in Idaho is $2.1 million, in Oregon is $4.1 million, and in Washington is $11.2 million, and not all Tribes have access to these funds due to distribution by the state**; AND**

WHEREAS, the CDC National Center for Health Statistics (NCHS), reported in 2016 that California had the second highest number of total deaths due to overdose and age-adjusted death rate for drug overdose, in the US with 4,654 total deaths**; AND**

WHEREAS, the SAMHSA allocated a total of $89 million for the Medication-Assistance Treatment for Prescription Drug and Opioid Addiction (MAT-PDOA) program, of which only 11% ($10 million dollars) was allotted for Tribes, Tribal organizations, or consortia**; AND**

WHEREAS, SAMHSA anticipated total available funding for Tribal Opioid Response (TOR) grants decreased from $50 million in FY 2018 to $35 million in FY 2019; **AND**

WHEREAS, AI/ANs continue to suffer some of the worst health disparities of all Americans and according to the CDC include, but are not limited to:

- Nationally, the AI/AN population has experienced the largest increases in drug and opioid-involved overdose mortality rates compared with any other racial/ethnic groups;
- Misclassification of AI/AN race is known to underestimate AI/AN mortality rates;
- Mortality rates among AI/AN were 2.7 and 4.1 times higher than rates among whites for total drug and opioid-related overdoses and heroin-related overdoses, respectively;
- AI/AN communities experience high rates of physical, emotional, and historical trauma and significant socioeconomic disparities, which might contribute to higher rates of drug use in these communities;
- AI/AN face barriers to receiving quality medical and behavioral health care, resulting in part from longstanding underfunding of the Indian Health Service (IHS), Tribal, and urban Indian clinics, as well as stigma associated with accessing behavioral health care in some communities; **AND**

WHEREAS, according to the SAMHSA 2012 National Survey on Drug Use and Health (NSDUH),

- The rate of substance dependence or abuse among people aged 12 and up was higher among the AI/AN population (21.8 percent) than among other groups;
- AI/AN individuals have the highest rate of binge alcohol use (30.2%) compared with other groups**; AND**

WHEREAS, the Government Performance and Results Modernization Act of 2010 (GPRA) places a burden on understaffed Tribes and Tribal Health Programs by requiring reporting measures at zero, three, six, and twelve months as part of the process for the TOR, MAT-PDOA, and SOR grant programs. This reporting can take up to three hours to complete thereby inhibiting effective implementation of education, prevention and treatment of individuals suffering from substance abuse; **AND**

WHEREAS, the opioid crisis in Indian Country could be dramatically improved with adequate investment into the health, public health and health delivery systems in Indian Country**; AND**

NOW THEREFORE BE IT RESOLVED, that the CRIHB and NPAIHB recommend the SAMHSA remove the Government Performance and Results Modernization Act of 2010 reporting requirements of Tribal Opioid Response, Medication-Assistance Treatment for Prescription Drug and Opioid Addiction, and State Opioid Response as it places further strain on understaffed Tribal Health Programs.

BE IT FURTHER RESOLVED, that the CRIHB and NPAIHB urge Congress to increase funding to $75 million for Tribal Opioid Response grants, $15 million for Medication-Assistance Treatment for Prescription Drug and Opioid Addiction, and $10 million to administer evaluation, data collection, training and technical assistance for Tribal Epidemiological Centers in order to combat the opioid crisis in Tribal Communities, which would provide much needed support for education, prevention, and substance abuse treatment programs, thereby reducing the number of opioid-related deaths in Indian Country.

BE IT FURTHER RESOLVED, that the CRIHB and NPAIHB urge states to ensure State Opioid Response funding is distributed to Tribes.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0

Against and 2 Abstain) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest