Good afternoon. I am Buford Rolin, Chairman of the Poarch Band of Creek Indians, Chairman of the Tribal Leaders Diabetes Committee (TLDC), and Vice-Chairman of the National Indian Health Board (NIHB). It is a pleasure to be here today to discuss with you the Special Diabetes Program for Indians (SDPI) and the opportunity for the Centers for Disease Control and Prevention (CDC) to make a greater investment into Diabetes prevention, education and surveillance for American Indians and Alaska Natives. The SDPI program is making a critical difference in the prevention and treatment of diabetes and cardiovascular disease (CVD) for American Indians and Alaska Natives (AI/ANs).

As I am sure you are aware, the rates of diabetes for AI/ANs are the highest in the U.S., with rates of diagnosed diabetes in adults as high as 60% in some of our communities. Between 1997 and 2004, the prevalence of diabetes increased by 45% in all major regions (all ages) served by the Indian Health Service (IHS). The highest rate of increase has occurred among AI/AN young adults aged 25-34 years, with a 160% increase from 1990-2004. Alarmingly, type 2 diabetes rose 128% in AI/AN adolescents, 15-19 years old.
Even though type 2 diabetes used to be rare in individuals under the age of 40, the prevalence of diabetes in AI/ANs under the age of 35 increased by 133% between 1990 and 2004. In 2003, of AI/ANs aged 35 years or older, nearly 70% had both diabetes and hypertension. The diabetes mortality rate is more than 3 times higher in the AI/AN population than in the general U.S. population (1999-2001). Complications of diabetes lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and End Stage Renal Disease (ESRD) than in the general U.S. population. For instance, in 2000 in New Mexico, the age-adjusted lower-extremity amputation rate was 3.5 times higher for AI/ANs with diabetes than for non-Hispanic whites. In 2001, the age-adjusted ESRD incidence among American Indians in the Southwest was 2.4 times that of persons with diabetes in the U.S. In 2002, one in every four (24.8%) AI/AN elders over age 65 years had coronary heart disease.

The prevalence of diabetes varies among different tribes but is increasing in all IHS Areas. A recent analysis of the IHS system patient data for AI/ANs under age 35 years showed that the prevalence rate of diagnosed diabetes doubled in just 10 years—rising from 8.5 cases per 1,000 people in 1994 to 17.1 cases per 1,000 in 2004. These data are based on the 60% of AI/ANs who used the IHS system for health care services during the 10-year period. Therefore, the effective rate of the remaining 40% could show even higher rates.

In 1997, Congress authorized the initial SDPI in response to these alarming trends of disproportionately high rates of type 2 diabetes in AI/AN communities. The SDPI program emerged in the wake of increasing public concern about the human and economic costs of diabetes in the U.S. and its growing prevalence among the AI/AN population. Congress funded the program and directed the IHS to implement a grant process to distribute the funding of the
SDPI. The SDPI was implemented through consultation with tribal and urban health programs to develop the methodology and the process for distribution of the funds as grant awards.

In 2002, the Congress reauthorized the SDPI reauthorization for $150 million per year for FY 2004-2008. The IHS was directed to expand the program and implement a competitive grant program. The competitive grants were awarded to eligible entities for the implementation of specific interventions proven to prevent diabetes and reduce CVD risk, the most compelling complication of diabetes. Funds were also directed towards data improvement. In addition, distribution of funds to original SDPI grantees for the prevention and treatment of diabetes continued.

SDPI funds originally provided “seed money” to the 333 non-competitive grant programs to begin or enhance diabetes prevention programs in Indian communities as well as to address diabetes treatment. The result has been the creation of innovative, culturally appropriate strategies that address diabetes. The SDPI funds have significantly enhanced diabetes care and education in AI/AN communities, as well as built a desperately needed infrastructure for diabetes programs. The IHS has continued to develop and operate the original SDPI grant programs with 333 IHS, tribal and urban Indian grant programs in 35 states. In FY 2004, an additional 66 competitive grants (30 CVD risk reduction grants and 36 diabetes prevention grants) were added to the funding. Today, the IHS provides funding and support for diabetes prevention and treatment programs, services, and activities to 399 grant programs.

The SDPI funding is set to expire in October 2008; however, working together, the National Indian Health Board, Juvenile Diabetes Research Foundation and the American Diabetes Association (ADA), we achieved a one-year extension of this program at $150 million. Although work will continue to realize a multi-year reauthorization of these programs, we believe that the CDC could and should play a more vital role in providing additional support for these efforts. Continuity is critical in programs such as the SDPI – and more partners can only strengthen the program and its outcomes. We invite CDC to be a partner in this critical effort.

The CDC’s National Center for Chronic Disease Prevention and Health Promotion addresses diabetes issues, among a number of other chronic diseases. According to CDC literature, “The center conducts studies to better understand the causes of these diseases, supports programs to promote healthy behaviors and monitors the health of the nation through surveys. Critical to the success of these efforts are partnerships with state health and education agencies, volunteer associations, private organizations and other federal agencies.” The NIHB applauds this approach to chronic disease prevention and health promotion, and asks that Tribes be included among the partnerships that CDC relies upon to address this epidemic in Indian Country.

We noted that since 1977, as a result of the work of a congressionally appointed National Commission on Diabetes, CDC has operated a National Diabetes Prevention and Control Program, through which all 50 States, the District of Columbia, seven US Territories and one former US territory (Palau) receive financial support and technical assistance. We would like to know the extent to which these entities are working with Tribal or indigenous populations within their borders to ensure that Native People are benefiting from these programs. A constant theme among American Indians and Alaska Natives is that Federal Agencies, whether through block
grants or direct funding, often fund States with the assumption that the Tribes or Villages within the State's borders also will be served by these programs. That is not so. In many cases, the shocking health disparities of American Indians and Alaska Natives are used by States when applying for funding, yet the Tribes do not often enjoy the benefits of the programs once funding is secured. In the case of diabetes, we request that CDC place accountability standards in place through which the States provide a detailed report on their work with Tribes. In addition, we recommend that a separate line item be identified for disease prevention and health promotion activities specifically for American Indians and Alaska Natives.

We want to acknowledge the work CDC is doing through the “Eagle Books,” diabetes education awareness books and supporting materials designed to educate Native children about diabetes prevention. We look forward to seeing the National Museum of the American Indian exhibit of the artwork contained in the books. We also appreciate the work ODO is accomplishing through the health education programs targeting minority populations, the Native Diabetes Wellness Program and the National Diabetes Education Program. But, we need to see a greater commitment to appropriately funding and expanding these programs so that all American Indians and Alaska Natives can benefit.

Overall, the CDC 2009 budget request for diabetes activities nationally is only $62,454,000 – and this represents a decrease from the FY08 enacted level of $257,000. This is simply not adequate for the United States, which is seeing an alarming increase of Type 2 diabetes in all populations – and is particularly pronounced among American Indians and Alaska Natives.

Since its inception in 1997, the SDPI has become an essential and effective program to reduce the incidence of diabetes in AI/AN individuals and communities. In fact, it is proving to be both a successful effort and a good investment. We would like to see the CDC become an equal partner in this battle for Native lives and wellness.

The SDPI funding has enabled the Indian Health Service (IHS), tribal, and urban Indian programs to provide expanded prevention, screening and treatment diabetes services. Through an increase in prevention and screening activities, the economic costs of treating diabetes and diabetes-related complications in Indian communities should be lessened. But more importantly, the SDPI prevention and screening activities are intended to improve the lives of AI/ANs with diabetes and their families and communities by early detection and management.

The following is a sample of some of the prevention, screening, and treatment services provided by the IHS, tribal, and urban model diabetes programs:

- Clinical annual examinations of the eyes, teeth, and feet to prevent diabetes-related complications
- Newer and more effective medications and therapies, such as medications to lower blood glucose levels
- Laboratory tests to assess diabetes control and complications
- Screening of elders and children for risk factors associated with diabetes
- Nutrition education and counseling services by registered dieticians
- Culturally appropriate diabetes education and awareness activities
• Diabetes primary prevention programs for children and families
• Community-based healthy eating programs at area schools and nursing homes
• Community physical fitness activities

The SDPI has allowed many of the IHS, tribal and urban programs to provide preventive and other basic elements of diabetic care not that were not available to AI/ANs prior to the SDPI funding.

Think of what we could do if CDC were a full partner in this effort.

The vision of the TLDC is to empower AI/AN people to live free of diabetes through healthy lifestyles while preserving cultural traditions and values through tribal leadership, direction, communication, and education. The SDPI is a vital program needed to fulfill the mission of the TLDC. The SDPI needs to be reauthorized with an increase in funding. If the program is not reauthorized, all of the work and accomplishments of the last ten years will be lost, and many AI/AN lives and communities as well.

On behalf of the National Indian Health Board, I appreciate having this opportunity to provide these views. Thank you for inviting me here and I am happy to answer any questions you may have.