

National Indian Health Board



TESTIMONY OF BUFORD ROLIN

CHAIRMAN, POARCH BAND OF CREEK INDIANS,
VICE-CHAIRMAN, NATIONAL INDIAN HEALTH BOARD &
CO-CHAIRMAN, TRIBAL DIABETES LEADERS COMMITTEE

BEFORE THE HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
FOR THE HEARING ON
THE BATTLE AGAINST DIABETES: PROGRESS MADE; CHALLENGES UNMET
THURSDAY, JULY 1, 2010, AT 10:00 A.M.
2322 RAYBURN HOUSE OFFICE BUILDING

Good Morning Mr. Chairman, and Members of the Subcommittee:

I am Buford Rolin, Chairman of the Poarch Band of Creek Indians and Vice-Chairman of the National Indian Health Board (NIHB). Thank you for inviting the NIHB to discuss the crisis of diabetes facing our American Indian and Alaska Native (AI/AN) people.

Established in 1972, the NIHB serves all 564 federally recognized AI/AN Tribal Governments by advocating for the improvement of health care delivery, as well as upholding the federal government's trust responsibility to AI/ANs. We strive to advance the level and quality of health care and the adequacy of funding for health services delivered directly by the Indian Health Service (IHS) or directly operated by Tribes and Tribal Organizations. Our Board Members represent each of the twelve IHS Areas and are generally elected at-large by their respective Tribal Governmental Officials within their regional area. The NIHB is the only national organization solely devoted to the improvement of Indian health care on the behalf of the Tribes.

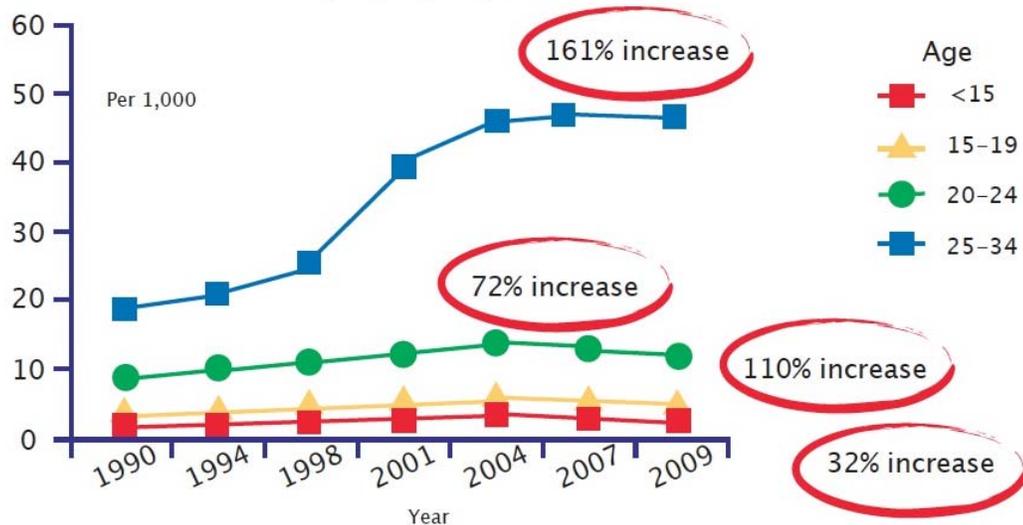
AI/AN people suffer disproportionately lower health status and experience higher health disparities. In many tribal communities, diabetes is three to five times the national average. I am pleased that your Committee is working to both elevate this issue in Congress and to develop and support policies and programs to address the problem.



Diabetes in Indian Country

Less than 100 years ago, diabetes was virtually unknown in Native communities. Today, AI/AN communities suffer disproportionately high rates of type 2 diabetes. AI/AN adults are 2.2 times more likely to have diabetes compared with non-Hispanic whites.¹ Furthermore, in comparison with 8.7% of non-Hispanic whites, 16.3% of AI/AN adults have been diagnosed with diabetes.² In some AI/AN communities, more than half of the adults aged 18 and older have been diagnosed with diabetes, with prevalence rates reaching as high as 60%.³ Adding to these troubling statistics is the rise of obesity and type 2 diabetes among our young people. The highest rate of increase has occurred among AI/AN young adults aged 25-34 years, with a 161% increase from 1990-2009. Alarming, type 2 diabetes rose 110% in AI/AN adolescents, 15-19 years old.

Prevalence of diagnosed diabetes among
AI/AN children and young people
by age group, 1990-2009



Source: IHS Diabetes Program Statistics

AI/AN people are also more likely to die from diabetes or diabetes related causes than other Americans. The diabetes mortality rate is nearly three times higher in the AI/AN population than the general U.S. population (2003-2005)⁴. The diagnosis of diabetes also leads to diagnosis of other diseases, which lead to further health complications. For example, AI/ANs have a 3.5

¹ Indian Health Service (June 2008). *Diabetes in American Indians and Alaska Natives: Facts at a Glance*. Retrieved from http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=resourcesFactSheets_AIANs08.

² Id.

³ *Special Diabetes Program for Indians: Together We Fight Diabetes for our Ancestors, Our Communities and Future Generations* citing the Indian Health Service Report to Congress, 2007.

⁴ Indian Health Service (January 2010). *Indian Health Service Factsheets: Indian Health Disparities*. Retrieved from <http://info.ihs.gov/Disparities.asp>.



times higher of rate of diabetes-related kidney failure compared to the general U.S. population in 2004.⁵

The Special Diabetes Program for Indians

Despite these alarming statistics, there is progress being made that, if continued, will help to stem the tide of diabetes in Native communities. It is difficult to highlight this progress without calling attention to the Special Diabetes Program for Indians (SDPI). That is because prior to the creation of SDPI, there was no focused federal effort to address diabetes in tribal communities. Moreover, in the twelve years since SDPI began providing support to communities for diabetes treatment, prevention and education, data has been collected that shows real progress.

Congress created the SDPI in 1997 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. The SDPI was implemented through consultation with Tribes to develop the methodology and the process for distribution of the funds. In 1998, the IHS formally established the Tribal Leaders Diabetes Committee (TLDC) to provide advice and recommendations on policy and issues concerning diabetes and related chronic diseases. The TLDC is comprised of an elected Tribal Leader from each of the 12 IHS Areas, one IHS representative and one representative from five national organizations, including the NIHB. Currently, I have the honor to serve as the Co-Chair of the TLDC along with Dr. Kelly Acton with the IHS Division of Diabetes Treatment and Prevention.

The TLDC's collaborative effort with the IHS has been an important factor of the SDPI. The IHS recognized from the start of this program that it would have to make careful choices about where to invest these funds and knew these choices would best be made with input from Tribal leaders who serve on the TLDC. In addition, the TLDC plays a key role in ensuring that the IHS consults with Tribes before making decisions on diabetes treatment and prevention efforts.

Growth and Impact of SDPI

In the beginning, the SDPI funds provided funding to 333 non-competitive grant programs to IHS, Tribal, and urban Indian health programs in 35 states to begin or enhance diabetes treatment and prevention programs in Indian communities. The result has been the creation of innovative, culturally appropriate strategies that address diabetes. The Community-Directed Diabetes Programs continue today with 385 grant programs funded. The IHS encourages the use of the Indian Health Diabetes Best Practices and promotes the development of local programs based on local community needs and priorities. This focus on the local priorities and community centered has been the key to the success of the program as the local tribal community designs the program based on the needs of their community.

In 2004, at the direction of Congress, the SDPI expanded with the addition of two demonstration projects, which included 66 competitive grants. Thirty-six grantees participated in the Diabetes Prevention Demonstration Projects, which focused on preventing diabetes through lifestyle changes, such as exercise and weight loss. The remaining 30 grantees participated in the Healthy

⁵ See note 1.



Heart Demonstration project that targets Indian people who have been diagnosed with diabetes by treating for related cardiovascular diseases.

Today, the IHS provides funding and support for diabetes prevention and treatment programs, services, and activities to over 450 IHS, Tribal and urban Indian program, serving nearly all federally recognized tribes. The following is a sample of some of the prevention, screening, and treatment services provided by the IHS, Tribal, and urban diabetes programs:

- Clinical annual examinations of the eyes, teeth, and feet to prevent diabetes-related complications
- Laboratory tests to assess diabetes control and complications
- Nutrition education and counseling services by registered dietitians
- 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

Diabetes-related health outcomes have improved significantly in AI/AN communities since the inception of the SDPI. For example:

- One of the most important improvements is an 11 percent decrease in the mean blood sugar level (A1C) of AI/ANs with diagnosed diabetes, a major achievement over 12 years. Decreases of this magnitude translate to a 40% reduction in diabetes-related complications such as blindness, kidney failure, nerve disease and amputations.⁶
- The mean total cholesterol level has decreased by 16% from 1997-2009, and mean LDL cholesterol (“bad” cholesterol) has been reduced 20%. Research has shown that lowering cholesterol levels may help reduce the chance of developing cardiovascular complications associated with diabetes such as heart attacks, stroke or heart failure.
- The prevalence of protein in the urine (a sign of kidney dysfunction) was reduced by 32% between 1997-2009.⁷ New cases of diabetes-related dialysis in AI/ANs decreased 31% between 1999 and 2007, while remaining relatively unchanged in whites and blacks. Preventing kidney failure is critical to preventing people with diabetes from needing dialysis or kidney transplants.⁸

The SDPI has allowed many of the IHS, Tribal and urban programs to provide preventive and other basic elements of diabetes care that was not available to AI/ANs prior to the SDPI. In fact, it is proving to be both a successful effort and a good investment. The SDPI funding has enabled the 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

⁶ *Special Diabetes Program for Indians: Together We Fight Diabetes for our Ancestors, Our Communities and Future Generations* citing Indian Health Service Report to Congress, 2007.

⁷ *Special Diabetes Program for Indians: Together We Fight Diabetes for our Ancestors, Our Communities and Future Generations* citing Indian Health Service, DDTP Fact Sheet.

⁸ *Special Diabetes Program for Indians: Together We Fight Diabetes for our Ancestors, Our Communities and Future Generations* citing 2009 USRDS Atlas available at <http://www.usrds.org/atlas.htm>.



should be lessened. However, more importantly, 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 outcomes of the SDPI have helped to advance other IHS diabetes programs such as the Model Diabetes Program, which was established under the Indian Health Care Improvement Act. The Model Diabetes Program also promotes collaborative strategies with Tribes for the prevention and treatment of diabetes. The 19 Model Diabetes Programs in the Indian health system have made significant contributions, including state-of-the-art comprehensive, clinical diabetes care through a multidisciplinary preventive and treatment approach, and education and nutritional counseling services.

The Future

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. The SDPI is a vital program that is fulfilling this mission of the TLDC. I am proud of what the SDPI has accomplished. This program has been life saving to people who have diabetes, life-changing to those who have avoided diabetes because of early detection and prevention efforts, and perhaps most importantly, it is helping to ensure a diabetes-free future for our children and future generations.

Diabetes is one of the greatest public health challenges facing Native communities as well as our country as a whole. Making real progress in this area and ensuring that future generations will be free of the burden of this disease will take the federal government and tribal governments working together. We have shown it can work. Now we need to recommit ourselves and this hearing is a good first step.

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

