Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

April, 2006 Issue

Our Mission is to assist Northwest tribes to improve the health status and quality of life of member tribes and Indian people in their delivery of culturally appropriate and holistic health care.

Northwest Tribes Conduct the 17th Annual All Tribes Meeting

The All Tribes meeting provides Tribal leaders and health directors with a forum for developing recommendations on the IHS budget. The President's FY 2007 budget will fall short by $312 million to maintain current services. In FY 2007, the Northwest Portland Area Indian Health Board (NPAIHB) estimates that it will take at least $436.7 million to maintain the current levels of service. *See page 4 for article.*

In This Issue

From the Chair:

Linda Holt

Northwest Portland Area Indian Health Board

Executive Committee Members

Linda Holt, *Chair*
Suquamish Tribe
Andy Joseph, *Vice Chair*
Colville Tribe
Janice Clements, *Treasurer*
Warm Springs Tribe
Pearl Capoeman Baller, *Sergeant-At-Arms*
Quinault Nation
Stella Washines, *Secretary*
Yakama Nation

Delegates

Barbara Sam, Burns Paiute Tribe
Dan Gleason, Chehalis Tribe
Leta Campbell, Coeur d'Alene Tribe
Andy Joseph, Colville Tribe
Mark Johnston, Coos, Lower Umpqua & Siuslaw Tribes
Eric Metcalf, Coquille Tribe
Sharon Stanphill, Cow Creek Tribe
Jim Sherrill, Cowlitz Tribe
Cheryle Kennedy, Grand Ronde Tribe
Felicia Leitka, Hoh Tribe
Bill Riley, Jamestown S'Klallam Tribe
Darren Holmes, Kalispel Tribe
Nadine Hatcher, Klamath Tribe
Velma Bahe, Kootenai Tribe
Rosi Francis, Lower Elwha S'Klallam Tribe
William Jones, Sr., Lummi Nation
Debbie Wachendorf, Makah Tribe
John Daniels, Muckleshoot Tribe
Gary Greene, Nez Perce Nation
Norine Wells, Nisqually Tribe
Rick George, Nooksack Tribe
Shane Warner, NW Band of Shoshone Indians
Rose Purser, Port Gamble S'Klallam Tribe
Rod Smith, Puyallup Tribe
Bert Black, Quileute Tribe
Pearl Capoeman-Baller, Quinault Nation
Billie Jo Settle, Samish Tribe
Ronda Metcalf, Sauk-Suiattle Tribe
Marsha Crane, Shoalwater Bay Tribe
Belma Colter, Shoshone-Bannock Tribes
Judy Muschamp, Siletz Tribe
Marie Gouley, Skokomish Tribe
Bob Brisbois, Spokane Tribe
Francis De Los Angeles, Snoqualamie Tribe
Whitney Jones, Squaxin Island Tribe
Tom Ashley, Stillaguamish Tribe
Linda Holt, Suquamish Tribe
Leon John, Swinomish Tribe
Marie Zacouse, Tulalip Tribe
Sandra Sampson, Umatilla Tribe
Marilyn Scott, Upper Skagit Tribe
Janice Clements, Warm Springs Tribe
Stella Washines, Yakama Nation

This marks my first official report to Northwest Tribes. I have always respected the tradition of leadership at the Board with people like Pearl Capoeman Baller, Julia Davis, Mel Sampson, and many others. Our recent Chairs Pearl and Julia are respected nationally and we all know of their work and dedication to Indian health issues. Following in the footsteps of these two wonderful leaders will not be easy, but I will give it my best. I want to thank all the wonderful Tribal leaders that have served before me here at the Board for their hard work and dedication to Indian people.

Only three months into my term as the Chairperson, there has been so much that I have been involved in and could report. My first months have had me testifying before Congress, participating in consultations with the Department of Health and Human Services, representing Northwest Tribes with the Indian Health Service (IHS), meeting with Members of Congress, and much more. I have also been in routine communication with our new Executive Director, Joe Finkbonner, to review elements of his transition plan and implementation of the Board's new strategic plan. In the coming months, I will be visiting the Board offices in Portland to learn more about our operations and programs and how to best organize my work when representing Northwest Tribes and the Board.

I testified before the House Interior Appropriations Subcommittee on the IHS budget and once on behalf of the National Indian Health Board (NIHB). My comments to the committee were about the importance of funding the mandatory components of current services (population growth, inflation, and pay act increases). In typical fashion it was good to see the representation by Northwest Tribal leaders. The hearing had 48 witnesses and our count on the agenda indicated that over half were from Northwest Tribes. After the hearing, Jim Roberts and I, made a number of hill visits to talk about the IHS budget and other Indian health matters with a number of our Northwest Congressional delegation.

In March, Joe Finkbonner and I participated in the HHS Divisional Budget Consultation session in Washington, D.C. Joe provided testimony on data and research issues in Indian Country, while I testified on the methamphetamine epidemic. Copies of our testimony are available on the Board's website. Our testimony outlining the methamphetamine issues is being used by organizations like the One Sky Center, the National Congress of American Indians, and others nationally. We have also been invited by the Senate Committee on Indian Affairs to submit testimony for their Oversight Hearing on the

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Spring into Action

Spring is the season that activities increase in order to prepare for the rest of the year. Activities around the Board have been busy in order to better prepare ourselves for the remainder of the year…and beyond. I've outlined some of the activities that Linda Holt, Andy Joseph, Jr., Jim Roberts, and I have represented our Northwest Tribes.

Early discussions about developing a process for evaluating the feasibility of a Regional Medical Facility that are included in the Area Facilities master plan have begun. The form that the facility will take is yet to be determined and will be shaped based on the information gathered and the analysis that follows. An initial conference call was held to brainstorm the type of information that will be needed to determine the nature of the facility and what information we currently have. Specific activity will take place to gather the gaps in the information. A key part in developing the recommendation would be to assemble a workgroup that would assist with pulling together the necessary information, analyze it, and make a recommendation about the nature of a regional medical facility, what services it should provide, and location(s) to be the greatest benefit to the Portland Area.

The NPAIHB participated in agenda planning and discussions to highlight Indian health and the state it is in during Senator Daschle's visit to Portland. Senator Daschle was able to pull in Governor Kulongoski, Representative Wu, and a panel of tribal leaders from Oregon to discuss the health disparities that exist in Indian County and for us to make recommendations on how best to address them. Suggestions were offered on the Indian Health Service Budget, with respect to the elimination of the urban programs in the 2007 budget. Tribal leaders and Tribal organizations elucidated that the urban programs were not duplicative of the Community Health Centers, but offered services that were additive in scope and the populations that they served. We also seized the opportunity to focus on State relations and how Governor Kulongoski could play a role in assisting with the passage of the Indian Health Care Improvement Act.

The same messages were echoed again during our time at the National Congress of American Indians. Tribal leaders around the country spoke out on the importance of supporting the Urban programs, and the overall improvement of increasing the Indian Health Service budget to meet the overall needs of American Indians/Alaska Natives using the system.

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Northwest Portland Area Indian Health Board

Projects & Staff

Administration
Joe Finkbonner, Executive Director
Verné Boerner, Administrative Officer
Bobbie Treat, Controller
Mike Feroglia, Business Manager
Erin Moran, Executive Assistant
Elaine Cleaver, Office Manager

Program Operations
Jim Roberts, Policy Analyst
Sonciray Bonnell, Health Resource Coordinator
James Fry, Information Technology Director
Chris Sanford, Network Administrator
Chandra Wilson, Human Resource Assistant

Northwest Tribal Epidemiology Center
Joe Finkbonner, Director
Joshua Jones, Medical Epidemiologist
Tom Becker, Medical Epidemiologist
Doug White, NW Tribal Registry Director
Katrina Ramsey, Navigator Project Coordinator
Matthew Town, Navigator Project Coordinator
Claudia Long, Navigator Research Director
Tam Lutz, TOT's/PTOTS Director
Julia Putman, TOT's Project Coordinator
Nicole Smith, Biostatistician
Kerri Lopez, Western Tribal Diabetes Director
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Crystal Gust, WTD & National Project Specialist
Michelle Edwards, Development Specialist
Clarice Hudson, IRB & Immunization Project Coordinator
Luella Azule, NTRC Project Coordinator
Ticey Casey, EpiCenter Administrative Assistant

Western Tobacco Prevention Project
Brandy Moran, WTPP Project Coordinator
Karen Schmidt, Project Assistant
Elaine Dado, Project Assistant

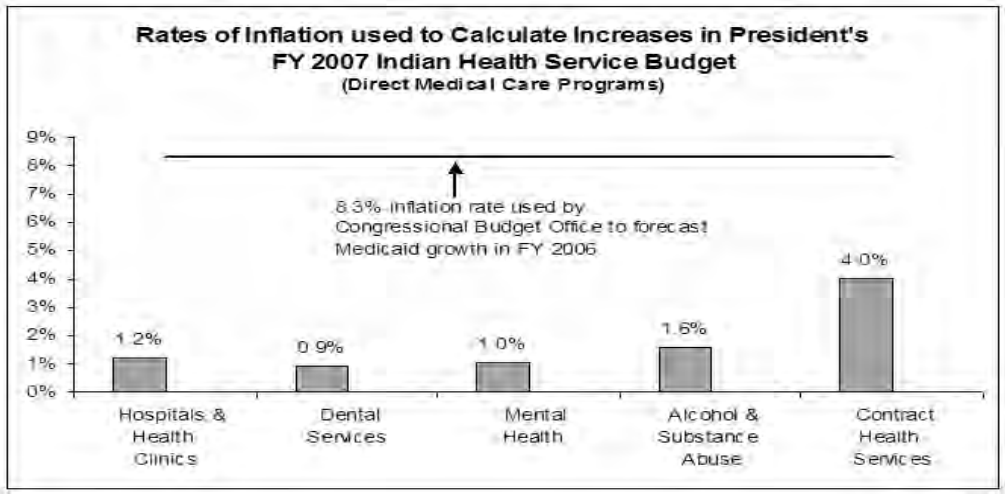
Northwest Tribal Cancer Control Project
Kerri Lopez, Project Director
Cicelly Gabriel, Project Assistant
Eric Vinson, Survivor & Caregiver Coordinator

Project Red Talon
Stephanie Craig, Project Director
Lisa Griggs, Project Assistant

Annual All Tribes Meeting and FY 2007 IHS Budget

by Jim Roberts, Policy Analyst

On March 14, 2006, Portland Area Tribes conducted their 17th Annual All Tribes meeting that continues a long-standing a tradition of close scrutiny of the Indian Health Service (IHS) budget. The All Tribes meeting provides Tribal leaders and health directors with a forum for developing recommendations on the IHS budget. Northwest Tribes understand the significance of the IHS budget; singularly it provides the preponderance of funding for Indian health programs and is the Administration's ultimate policy statement on priorities for Indian health programs. Sad but true, this year's IHS budget will result in drastic cuts in health services and leave millions in unfunded inflation and population growth. The President's budget is clear: he does not support adequate increases for Indian health programs nor does he believe funding the health disparities of Indian people is a very high priority.



In FY 2007, the Northwest Portland Area Indian Health Board (NPAIHB) estimates that it will take at least $436.7 million to maintain the current levels of service. Anything less will mean cuts in health services for Indian people served by the IHS system. The costs associated with maintaining current services include general and medical inflation, population growth, and pay cost increases. For FY 2007, Portland Area Tribes estimate the costs of current services items as follows: general and medical inflation $232.8 million, Contract Support Cost increases $150 million and population growth $53.8 million. The President's FY 2007 budget will fall short by $312 million of maintaining current services.

In addition to the current services estimates, Northwest Tribes also developed recommendations to address high priority needs. These recommendations highlight the significant health disparities that American Indian and Alaska Native people suffer and represent areas to make major improvements in health status. This year, Portland Area Tribes recommended $416 million in program enhancements to address high priority needs. The recommendations included additional funding for the Contract Health Service program in order to address the growing number of deferred and denied services, increases for behavioral health programs, more funding for pharmaceuticals and Part D triage, a higher priority of funding for health promotion and disease prevention activities, information technology, and facilities construction and maintenance needs. In FY 2007, the amount of funding to address the real needs of Indian health programs—current services and program enhancements—to address health disparities, is at least $866 million.

Most notable of the cuts in the President's budget is his proposal to eliminate the $33 million used to fund 34 different urban health programs across the country. The justification for cutting the Urban Indian Health Programs (UIHP) relates to an earlier assessment by the Performance Assessment Rating Tool (PART) in which the Administration found that the urban health program score was "adequate" and its purpose was not clear and duplicative of other publicly-funded health programs. The IHS congressional justification rationalizes that urban Indians—unlike other Indian people that live in isolated

rural areas—have access to hospitals and other health services like Medicaid and other Federal, State and local health care programs, on the same basis as other Americans. If the UIHP is eliminated, there is no transition plan to closeout funding to the 34 urban Indian health programs other than what is described in the IHS congressional justification. IHS indicates it will notify all of its urban health programs that no funds are available in FY 2007. The Agency will begin to identify urban programs that are receiving other IHS funding (i.e. Special Diabetes Program for Indians, Stevens Bill, Alcohol & Substance Abuse, Elders, etc.) due to their special status for guidance and oversight. IHS reasons that an important source of health care for the urban Indian population will be the Community Health Centers program, administered by the Health Resources Services Administration (HRSA), which currently operates health centers in all 34 cities served by the IHS urban Indian health program. The justifications for the elimination of the urban program have many Tribal leaders concerned that the reasons for eliminating the UIHP could be extended to Tribally-based program operating in an urban environment.

FY 2007 IHS Budget Scenario

The following graphs demonstrate a probable budget scenario on the FY 2007 IHS budget. It is anticipated that Congress will likely restore the funding for UIHPs. There is broad based support nationally by Tribal leaders and member of Congress. It is also anticipated that Congress will continue the use of rescissions to comply with spending caps in the appropriations process. Finally, IHS must provide funding for phasing in staff at newly constructed health centers in Clinton, OK, Red Mesa, AZ, Sisseton, SD, and St. Paul, AK. The illustration shows the effect on the proposed President's increase in each step of the process. As the illustration demonstrates after the $33 million is restored to the UIHP, the $46 million effect of recessions is considered, and the phasing in of $32 million for new staff is factored—there is only $13 million to cover the costs of inflation, population growth and pay act increases. This means that IHS and Tribal health programs will ultimately cut health services to absorb the costs of these components.

The point of this illustration is that Congress is expected to restore the urban program, there will be rescissions, and IHS must cover the costs of staffing new facilities. This means there will be little to cover the costs of inflation and population growth. The components of pay act increases ($41.4 million), staffing for new facilities ($32.2 million), and implementing the new Uniform Financial Management System ($11 million) totals $84.6 million and this total does not include inflation and population growth. IHS' own estimates indicate it will take at least $92.7 million to cover the costs of inflation and population growth and once that number is added to the

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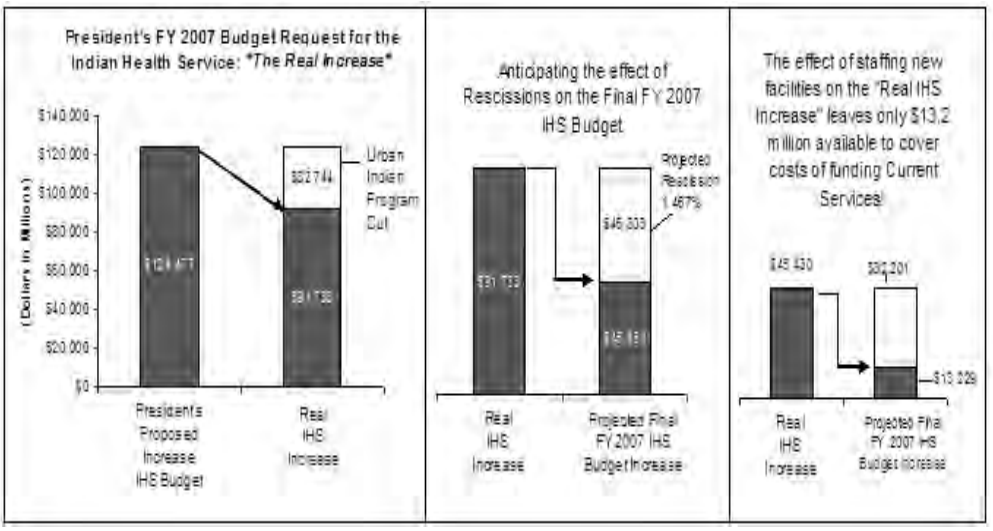

Annual All Tribes Meeting and FY 2007 IHS Budget

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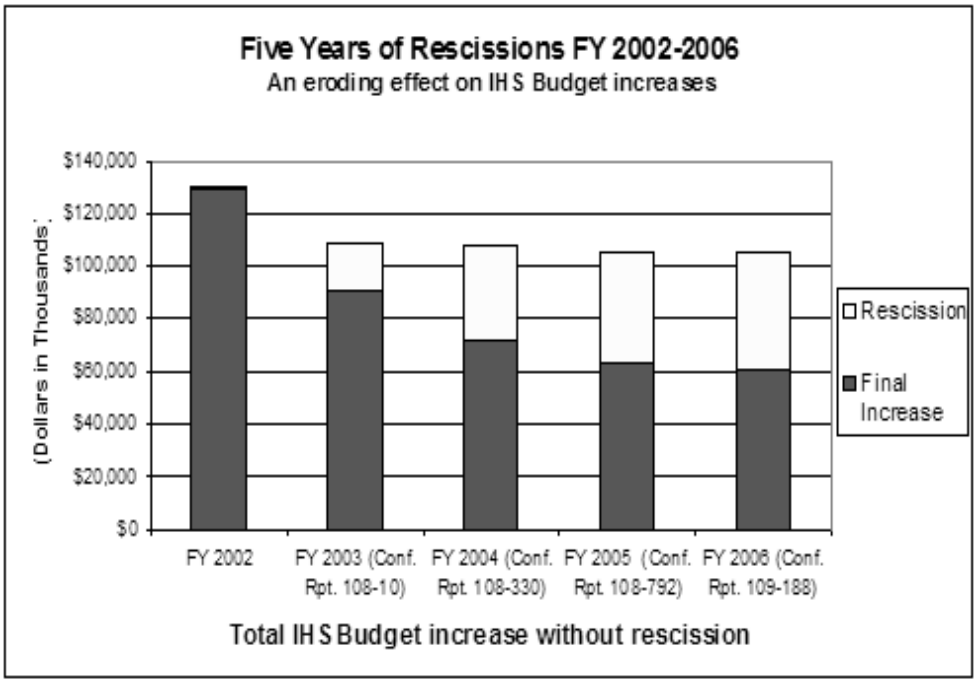
program increases of $84.6 million, one can quickly see that the President increase is simply not enough for IHS and Tribes to maintain current services. This means that Indian health programs will ultimately cut health services in order to absorb this budget shortfall.

The Board FY 2007 appropriation season will be extremely challenging for Tribes. This year, there is not much funding proposed for domestic discretionary spending. In March, the Senate approved their budget resolution authorizing $390 billion for domestic discretionary programs (the pool that IHS programs are funded out of). Last year, the final enacted level was $381 billion and while the FY 2007 amount is 2.4% more, the chances of this making it down to Tribal programs are not good. It is expected that the small increase contained in the Senate resolution will be targeted for spending in Iraq and for continued support for hurricane relief. The proposed House budget resolution is worse than the Senate's version. The House measure would cut domestic discretionary spending by $10.3 billion in FY 2007. This means that supplemental spending bills to support Iraq and hurricane relief would have to come out of the reduced pool of discretionary funds and reduce significantly the $124 million increase proposed for IHS programs. The Board realizes that this is the most critical budget year that IHS and Tribal programs have seen in some time and will work increasingly hard to make sure that IHS programs receive the funding they need.



From the Executive Director: Joe Finkbonner

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NPAIHB also participated in the annual All Tribes meeting in Portland, a summary of which is provided on page four this newsletter.

Pandemic Flu summits will have all taken place by the reading of this newsletter. Secretary Leavitt is conducting a series of in-state summits to address pandemic preparedness across the country to help the public health and emergency response community inform and involve their political, economic, and community leadership in this process. More information on pandemic flu readiness is available at www.pandemicflu.gov. The specific dates that Secretary Leavitt was in each of your respective States were:

- March 27th - Idaho
- March 30th – Oregon
- April 14th – Washington

The NPAIHB has also been working to secure additional resources and personnel to better assist our tribes in the Portland Area. We were able to secure from the Department of Health and Human Services Office of Minority Health funding to identify the barriers to the utilization of data that Tribes have available to them for policy or programmatic planning. The scope of this project, along with the Epi consortium, will fit hand in glove to allow us to develop some useful information that will better assist our tribes in the Portland Area and beyond.

From the Chair:
Linda Holt

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Problem of Methamphetamine in Indian Country that was conducted on April 5th. I have heard the message from our delegates on this issue and will work it elevate it with the Department, Congress, and this Administration.

This year saw over 57 people participate in the Annual All Tribes Meeting held in Portland. Please see the related article on page four for details.

Last month Andy Joseph and I participated in the Annual IHS National Budget Formulation meeting in Washington, DC. This was Andy's third meeting as our Portland Area representative and my first. We did carry forward the recommendations from our December 8, 2005 Area Budget Formulation meeting held in Portland. This year's budget formulation workgroup recommended submitting a budget increase of 20% or $634 million. The recommendation would provide $346 million for current services and $285 million for program increases.

I attended the Region X HHS Tribal Consultation held in Anchorage, Alaska and am in the process of preparing for the HHS Department-wide Annual Budget Consultation sessions May 16-18, 2006 in Washington DC. The Board has been actively engaged in the work of the planning committees for both meetings. Current issues pertaining to these meetings include Medicare and Medicaid concerns, pandemic flu planning, IHS budget and other related issues, the new Centers for Disease Control consultation policy and seating its new Tribal Consultation Advisory Committee (TCAC), and others. Sonciray Bonnell, Health Resources Coordinator, worked hard on the Region X meeting, while Jim Roberts, Policy Analyst, has been working with members of the Department to plan the Washington, D.C. session.

The Board has been working to elevate the importance of reaching out to Tribal health programs in the process of preparing for an influenza pandemic. As most know, HHS recently made available $100 million to states for local planning efforts. Northwest states have received $4.2 million for their planning activities and it is not entirely clear the role that Tribes will play in this process. An additional $250 million will be made available later in the year by HHS, and will be awarded based on the state's progress and performance toward planning activities. To help coordinate planning, HHS and other federal agencies are holding pandemic planning summits with public health and emergency management and response leaders in each state. The Board has requested that tribes participate in these state summits and will work to make sure Tribes are included in the process.

There are several other items that I could report, but will leave you with my commitment to work hard on behalf of our Northwest Tribes and follow in the foot steps our wonderful Northwest Tribal leaders. Thank you all for your support!

Annual Diabetes Audit Due August 1, 2006

The Indian Health Service annual audit deadline, August 1, 2006, is approaching fast. The Western Tribal Diabetes Project is busy scheduling and conducting site visits to assist Northwest tribes prepare to submit the audit. The annual audit reports all care delivered to patients with diabetes between April 1, 2005 and March 31, 2006, and is a required component for the Special Diabetes Program for Indians grants awards. Audit data can also be converted to the Health Status Report, and is used in the NW aggregate tribal report. These reports can assist NW tribes in utilizing tribal specific data to improve case management, track diabetes care, identify program gaps, and secure new funding. Act now to prepare for the audit. WTDP staff is available to assist in chart audits, technical assistance, and program planning. To request a site visit, please call 800-862-5497.

Western Tobacco Prevention Project Receives Policy Funding

by Karen Schmidt, Western Tobacco Prevention Project

The Western Tobacco Prevention Project (WTPP) provides training and technical assistance in the area of tobacco prevention and education to all tribes in the Northwest. We are pleased to announce that the project recently received funding from the Robert Wood Johnson Foundation (RWJF) (Contract # 907-00-01), to provide assistance in tobacco-related policy development at the tribal level.

This is a very exciting project, with many opportunities for NW tribes to receive direct support and financial assistance to facilitate policy change. A few of these opportunities include: 14 mini-grants aimed at creating tobacco-related policy at the tribal level, support and financial assistance for community readiness surveys and/or casino economic impact surveys, and two Tobacco Policy Summits for tribal leaders and decision makers. The WTPP is currently in the process of conducting a Tobacco Policy Needs Assessment, which will help WTPP staff assess the current policy status and technical assistance needs of NW tribal communities. All NW tribes that completed the needs assessment will be eligible to apply for the 14 policy mini-grants. Applications for the mini-grants will be sent to the Tribal Tobacco Coordinators in April 2006.

On April 17, 2006, in concurrence with the NPAIHB quarterly board meeting, the WTPP will be holding the first of two Tobacco Policy Summits. This Summit is an excellent opportunity for tribal leaders and decision makers to learn more about the policy change process. It will also provide a venue for tribes to share and discuss their experiences in tobacco policy. The WTPP will be providing additional information on the available mini-grants, community readiness surveys, and casino economic impact surveys during the Summit. If you are interested in hearing about the results of the Summit, please contact Brandy Moran at 503-228-4185, or email her at bmoran@npaihb.org.

Teens Against Tobacco Use (TATU) Committee Members

In addition to increased efforts in policy development, the WTPP has continued working in youth prevention and developing a comprehensive media campaign. Through a contract with the Washington State Department of Health (Contract #: N12228(3)), the WTPP has facilitated the coordination of a committee of Washington Tribal Tobacco Coordinators, in collaboration with the American Lung Association and the American Cancer Society, aimed at revising the Teens Against Tobacco Use Curriculum (TATU) and the SPEAKOUT curriculum. This revision is intended to be culturally appropriate for American Indian communities. The final version of the revised TATU curriculum is planned to go into printing during the summer of this year.

Funding through Washington State Department of Health is also allowing for a collaborative process with GMMB advertising company and Washington State Tribal Tobacco Coordinators to create and implement a media campaign across all Washington Tribes. Print ads are currently being placed within Tribal newsletters/newspapers, and T-shirts & posters have already been distributed to the Washington Tribes, however the majority of media materials for this campaign can be expected to come out during this summer.

We wish you and your community clean air and healthy lungs in 2006! Sincerely, the WTPP staff.

VoIP - What's the Deal?

by Chris Sanford, Network Administrator

As some of you may know, the Board recently replaced our aging phone system (PBX) with a new system, one that uses VoIP technology. VoIP stands for Voice over Internet Protocol, which in basic terms, means sending phone calls over the Internet, or by another network that utilizes the now common Internet Protocol. Traditionally, phone calls traveled by way of the PSTN, which stands for Public Switched Telephone Network. The PSTN uses a technology called 'circuit-switching', which establishes a dedicated physical connection from end to end. In contrast to the PSTN, VoIP systems use a technology called packet-switching, whereby, data (your phone conversaton, in this case) is broken into discreet pieces (packets) of information, and then routed across network connections which are shared. These shared networks carry other people's data along with your VoIP phone call.

Potential Cost Savings

One of the basic ideas behind VoIP is that because you are bypassing traditional sources for phone services (ie, THE PHONE COMPANY), there should be opportunties for cost savings. While this sounds good in theory, in practice, things are not that clear cut. For instance, here at the Board, our new system could have utilized our existing data network, so we could have cut costs by eliminating the dedicated T-1 circuit used by our old phone system, however it turned out that our existing data network had very little extra capacity, so we have had to keep our existing phone T-1, so no saving there. But what about phone calls travelling over the Internet? Shouldn't this save money? Well, yes, again, in theory. In the case of an office with several remote sites, it is possible to configure VoIP traffic to pass over the Internet from remote office to remote office, providing that the systems on each end are interoperable. Since the Board only has one main office, we can't take advantage of this potential savings, but for an organization which has, say, both East Coast and West Coast offices, there could be significant savings with a VoIP system.

Realized cost savings

While our new VoIP system hasn't actually saved us money on our monthly phone bill, it has saved us money in other ways. First, we had been spending quite a bit of staff time dealing with adds/moves/changes. Anytime a new staff member was hired, or someone changed office locations, our IT department had to spend several hours re-routing connections to our old phone system, and creating new accounts in our (separate) voice-mail system. Second, anytime there was something complicated to set up – such as a hunt group, or an 800 number that needed to be routed to a specific user – we would have to call in a technician from our phone vendor for help. Happily, with our new VoIP system, managing adds/moves/changes has never been easier. Our new system can be configured over the network by using a web browser, and the voice mail is actually integrated with the PBX! Also, since our system has been up and running, we have not had to pay for a single technician visit.

Features, Features, and more Features

While there are a few things that our old system could do which our new one can't, in general, the new system is extremely feature-rich. Some of the highlights include phone client software which integrates with our Outlook 'contacts.' This enables us to initiate calls to anyone in our address books by using the 'call manager' application. For incoming calls, this software will identify the caller (once we get caller ID capability from our T-1 circuit) and open the appropriate Outlook contact record when a match is found. We also have 'soft-phone' capability, so that users can make calls, take calls, or pick up voice mail messages via their laptop computers, when travelling. Since we have many users who spend a lot of time on the road, we anticipate that this feature will be widely used.

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What we need to Know, but were Afraid to Ask:

by Stephanie Craig, Project Red Talon Director

Sexually Transmitted Diseases (STDs) cause significant harm to tribal communities in the Pacific Northwest. In 2003, American Indians were nearly six times more likely than Whites to get chlamydia, over three times more likely to get gonorrhea, and twice as likely to have syphilis. These infections compromise not only individual well being, but the well being of the community as a whole.

While substantial progress has been made in preventing, and treating certain STDs, experts estimate that 19 million new infections occur each year, with almost half of them presenting among young people. In addition to the physical and psychological consequences, these diseases also exact a tremendous toll on the Indian Healthcare System. Nationally, direct medical costs associated with STDs are estimated at $13 billion annually.

Because of factors such as geographic isolation, early sexual debut, close-knit sexual networks, and high rates of hepatitis C, substance abuse, and sexually transmitted diseases, many experts now believe that HIV/AIDS is a “time bomb” that may reach epidemic proportions among Native communities. The number of American Indians and Alaska Natives diagnosed with AIDS has grown more rapidly than in any other ethnic group, increasing almost 800% from 1990 to 1999.

The Cost: Including the cost of STD testing, treatment, and care for untreated or inadequately treated infection, in the year 2000, each chlamydia infection resulted in an average lifetime direct medical cost of $20 for men and $244 for women, each gonorrhea infection resulted in an average lifetime cost of $53 for men and $266 for women, each case of HIV resulted in an average lifetime cost of $199,800, and each case of genital herpes (excluding neonatal herpes) resulted in an average lifetime cost of $417 for women and $511 for men.

The Facts

Chlamydia - When comparing rates by ethnicity, American Indians have the second highest chlamydia rate in the United States. From 2000-2004, the chlamydia rate among American Indian and Alaska Native women was nearly 5 times higher than the rate reported among white women. Among Native men, the chlamydia rate was 4.75 times higher than the rate reported among white men. In Idaho, Oregon, and Washington, American Indians make up nearly 2.5% of the total population, and account for approximately 3% of all reported chlamydia cases.

Age Distribution: Nearly ¾ of all chlamydia cases occur among 15-24 year olds.

Health Consequences: Chlamydia is a bacterial infection that can easily be cured with antibiotics, but it is usually asymptomatic and often undiagnosed. Untreated, it can cause severe health consequences for women, including pelvic inflammatory disease (PID), ectopic pregnancy, and infertility. Up to 40% of females with untreated chlamydia infections develop PID, and 20% of those may become infertile. Additionally, women infected with chlamydia are up to 5 times more likely to become infected with HIV, if exposed. Complications from chlamydia among men may include epididymitis and urethritis, which can cause pain, fever, and in rare cases, sterility

The Facts about Sexually Transmitted Diseases

Gonorrhea - In 2004, American Indians and Alaska Natives had the second-highest gonorrhea rate, with 117.7 cases per 100,000, a rate that was 4 times higher than rates reported among whites. From 2000 to 2004, gonorrhea rates increased 19.4% among American Indians and Alaska Natives.

Age Distribution: In 2004, AI/AN gonorrhea rates were highest among 20-24 year olds.

Health Consequences: While gonorrhea is easily cured, untreated cases can lead to serious health problems. Among women, gonorrhea is a major cause of pelvic inflammatory disease (PID), which can lead to chronic pelvic pain, ectopic pregnancy, and infertility. In men, untreated gonorrhea can cause epididymitis, a painful condition of the testicles that can result in infertility. In addition, studies suggest that presence of gonorrhea infection makes an individual three to five times more likely to acquire HIV, if exposed.

Syphilis - Between 2003 and 2004, the rates of primary and secondary syphilis increased 14.3% among American Indians and Alaska Natives. During this period, the number of reported syphilis cases decreased among AI/AN men (from 50 to 42), but increased among AI/AN women (from 19 to 35).

Age Distribution: In 2004, AI/AN syphilis rates were highest among 35-39 year olds.

Health Consequences: Syphilis, a genital ulcerative disease, is highly infectious, but easily curable in its early stages. If untreated, it can lead to serious long-term complications, including nerve, cardiovascular, organ damage, and even death. Congenital syphilis can cause stillbirth, or physical deformity and neurological complications in children who survive. Syphilis, like many other STDs, facilitates the spread of HIV, increasing transmission of the virus at least two- to five-fold.

HIV/AIDS - AIDS has steadily increased in recent years, becoming the ninth leading killer of Native people between the ages of 15 and 44 -- approximately 3,084 AI/ANs have been diagnosed with AIDS since the disease was first encountered in 1980. In 2004, the rate of HIV/AIDS diagnosis for Native men (20.8 per 100,000) was 1.1 times higher than that for whites. Among Native women, the rate (at 7.7 per 100,000) was 2.4 times higher than that for whites. When compared by ethnicity, AI/AN men and women both had the third highest HIV/AIDS rate in 2004. Among AI/AN males, the HIV/AIDS case rate increased 2.4% from 2001 to 2004, the most significant increase observed among any reported racial/ethnic group. And among females, the rate increased 4.8%, an increase that was second only behind Asians/Pacific Islanders. In 2004, HIV was newly diagnosed for an estimated 206 American Indians and Alaska Natives.

Women: Women are more biologically susceptible to the transmission of STDs and HIV than men — and adolescent girls are more susceptible than adult women. At all ages, women are more likely than men to contract genital herpes, chlamydia or gonorrhea. Most Native women acquire HIV through heterosexual

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The Facts about Sexually Transmitted Diseases

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contact. AIDS diagnoses among women have increased significantly since the beginning of the epidemic -- Among American Indian and Alaska Native females, the HIV/AIDS case rate increased almost 5% from 2001 to 2004.

Teens and Young Adults: Early sexual debut, multiple sex partners, and infrequent condom use puts Native youth at heightened risk for STDs, HIV, and teen pregnancy. The data are compelling:

- **1 out of every 4 sexually active teens will get an STD this year, and Native youth may be at even higher risk.** According to a 2001 survey involving a nationally-representative sample of 8,500 BIA high school students, Native youth were more likely to have had sex than the national average. Slightly more than half (52.3%) of Native American female high school students reported having had sex, compared to 42.9% of all female high school students, and 65.5% of Native American male students reported having had sex, compared to 48.5% of all male high school students.

- **1 in 10 sexually active adolescents has chlamydia.** Because adolescent women are physically more susceptible to infection (and 75% of infections produce no symptoms), adolescent women are at particularly high risk of getting infected.

- **2 U.S. teens are infected with HIV every hour of every day.** Increasing their risk for HIV and other STDs, female Native American students report less condom use than the national average (45.0% vs. 51.3%).

- **1 of every 5 sexually active teen females will get pregnant this year.** While teen pregnancy rates for Native American youth are not available from national data sets (due to a lack of available abortion data), in 2002 the birth rate for Native American 15- to 19- year olds was 53.8 per 1,000, much higher than the national rate of 43.0 per 1,000. Only 8.3% of AI/AN students reported using birth control pills at that time, compared to 18.2% of high school students nationally.

Elevated STD rates among American Indians and Alaska Natives put us and our children at heightened risk for HIV transmission. Rural geography, low rates of condom use, and risky sexual norms could further contribute to an epidemic of HIV among our NW Tribes.

It is vitally important that we work together to address this common concern! **For more information, please visit Project Red Talon at: www.npaihb.org/std-aids/prt**

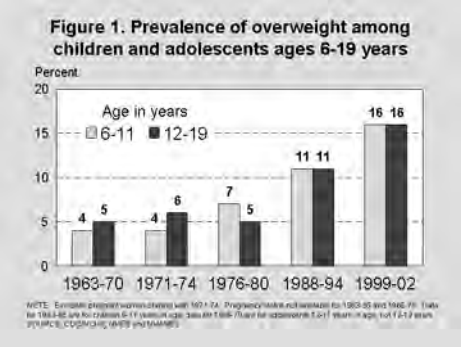
Here's what You Can Do...

- Learn more about STDs/HIV and their impact on your community.
- Encourage community awareness by participating in community STD/HIV observances.
- Protect yourself against STDs and HIV infection. Know the risks associated with sex and drug use.
- Get tested - and encourage others to do the same. It's important to know your STD & HIV status to protect yourself and others. Blood, urine, and saliva test are available for different STDs. Most infections can be treated or cured!
- Volunteer with your tribe's STD/HIV Prevention Program.
- Get medical care and support if you're living with HIV. Effective treatments exist.
- Help someone living with HIV/AIDS by being a friend. Help end the stigma.

References: STD Surveillance 2004 (CDC), the National Campaign to Prevent Teen Pregnancy, and the HIV/AIDS Surveillance Report (CDC 2004), HW Chesson, JM Blandford, TL Gift, G Tao and KL Irwin. The Estimated Direct Medical Cost of Sexually Transmitted Diseases Among American Youth, 2000. Perspectives on Sexual and Reproductive Health, Volume 36, Number 1, January/February 2004.

TAKE A HIKE - Diabetes and Obesity in Children:!

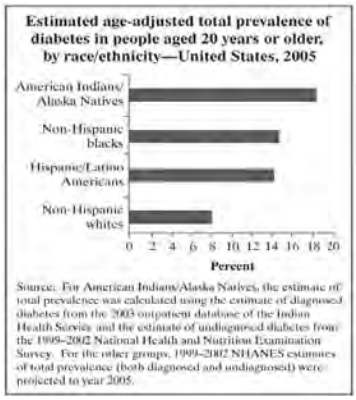
It's no secret that children are spending more time engaging in sedentary activities, such as going to movies, watching television, or playing videogames. The dilemma then becomes that they are spending less time engaged in physical activities like walking, biking, playing, or sports, organized or otherwise. With the abundance of television channels that are currently available, as well as the explosion of the videogaming industry, the power of entertainment options available at the click of a remote cannot begin to compare to what previous generations had access to in their youth. Additionally, access to physical activity has decreased, activity program costs are common, neighborhoods are more insular, and parents are cautious about their children having the unrestricted freedom once enjoyed by so many.



Correspondingly, the prevalence of overweight in children has been steadily rising for over 20 years. The Centers for Disease Control and Prevention (CDC) has indicated that between 1980 and 2000, the prevalence of overweight in children has risen from approximately 6% to greater than 15%.

Along with the host of health concerns that being overweight can cause, parents and children now have to face the reality that prediabetes, the primary risk factor for the development of type 2 diabetes, is a valid concern. The American Diabetes Association estimates that of the people aged 12-19 who are overweight, 2 million, or one in six, has prediabetes. It is true that type 2 diabetes in children is rare, but the rise in prediabetes sets the stage for the development of type 2 diabetes in adulthood, at increasingly earlier ages.

These numbers in many Indian communities in the Northwest are even more cause for concern. The prevalence of overweight in Indian children is two to three times higher than the national statistics captured by CDC.



American Indians and Alaska Natives are already experiencing an epidemic of diabetes in their communities. Now, with the higher prevalence of overweight in children, and the related rise in cases of prediabetes, it appears as though that epidemic will continue into the next generation.

Despite these numbers, the development of type 2 diabetes is not inevitable. Although some may feel that children who have developed prediabetes are inescapably going to develop type 2 diabetes, **this is not the case!**

The Diabetes Prevention Program (DPP) established that type 2 diabetes is preventable through lifestyle changes. Prediabetes is not just a risk factor for diabetes, but also can serve as an early warning device that the children and parents need to make lifestyle changes. A study provided by the American Family Physician has indicated that while general, population-based interventions are working, it is the individually tailored interventions that provide the most benefit for children who are overweight. Studies resonate clearly that children learn important lessons regarding their health that will last a lifetime

In Indian country, our communities have long recognized children as our most valuable resource. Traditionally, our children engaged in active sports such as stickball. The focus

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New NPAIHB Employees

Elaine Dado rejoins the Northwest Portland Area Indian Health Board after relocating back to Oregon from a one year stay in Washington, DC where she was working for the National Indian Health Board. She previously had worked for the Health Board for 10 years. She began working for the Western Tobacco Prevention Project on April 6, 2006 as the Project Assistant and will be working with member tribes in Idaho, Oregon and Washington. She is an enrolled member of the Rosebud Sioux Tribe.

Elaine is so excited to be back at the Health Board and is so looking forward to working with Northwest tribes again in her new capacity with the Tobacco Project.

In her spare time she enjoys any kind of sports activities, reading, and beading. She is anxiously awaiting the birth of her first grand baby, due in October.

Hi, my name is Claudia We-La-La Long and I'm so grateful to have been hired as the Research Director of the NWTCN (Northwest Tribal Cancer Navigation) Program. I am looking forward to working with my esteemed colleagues Josh Jones, Katrina Ramsey, newly hired, Matt Town, and Navigators at Yakama and Puyallup. We are in the process of adding three more sites (and staff) and several comparison communities this year. We'll keep you posted! I am also working as PSU adjunct faculty.

My tribal background is Ni Mii Puu (Nez Perce) and I was named for my great, great grandmother, We-La-La. My daughters, Lori and Lisa are both social workers and I have four beautiful grandchildren, It'se ye ye nm' silu Alexis (11) , Lila (7), Jimmy (5) and Joseph (4) ~ my life is truly blessed. It's as though I have completed the circle and have returned from where I began. My hobbies vary with the season: Native flute playing, storytelling, gardening, skateboarding …(no just kidding)--but mostly, just hanging out in old book stores and coffee shops.

Most recently I was involved in a research project with NARA-NW Residential program; prior to that I spent six years teaching Native Indian social work practice courses and conducting research studies with several Northern Plains reservation and Southwestern pueblo communities. Returning to the Pacific Northwest has reconnected me with family and friends and opportunities to make new acquaintances.

My past professional life is sprinkled with social worker jobs with Native children and families. After completing the doctoral work (social work and social research) at PSU in 1997, my work evolved into teaching, writing, and research associated with Native Indian communities. My new NPAIHB research position I consider the "frosting on the cake:" following a lifetime of social justice work with issues of Native identity and violence, my energies have been redirected into a critical study about the community-based cancer navigation process with Native people. Qe'ci yew yew' [Thank you, Nez Perce].
Claudia [We-La-La] Long, PhD, Ni Mii Puu

VoIP - What's the Deal?

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Problems

VoIP systems have a few limitations. The first has to do with call quality. As I mentioned before, with VoIP, the phone converstation is broken into packets and sent over shared networks. Because these networks are shared, there can be bandwidth issues, and if some of the networks your call happens to be using are congested, that can lead to latency (delays, dropouts, poor voice quality, etc). Another potential problem with VoIP systems is that since they rely on your network connection, if your network goes down, then so does your phone system. Related to this issue, is the fact that VoIP phones require power, so a power failure also means that phones will not function. With older PBX systems, having a generator or battery backup for the phone system meant that one could still place a call, but VoIP systems require that phones have backup power as well. Finally, there can be a problem with 911 emergency calls, as it may be difficult to determine where a VoIP call is originating from. Typically, this is more of an issue with mass-market VoIP solutions than with newer VoIP PBXs, but it does bear consideration.

Where things are headed

Telco industry analysts predict that 2005 will be the 'inflection' year, where more VoIP capacity will be sold than than digital PBX capacity. It remains to be seen if this is the case, but we at NPAIHB are happy that we chose VoIP (its drawbacks notwithstanding).

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on children and involvement in sports and activity is still primary, as Indian families follow their community schools through basketball, football, or other activities. Indian families are still multi-generational, allowing for a larger impact of family interventions on youth. Our challenge is to get our children to increase activity levels and eat right. Making time for family activity has become a bigger challenge in today's world. So, the next time you are tempted to pop in a DVD, go shoot some hoops, or go to the local fitness center, or better yet…TAKE A HIKE!

The CDC has published guidelines for overweight children and adolescents that involve screening, assessment, and management. These guidelines can be accessed through the CDC website under the Division of Nutrition and Physical Activity. For more information, or if you have questions, please feel free to contact the Western Tribal Diabetes Project at 1-800-862-5497.

Congratulations Nicole Smith on the birth of your son, Isaac Stephen. Issac was born on February 28, 2006 at 12:20 AM, weighed 7 lbs 5 ounces, and was 18 ¾" long. Congrats again to Nicole, Cory (Dad), and Asher (Big Brother).

Health News and Notes is published by the Northwest Portland Area Indian Health Board (NPAIHB). NPAIHB is a nonprofit advisory board established in 1972 to advocate for tribes of Washington, Oregon, and Idaho to address health issues. Previous issues of *Health News and Notes* can be found on the NPAIHB webpage www.npaihb.org.

Contact Sonciray Bonnell (503) 228-4185 or sbonnell@npaihb.org., *Health News and Notes* Editor, to submit articles, comments, letters, and requests to receive our newsletter via mail.

Northwest Portland Area Indian Health Board

RESOLUTION # 06-02-01
Support for a collaboration between the Northwest Tribal Epidemiology Center and the Northern Plains Tribal Epidemiology Center to replicate the NPAIHB HITS Project

RESOLUTION # 06-02-02
Support for Tooth Decay Prevention by Appropriate Food/Drink Choices for Tribal Toddlers, A Dental Ancillary Study (DAS)

RESOLUTION # 06-02-03
Support for Childhood Injury Prevention Program (CHIPP) on Northwest Indian Reservations

RESOLUTION # 06-02-04
Support a project to evaluate AI/AN patient dropout from cancer treatment and follow-up activities

RESOLUTION # 06-02-05
Support for the 2006 STD/HIV Tribal Action Plan

RESOLUTION # 06-02-06
Support to Exempt Indian people from detrimental Medicaid provisions in Deficit Reduction Act of 2005

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