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DIABETES IN INDIAN COUNTRY

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

ON

DIABETES IN INDIAN COUNTRY, WITH PARTICULAR FOCUS ON THE SPECIAL DIABETES PROGRAM

FEBRUARY 8, 2007
WASHINGTON, DC

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CONTENTS

Page

Statements:
- Baker, Biron, Primary Care Physician, MED, Center One 22
- Brosseau, James, director, Altru Diabetes Center, member of the American Diabetes Association Native American Community 18
- Dorgan, Hon. Byron L., U.S. Senator from North Dakota, chairman, Committee on Indian Affairs 1
- Fradkin, Judith, director, Division of Endocrinology, and Metabolic Diseases, National Institute of Diabetes and Digestive and Kidney Disease, National Institutes of Health, Department of Health and Human Services 6
- Grim, Charles W., director, Indian Health Service, Department of Health and Human Services 3
- Knowler, William, chief, Diabetes Epidemiology and Clinical Research Section, Division of Intramural Research, National Institute of Diabetes and Digestive and Kidney Disease, National Institutes of Health, Department of Health and Human Services 6
- McCracken, Sam, director, Nike Native American Business Program 20
- Moore, Kelly, clinical specialty consultant, Division of Diabetes Treatment and Prevention, Department of Health and Human Services 3
- Rolin, Buford, chairman, Poarch Band of Creek Indians, cochair, Tribal Leaders Diabetes Committee, and cochair, National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act 16
- Thomas, Hon. Craig, U.S. Senator from Wyoming, vice chairman, Committee on Indian Affairs 2
- Vandall, Donna, director, Whirling Thunder Wellness Center 26

APPENDIX

Prepared statements:
- Baker, Biron 33
- Barnard, MD, Neal D., president, Physicians Committee for Responsible Medicine (with attachment) 43
- Brosseau, James (with attachment) 69
- Bursell, Sven-Erik, Joslin Diabetes Center 90
- Grim, Charles W. 93
- Inouye, Hon. Daniel K., U.S. Senator from Hawaii 35
- Johnson, Jacqueline, executive director, National Congress of American Indians (with attachment) 102
- Knowler, William (with attachment) 36
- McCracken, Sam 40
- Rolin, Buford 107
- Vandall, Donna (with attachment) 113

DIABETES IN INDIAN COUNTRY

THURSDAY, FEBRUARY 8, 2007

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:39 a.m. in room 485 Senate Russell Office Building, Hon. Byron Dorgan (chairman of the committee) presiding.

Present: Senators Dorgan, Cantwell, Conrad, Smith, Tester, and Thomas.

STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. Next, we will turn to the purpose of the hearing this morning. Let me thank my colleagues for allowing us to pass these four pieces of legislation early on. As I indicated, three of them had previously gotten through the entire Senate, but did not get through the House. We want very much for there to be an opportunity to move all legislation through the full Congress and get them signed. That is why we wanted to start early on this occasion.

Let me talk about the oversight hearing today, diabetes in Indian country. In 1997, as part of the Balanced Budget Act, Congress established what is called a designated fund to address diabetes in Indian country. It created the Special Diabetes Program for Indians, along with a separate authorization for Special Diabetes Programs for children with type 1 diabetes; $30 million was authorized for the Special Diabetes Program for Indians in each of 1998 through fiscal year 2002.

The program has grown to $150 million per year. The Special Diabetes Program for Indians is administered by the IHS Division of Diabetes Treatment and Prevention. It is recognized as the most comprehensive rural system of care for diabetes in the United States. Grants under this program have been awarded by the Indian Health Service to 400 Indian Health Service, tribal and urban Indian programs within the 12 IHS areas and 35 States. The program now serves about 116,000 Native American people with various prevention and treatment services.

The committee has not held an oversight hearing on diabetes since the Special Diabetes Program for Indians was established in 1997. The program will need to be reauthorized after fiscal year 2008, so today's hearing is timely.

I wanted to just make a point that we are going to talk a lot about health care on Indian reservations in this Congress. I believe

that there is health care rationing going on on reservations. Nobody talks much about it. We have a bona fide crisis in health care. One part of that crisis has to do with diabetes, a very significant problem, a scourge that we need to deal with. There are programs underway, as I have just described, that provide some hope. We want to find out how they work, what more we can do. But this is an illness that afflicts Native Americans more than any other group in our country.

I have been to the dialysis centers. I have been to the diagnostic centers on reservations all across this country. The stories you hear are just heartbreaking, of people who struggle, whose families struggle with this.

Yesterday, I had a group of I believe 30 American Indians in my office, some of them young college students. I asked how many of them have in their family someone who is affected by diabetes. I think 80 percent of them raised their hands.

We are going to have substantial testimony today from people from around the country to talk about these issues. I want to thank the witnesses who have decided to come at our invitation. I am going to ask that when witnesses testify, they would summarize their testimony. We have in almost all cases the testimony that has been submitted, and all of the written testimony will be included in full in the record. Our record will remain open for 2 weeks to allow others who might wish to submit additional testimony for this hearing.

I now want to recognize my colleague, Senator Thomas, the vice chairman, for an opening statement.

Senator THOMAS. Thank you very much, Mr. Chairman. I appreciate your holding this hearing today.

STATEMENT OF HON. CRAIG THOMAS, U.S. SENATOR FROM WYOMING, VICE CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

Senator THOMAS. I share the concerns about the high rate of diabetes in the Indian communities. Indians have the highest known rate of type 2 diabetes in the world, according to the NIH. Type 2 diabetes is a major cause of blindness, kidney failure, cause of death and lower limb amputations. And it is largely preventable, according to IHS. So I think it is good that we move forward and seek to take advantage of those potential possibilities for prevention.

I do encourage the Indian tribes to take the lead in fighting and preventing this disease. I am pleased that partners such as those we will hear from today have joined in the effort, particularly those directed at Indian Youth, before diabetes has a stronghold in their lives.

So welcome to the witnesses, and I look forward to the testimony.

The CHAIRMAN. Senator Thomas, thank you very much.

As I prepare to call the first panel, I want to just mention to you the first story I think I told on the floor of the U.S. Senate, as I talked about Indian health care and diabetes, was a story about a man named Laidman Fox. He was a traditional Mandan, Hidatsa, Arikara man who, like many other members of his family, had diabetes. He had his feet amputated, then he had his knees gone, and then he had his legs gone. When the doctors finally told him that

he was going to lose his hands, he decided that he would go home and prepare to die. He wanted to discontinue the dialysis machine and go home, and he did. He had been on the pow-wow trail for many years, so he had a lot of friends around the country, and they came to see him as he stayed at home and his health deteriorated. He sang Indian songs and prepared to die. And he died 2½ years ago.

But it is not a unique or unusual story. It is happening all the time all over this country, and it is a devastating illness that we need to continue to battle.

So let me, with that, ask Dr. Charles Grim, director of Indian Health Service, to come forward, accompanied by Dr. Kelly Moore. Is Dr. Grim here? Dr. Grim. Dr. Kelly Moore is a clinical specialty consultant from Albuquerque, NM.

Mr. William Knowler is the chief, Diabetes Epidemiology and Clinical Research Section, at the NIH, accompanied by Dr. Judith Fradkin, director of the Division of Diabetes, also at the NIH.

Let me thank the four of you for being here.

Let me mention that the second panel today will be Buford Rolin, chairman of the Poarch Band of Creek Indians; Dr. James Brosseau, Altru Diabetes Center; Sam McCracken, director, Nike Native American Business Program; and Donna Vandall, director, Whirling Thunder Wellness Center.

Let me thank all of you for being here.

With our first panel, Dr. Grim, let me ask you to proceed.

STATEMENT OF CHARLES W. GRIM, DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY KELLY MOORE, CLINICAL SPECIALTY CONSULTANT TO THE DIVISION OF DIABETES TREATMENT AND PREVENTION

Mr. GRIM. Good morning, Mr. Chairman and Mr. Vice Chairman. My name is Dr. Charles Grim, director of the Indian Health Service. As you mentioned, I am accompanied today by Dr. Kelly Moore, who is our Clinical Consultant at our National Diabetes Program in Albuquerque.

We are pleased to be here to testify on behalf of Secretary Leavitt on the Special Diabetes Program for Indians. We are very appreciative of the committee taking time to have an oversight hearing on this important issue.

Diabetes has quickly emerged as one of the most serious and devastating health problems of our time. American Indians and Alaska Natives, as you noted in your opening statement, carry the heaviest burden and suffer from among the highest rates of diabetes in the world. In some of our communities, more than one-half of adults have diabetes, with prevalence rates reaching as high as 60 percent.

American Indians and Alaska Natives have the highest age-adjusted rates of diabetes, at 16.3 percent, among all U.S. racial and ethnic groups. On average, American Indians and Alaska Natives are 2.3 times as likely to have diabetes as non-Hispanic whites of similar age.

The rates of diabetes in our communities vary across the country. The lowest rates are found among the Alaska Natives, while the

highest are found among our Nashville and Tucson area tribes. Yet, while Alaska has the lowest prevalence, the data from our systems show that the increases in adults in Alaska from 1997 to 2002 show that they have had the greatest increase in that time period.

Alarmingly, the disease is increasingly affecting our American Indian and Alaska Native youth. I know you have seen over the years that our statistics show in a 14-year period from 1990 to 2004, we have seen an increase of 128 percent among 15 to 19 year olds and a 77-percent increase was seen among American Indian and Alaska Native children and youth less than 15 years of age.

As you noted in your opening statement, Senator, in 1997 Congress passed the Special Diabetes Program for Indians in recognition of the enormity of the problem in Indian country. You all recognized that should be a grant program that would provide funding for diabetes prevention and treatment at IHS, tribal and urban Indian health programs across the Nation. That program has now been in operation for almost 10 years, and recognized as one of the most comprehensive health programs ever developed for American Indian and Alaska Natives, reaching nearly all federally recognized tribes around the Country.

The Indian Health Service, as directed by Congress, established three major components of that program. I just want to briefly point them out for you. There is a community-directed program that provides grants to 333 IHS tribal and urban programs in 35 States to begin or enhance diabetes prevention and treatment programs. These grant programs make up the community-directed diabetes program, and those grant programs are designed to carryout interventions that will best address the problems of diabetes in their individual communities.

The second area is the targeted demonstration projects. In 2004, Congress directed the Indian Health Service to develop and implement a comprehensive grant program which was to prevent diabetes in high-risk individuals, and then to prevent cardiovascular disease, one of the most compelling complications of diabetes. We have now established competitive grants in those two areas and have 66 of those that are awarded across the country.

A third area was strengthening our diabetes data infrastructure. We have used the administrative funding from the Special Diabetes Program for Indians to strengthen our diabetes data and to use on the expansion and implementation of our electronic health record.

The Indian Health Service has been evaluating the program ever since Congress gave us the money. In two interim reports in both 2000 and 2004, we presented extensive data to Congress that evaluated those programs. In fact, I have given to your staff today about a half dozen copies of that 2004 report, if any of you would like additional copies of that.

We have used well established public health evaluation methods to document the accomplishments of that program. I think you will find some of the results in there remarkable and outstanding. Just to mention a few, we have increased the number of people with diabetes that are screened for kidney disease. We have increased the number of people who are screened for diabetic eye and foot disease. We have improved blood sugar control at the population level

with mean A1C levels decreasing from 8.9 percent to 7.9 percent. We have decreased population mean blood levels. We have decreased population mean cholesterol levels, as well as triglyceride levels.

Just a few of the programmatic accomplishments, we have striking results in almost every area that you can look at. As an example, we have seen improvements in physical activity programs, now with 92 percent of the grant programs having community walking or running, as opposed to 20 percent before the program started. About 80 percent now offer some sort of exercise class, compared with 16 percent before. There are huge numbers of percentage improvements like that, both before and after the program.

We have tracked how we have spent the money and shown that $48 million has been spent going toward primary prevention of diabetes, one of the most cost effective methods known. We have invested approximately $57 million of that toward screening and treatment activities for complications of diabetes. We are consistently using best practices around the country in our programs, utilizing some of the most cost effective interventions that are known in the country.

In closing, the Special Diabetes Program for Indians has brought tribes together over these past nine years to work toward a common purpose and sharing information and lessons learned along the way. We have shown in public health evaluation activities that these programs have been very successful in improving diabetes care and outcomes, as well as launching primary prevention efforts on reservations and in urban areas where none existed.

Our evaluation of the program and its clinical measures suggest that population levels of diabetes health is better than ever among our American Indian and Alaska Native patients since the implementation of the program. In its 9 years, we have demonstrated positive public health impact is possible when the tribes and congressional initiatives are focused on a common outcome, which is building a diabetes-free future for our American Indians and Alaska Natives.

Mr. Chairman, that concludes my comments. I would be pleased to answer any questions that you or members of the committee have.

[Prepared statement of Dr. Grim appears in appendix.]

The CHAIRMAN. Dr. Grim, thank you very much.

Next, we will hear from Dr. William Knowler, chief, Diabetes Epidemiology and Clinical Research Section at the National Institutes of Health.

Mr. Knowler, thank you for being with us.

STATEMENT OF WILLIAM KNOWLER, CHIEF, DIABETES EPIDEMIOLOGY AND CLINICAL RESEARCH SECTION, DIVISION OF INTRAMURAL RESEARCH, NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY JUDITH FRADKIN, DIRECTOR, DIVISION OF DIABETES, ENDOCRINOLOGY, AND METABOLIC DISEASES, NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES

Mr. KNOWLER. Thank you.

Mr. Chairman, members of the committee, I am Bill Knowler, as you heard, from the NIDDK. Our institute has the primary responsibility for diabetes research at the National Institutes of Health. I am accompanied by Dr. Judith Fradkin, director of NIDDK's extramural Division of Diabetes, Endocrinology and Metabolic Diseases.

I am pleased to testify today regarding NIDDK's efforts to combat diabetes in American Indians, the population with the highest known rates of type 2 diabetes in the world.

For the past 31 years, I have conducted diabetes research with the Gila River Indian Community at the NIDDK's Phoenix branch in Arizona, a part of NIDDK's intramural research program. Our goals are to gain greater knowledge of the genetic, environmental and behavioral factors that lead to type 2 diabetes, obesity and their complications, and develop more effective treatments and ways to prevent these diseases.

Most of our research is conducted in collaboration with the Pima Indians of the Gila River Indian Community near Phoenix. Some of our programs also include other American Indians in Arizona and New Mexico. In our longitudinal population study in the Gila River Community, begun in 1965, we conduct periodic examinations focused on diabetes and its risk factors and complications.

This study has contributed much to the world's current understanding of the causes and consequences of type 2 diabetes and its complications, including the serious long-term consequences of childhood obesity and type 2 diabetes, the importance of obesity in the development of type 2 diabetes, and the concept that type 2 diabetes and its complications can be prevented or delayed by modifying or treating factors that put people at high risk. We are all indebted to this community for these advances in medical knowledge.

Our research has also facilitated improved treatment and prevention services in this community, leading to improved hemoglobin A1C, the main measure of glucose control in patients with diabetes, and lower blood pressure.

In fact, attainment of American Diabetes Association treatment goals for diabetes is better in this community than in the Nation as a whole, thanks to the diligent efforts of the tribal health program in implementing research-based standards of care.

Another example of a successful intervention is the Diabetes Prevention Program, or DPP, that was stimulated by the results of research suggesting that type 2 diabetes is preventable. The findings of the DPP are among the most encouraging to come from diabetes

research in the past decade. I would like to tell you briefly about this clinical trial.

Our branch, along with 22 university sites, conducted the DPP to examine the effects of a lifestyle-based weight loss intervention and drug treatment on the development of type 2 diabetes in adults at high risk. The weight loss intervention resulted in a 58 percent reduction in the rate of developing type 2 diabetes. The drug metformin reduced diabetes risk by 31 percent.

These interventions worked equally well in men and women and in all ethnic groups studied, including American Indians. These results convey an important message to American Indians and others at high risk for type 2 diabetes: You can prevent or delay diabetes.

The DPP participants continue to be followed in the DPP outcome study to assess the long-term effects of the interventions on preventing type 2 diabetes and diabetes complications. The DPP was primarily funded by NIDDK, but also had substantial personnel and financial support from the IHS. It is an outstanding example of collaboration between NIDDK and the IHS in a research study, the results of which greatly influence clinical practice in Indian country and throughout the world.

The complications of diabetes affect the eyes, kidneys, heart, feet, gums and blood vessels. Poor control of blood glucose and blood pressure, long duration of diabetes, and genetic factors increase the risk of diabetes complications, such as those affecting the kidneys, a major problem for Southwestern American Indians and a focus of our research.

I am pleased to report that the rate of progression to kidney failure among diabetic Gila River Indian Community members at least 45 years of age has declined since 1990, suggesting that newer treatments for diabetic kidney disease are slowing its progression. Since 1999, a similar decline in the rate of diabetic kidney failure has been seen nationally in American Indians, but not in other racial or ethnic groups.

Unfortunately, the frequency of kidney failure is increasing among younger Gila River Indian Community members because of the increasing rate at which diabetes develops in youth.

Most of the research I have described has had a large and immediate impact on prevention and treatment of type 2 diabetes. To achieve even greater progress or to eliminate the disease altogether, we believe that a more fundamental understanding of its causes and biological mechanisms is needed. To this end, we have also pursued research in the genetic susceptibility factors for obesity, type 2 diabetes, and its complications.

Our research to date suggests that some genetic factors important for obesity and diabetes in Pima Indians are the same as in other racial or ethnic groups, but some are different. Understanding the genetic factors contributing to type 2 diabetes in different populations will help us understand the biologic mechanisms causing diabetes, which will lead to better ways of predicting those at highest risk and preventing onset of the disease or its progression.

A minute ago, I described the successful Diabetes Prevention Program, or DPP. To disseminate its important findings to people at risk for diabetes, the National Diabetes Education Program, or NDEP, developed the "Small Steps, Big Rewards, Prevent Type 2

Diabetes" education campaign. The NDEP is sponsored by the NIDDK, CDC, IHS, and over 200 partners. Dr. Kelly Moore, who is here today, chairs the NDEP's American Indian/Alaska Native Work Group.

In addition to the diabetes prevention campaign, the NDEP has developed culture-specific material for American Indians with diabetes. The NIDDK is committed to continuing these educational efforts to disseminate the positive results of its clinical trials to benefit public health.

I am pleased to report that the NIDDK works closely with the Indian Health Service to improve the health and quality of life of American Indians. The NIDDK's extramural Division of Diabetes, Endocrinology, and Metabolic Diseases, which Dr. Fradkin heads, has worked closely with IHS's Division of Diabetes Treatment and Prevention in the development of the Special Diabetes Program for Indians competitive grant program, which has developed a DPP-like lifestyle intervention program for American Indians with prediabetes, for implementation at 36 tribal grantee sites, among which the Gila River Indian Community is included.

In addition, the NIDDK, IHS, CDC, tribal colleges and universities, and the Tribal Leaders' Diabetes Committee jointly developed an educational program that aims to increase knowledge of the biomedical sciences in tribal schools. The Director of IHS's Division of Diabetes Treatment and Prevention and its National Diabetes Program, Dr. Kelly Acton, serves as a member of the statutory Diabetes Mellitus Interagency Coordinating Committee, which coordinates activities of all Federal diabetes programs.

Mr. Chairman and members of the committee, I hope these examples convey the firm commitment of the NIH and NIDDK, in partnership with our sister agencies, to combating diabetes in American Indians.

In conclusion, I thank the members of the U.S. Senate on behalf of the scientists who work in diabetes and the millions of Americans affected by it. Thank you for continuing support of biomedical research through which we are improving the health of all Americans.

I appreciate the opportunity to address you on behalf of the NIH and NIDDK, and would be pleased to answer your questions.

[Prepared statement of Dr. Knowler appears in appendix.]

The CHAIRMAN. Dr. Knowler, thank you very much.

It goes without saying that diabetes is a serious problem for our entire country. We focus today with respect to the Indian community because the incidence and rate of diabetes is so much higher. So that is the purpose of our having this hearing to try to evaluate how the Special Diabetes Program for Indians is working and what is happening out in the country.

Mr. Knowler, on page 5, after describing the Gila River Indian Community experience, you say:

> Unfortunately, the frequency of kidney failures is increasing among younger Gila River Indian Community members because of the increasing rate at which diabetes develops in youth.

You indicated in your testimony that tracking here has gone on since 1965, and we have intervened with a diabetes program, detecting the onset of diabetes, the treatment and a range of things.

I am encouraged by Dr. Grim's assessment of what has been done, but especially with the attention that has been paid to this particular tribe as a model to try to understand what is happening, tell me why do we find that there is an increasing rate at which diabetes develops in youth? What is going on there?

Mr. KNOWLER. As you point out, this is one of the disappointments of our progress in diabetes. We have not improved the situation in terms of incidence of diabetes in youth. There are a number of reasons for this. A major one is that the increasing amount of obesity seen throughout the country and most of the world is clearly affecting American Indians. Obesity is a very strong predictor of diabetes at all ages. So that is one of the serious problems.

The CHAIRMAN. On that point, I am sorry to interrupt you, but can you give me the connection between obesity and the onset of diabetes?

Mr. KNOWLER. Yes; the heavier a person is, the greater is the risk of diabetes. This is true in children and adults. I can't say that if you exceed so many pounds, all of a sudden you will get diabetes. But the greater a person's weight is relative to height, the greater is the risk of getting type 2 diabetes.

An encouraging thing about this, as we showed in the DPP, is that much of that risk is reversible. People who are overweight can lose weight, and that lowers their risk of diabetes. But the heavier a person is, the greater the risk that they develop type 2 diabetes. There are a number of reasons for that. We don't understand them fully, but too much fat in the body interferes with the action of insulin in the body to control blood sugar. Fat also produces hormones which have metabolic effects.

So there are a number of reasons that fatness increases risk of diabetes. This is now an important area of research these days, understanding why that is. But the fact is very clear that the heavier a person is, the greater the risk of diabetes.

The CHAIRMAN. I am going to ask a really fundamental question here. I probably should know the answer to this. But if you have a younger person, a juvenile with the onset of juvenile diabetes, and that person is obese, you are saying there probably is a connection there, and that person then loses a great deal of weight, does the diabetes stay with that person? Do you simply treat it? Or once you have on onset of type 2, I think I understand the answer, but why don't you tell me?

Mr. KNOWLER. First of all, I want to clarify one thing in case not everyone understands about juvenile diabetes. When we talk about American Indians, almost all diabetes in youth is type 2 diabetes, the kind that in most populations occurs in adulthood.

We are not talking about type 1 diabetes, the disease of islet cell destruction and lack of insulin production. That disease is not strongly related to obesity, if at all. But for type 2 diabetes, whether it occurs in youth or adults, weight loss is very important in the treatment, although it usually does not restore a person to normal once diabetes has developed.

The CHAIRMAN. It does not reverse the disease.

Mr. KNOWLER. Not completely, but partially. It certainly greatly improves the situation.

The CHAIRMAN. Dr. Grim, you describe what we have learned in 9 years. It seems to me that there is some reason for encouragement, although I mentioned the onset of diabetes as exists in Dr. Knowler's testimony, is increasing among young people in this tribe that is under great inspection to try to understand this.

What can we expect with substantial intervention and programs and so on, what can we expect in the next 5 to 10 years? You describe the progress we have had, but you know anecdotally that when we go to our Indian reservations and talk to people, to find a crowd, go to the dialysis center. You know, just talk to people. Diabetes is still a major, major problem, despite the fact that we are out there doing some things, you are out there doing some things. What can we expect in 5 to 10 years if we would continue these programs and be even more aggressive? What kind of progress do you think we can make?

Mr. GRIM. I am going to let Dr. Moore get prepared to say something about that, too, since she works intimately in that program.

The CHAIRMAN. All right.

Mr. GRIM. One of the things I will say is that because this is a disease that has still been on the rise in our population, and the fact that the moneys that Congress made available have allowed us to find people either at earlier and earlier ages, or people that never knew they had diabetes. About one-third of the people out there that have diabetes were not even aware that they did have it. So early on, our numbers, as we improved our data systems, spiked.

In my written testimony and in some of the oral, I talked about a lot of the clinical indicators. We have our entire diabetic active users being tracked for clinical indicators, their blood pressure, their cholesterol, their hemoglobin. We see a number of things, and we have seen population-wide improvements in all of those.

You heard me mention some of the statistical things that have occurred over time and the number of programs that are now there for nutrition and weight management and exercise, all the things that the trials that Dr. Knowler mentioned have shown were now proven to reduce either the incidence or prevalence of diabetes.

So we are hopeful that after a decade, we have seen some improvements and better control. We think that it will take another decade or perhaps longer before we really get a strong handle on it. We hope it is not an entire generation, a totally generational thing, but it is not a quick fight to end a chronic disease like this.

The CHAIRMAN. Dr. Moore, what can we expect in 5 to 10 years if we keep investing in these programs and work hard to do it?

Mr. MOORE. Thank you, Senator.

In 2008, we anticipate that we will have results available from our targeted demonstration projects, which actually are implementing the diabetes prevention program education curriculum, and some of the other activities such as lifestyle coaching in adults who have diabetes. This is a very cost effective strategy.

In 2008, we will be able to disseminate this information to other American Indian and Alaska Native communities who have not participated directly in this intervention.

The CHAIRMAN. Is there a particularly exciting demonstration project out there that you see? I know you don't have all the re-

sults, but give me an example of something that is really exciting with respect to these demonstration projects.

Mr. MOORE. Well, one of the examples is a program in Alaska that has managed to already have patients complete the intensive curriculum from DPP. All of the participants are enthusiastic, have learned much about diabetes prevention, and have been able to successfully manage their weight, which is the key ingredient here in terms of preventing diabetes.

I think what we can also expect to happen in another 5 to 10 years is that we will have results available on clinical trials that are currently taking place in youth related to the treatment of diabetes, as well as some prevention activities that are being studied that are school-based. Once those results are available, I think the Special Diabetes Program for Indians will have American Indian and Alaska Native communities poised to translate-those findings quickly, and to try and implement the findings from those studies in our communities.

The CHAIRMAN. Dr. Fradkin, can you describe just briefly, I understand that obesity is a predictor attendant to this issue of diabetes. I assume that there is a predisposition for diabetes among this population. Is that a genetic predisposition? And then second, tell me about the relationship of blood pressure to treatment, prevention, et cetera.

Mr. FRADKIN. Sir, there is a very strong genetic predisposition to diabetes. We know this from twin studies in which in type 2 diabetes there is an even stronger concordance of diabetes among twins than in type 1, the so-called juvenile diabetes. Dr. Knowler's group is pursuing genetic investigations to try to identify some of the genes involved in type 2 diabetes. We did, through the Diabetes Prevention Program, confirm that a gene that was recently discovered to be an important risk factor for type 2 diabetes occurs in American minority populations. This gene was initially discovered through an industry-supported effort in a European Caucasian population. It is also present in American minorities.

Most importantly, we showed that the people who carry that genetic variant were able to benefit from the Diabetes Prevention Program lifestyle.

I wonder if I could followup on what Dr. Moore said about what might happen in future years with regard to the Special Funding Program. I just want to make the point that the Diabetes Prevention Program that Dr. Knowler described, which showed that losing on average 15 pounds can reduce your risk of diabetes by 58 percent, now is being translated across Indian country through the IHS.

We at NIH have two major clinical trials now ongoing looking at childhood type 2 diabetes in minority populations, including American Indians. When the results of those trials become available, we anticipate that there will be additional findings that will need to be translated so that the American people can get the benefit of those.

One of those is a study of middle school children where we are actually randomizing the schools to test a school-delivered intervention. We think this could be more cost effective than trying individually to identify and treat people at high risk. We are changing

physical activity. We are changing the food service. We have a behavioral intervention. We are trying to involve the families.

If we show that this program decreases the risk factors for type 2 diabetes in middle school children, then that is something that the IHS will want to translate in Indian country. Likewise, because this problem of type 2 in children is really a new and emerging problem, we don't know how to treat type 2 diabetes in children, so we are doing a trial to figure out the best way of treating it. When we have that information, again, the IHS will want to translate that into their programs.

The CHAIRMAN. Thank you very much.

Mr. GRIM. Could I say something, Senator Dorgan?

The CHAIRMAN. Yes, Dr. Grim.

Mr. GRIM. Just very briefly, I think that is one of the strongest things about our program, the network that has been developed of IHS, tribal and urban programs all over the country and the passionate people that are out there. They say from research to clinical practice sometimes takes 10 to 13 years to put it in place. Once something has been proven in research, we have been able to get it spread all over the country almost immediately. I think that is one of the strengths that this program has brought to our system.

The CHAIRMAN. Thank you very much.

Senator Thomas.

Senator THOMAS. Thank you for your testimony. You go into great detail on the causes of diabetes, but we need to deal a little more with what we can do about it. The reports show that up until the early 2000's, there was an 80-percent increase, sometimes a 100-percent increase in diabetes among young people.

How effective have we been? You haven't really indicated the impact we have had over the last 4 years of this program.

Mr. MOORE. What we have been able to do in terms of prevention is that we have an enormous amount of programs that are addressing nutrition and physical activities.

Senator THOMAS. What has been the impact? What has been the result?

Mr. MOORE. The impact has been that now our youth are more aware of their risk for diabetes. Dr. Knowler mentioned in his testimony that I am the chair of the American Indian Alaska Native Work Group for the National Diabetes Education Program. From focus groups that we have conducted with teenagers, when we started a campaign to increase physical activity among youth, to reduce their risk for diabetes, many youth knew about diabetes, but they didn't know that they were at risk for the development of the disease themselves.

So certainly, awareness about diabetes has increased a great deal in American Indian and Alaska Native communities as a result of the Special Diabetes Program for Indians.

Second, this has been an incredible priority among our tribal leaders and among our SDPI communities. The majority of the programs are directing activities toward youth, and I think you will hear about a wonderful program in the Dakotas and Nebraska in the Aberdeen area that has really done some remarkable things with making kids feel better about themselves, maybe being less

likely to have depression, which is an associated risk factor for the development of diabetes.

Senator THOMAS. Do you have any idea of what impact the program has had on problem? The process and the education is fine, but what has been the impact overall?

Mr. MOORE. Well, one impact has been more partnerships in making a healthier environment.

Senator THOMAS. Well, what has it done? What have they accomplished?

Mr. MOORE. They have accomplished changes in vending machines in our school systems.

Senator THOMAS. I really would like to talk about the percentage of growth of the diabetes problem and the number of people who are involved. Has the diabetes rate been reduced? Are we making any progress other than building programs?

Mr. MOORE. Yes; I believe we are making progress, but as has been stated from NIH, it is still unknown in terms of what are all the factors that are related to the prevention of diabetes. Weight certainly is a factor, and we have been addressing that in our programs and have developed best practices. We have also developed a best practice on diabetes in youth, and have shared that with our American Indian and Alaska Native communities.

Senator THOMAS. Okay, please. You go on about the programs. I want to know the program results. Are there fewer people getting diabetes? Is the growth in the rate of diabetes less than it was? Are we making progress on the ground? Or is it just programs?

Mr. MOORE. I believe we are making a lot of grassroots progress.

Senator THOMAS. Do you have any figures? Do you have any real facts?

Mr. MOORE. Well, the facts that we have is that a number of programs are addressing it. We have our clinical diabetes audit outcome measures that we have been following related to our population who have diabetes.

Senator THOMAS. Okay. That is what I would like to hear.

Mr. MOORE. We have had improvement in control of blood pressure. We have had improvement in control of blood sugar among our patients with diabetes. We have seen a decline during the time period of SDPI for the A1C levels from 8.9 percent to 7.9 percent. Seven percent is considered ideal blood glucose control for people with diabetes.

Senator THOMAS. Do you have a smaller percentage of young Indians being involved than we did 5 years ago?

Mr. MOORE. The latest data from 2004 shows that the rate is increasing among our young patients.

Senator THOMAS. Increasing.

Mr. MOORE. It is increasing. However, as Dr. Grim pointed out earlier, because of the Special Diabetes Program for Indians, we have had more efforts directed towards screening for diabetes, which would also increase our rates, and, it will take decades to reverse the epidemic of type 2 Diabetes that we are seeing in our population.

Senator THOMAS. So would you comment, Doctor, on any progress being made?

Mr. GRIM. We are making progress on the clinical indicators, and programmatically on the number of programs that are out there that have been proven in science to help reduce or eliminate the risk of diabetes. What I would say is that the numbers that we see going up, we don't know what the rate of increase would have been if we didn't have this program. That is something that is hard to predict. The fact that we have increased our data systems and the amount of screening going on just normally would make one think that you are going to start finding more of it out there than you had found before because of the more intensive effort.

We cannot tell you would that rate of growth have been higher had we not had these programs.

Senator THOMAS. Is it lower because you have the programs?

Mr. GRIM. We believe that the rate would have been higher.

Senator THOMAS. You mean lower?

Mr. GRIM. No; the rates have increased actually. The rate in our youth have continued to increase, we would like to think at a slower rate than——

Senator THOMAS. Does that make you look at the programs to see if in fact it is effective? Are there other things we could do? What are the best practices that you mentioned?

Mr. GRIM. We are continuously evaluating the program. One thing I failed to mention, we have another report that is going to be coming to Congress we hope in 2007. We have the two other reports that we have turned in, but we do have 18 best practices that our experts, along with others around the country, have developed. There is not a single grant program out there that is not using one or more of those best practices. We have studied the literature——

Senator THOMAS. What is it would you say, are there some general reasons why it is more dominant in the Indian population than in the general population?

Mr. GRIM. I probably would leave that either to Dr. Moore or the scientists here about the scientific background of why it is more dominant.

Senator THOMAS. Is it behavioral, lifestyle? What causes it? Are there causes for it?

Mr. GRIM. Behavioral, lifestyle, plus probably genetic component as well, all of those things.

Senator THOMAS. Sixty years ago, we didn't know that there was any diabetes in the Indian tribes.

Mr. GRIM. And there was next to none 60 years ago, we believe. Some people say it has been the rapid change in lifestyle that the Indian population has seen in the last 100 years to 200 years, and that genetically they have not been able to keep up with the diet and lifestyle that is more predominant these days. I think that is an issue with the Nation as a whole. We are seeing diabetes rise in the Nation because of a more sedentary lifestyle, for the behavioral choices, as well as a number of perhaps public policy issues, too, in the country.

Senator THOMAS. I guess I am just saying, and I understand you are working very hard at it, but we need to try and determine what it is that is the cause for diabetes and then determine if we are making any progress. We can get into research until it is never-ending, but we have to study causes and results.

Mr. GRIM. I would have to say we have probably one of the most evaluated programs in the country for diabetes. We would love to share more information with you at your convenience, sir.

Senator THOMAS. Thank you.

Mr. MOORE. And please stay tuned for our next report. This is the cover. It has been submitted to DHHS for review. Once the review is completed, it will be available.

The CHAIRMAN. Dr. Fradkin, you wanted to make another comment?

Mr. FRADKIN. I do. I just want to emphasize that there are two aspects to this program. One is trying to prevent diabetes, but the other is trying to prevent complications in people who have diabetes. Now, preventing diabetes is hard because involves lifestyle, and that is a hard thing to change. But the things that can be changed in the clinics are the ways the diabetes is being taken care of.

Here, the numbers that Dr. Grim gave you are incredibly impressive. The IHS got the hemoglobin A1C down from 8.9 percent to 7.9 percent. Clinical research has shown that 1 percent difference would be expected, if sustained, to decrease diabetes complications by 40 percent. So it is a huge accomplishment that the IHS got the A1C down from what is close to poor control of blood sugar to what is near good control.

Senator THOMAS. How has that impacted the folks?

Mr. KNOWLER. Could I address that?

Senator THOMAS. Yes.

Mr. KNOWLER. I would like to give one example again in the area of management of diabetes that I mentioned briefly. According to the U.S. Renal Data System's, national data on new patients starting dialysis, the rates per person since 1999 have actually been going down in American Indians, while they continue going up in all the other ethnic groups in the country.

It is hard to attribute improvements like that to any single factor. The increased knowledge of the importance of treating blood pressure, the use of many new very powerful drugs that improve blood pressure and kidney function, and the resources that have gone into treating diabetes in American Indians are probably responsible for this improvement.

So there is a very hard outcome that has turned the corner. It is still a huge problem, as you know, but it is starting to get better.

Mr. GRIM. And just briefly, it has improved the quality of life of those patients because their diabetes is under better control so the progression and all the complications of diabetes has either been slowed or halted. It has also saved our system money. You saw in multiple people's testimony that the average cost to treat a patient with diabetes is about $13,000 a year, which is huge in our system, a huge prevalence of diabetes.

And so, bringing that population blood sugar under control just by that 1 percentage point has saved our system a lot of money in treatment costs, less pharmaceuticals that the patients have to be on, less complications or amputations. So it has led to both quality of life and savings to our system.

The CHAIRMAN. Let me thank all of you for your testimony. We would ask that you be available to answer written questions that we will continue to send your direction.

Thank you very much. We will have other hearings on this subject, but we appreciate your being here today.

I am sorry, Senator Smith. I apologize. I did not see you come back in.

Again, thank you very much, Dr. Grim.

Next, the panel will include Buford Rolin, chairman, Poarch Band of Creek Indians, cochair of the Tribal Leaders Diabetes Committee, and cochair of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act; Dr. James Brosseau, director of the Altru Diabetes Center in Grand Forks, ND, a member of the American Diabetes Association Native American Committee; Dr. Biron Baker, Primary Care Physician, Med Center One, Bismarck; Sam McCracken, director, Nike Native American Business Program, Beaverton, OR; and Donna Vandall, director of the Whirling Thunder Wellness Center.

We thank all of you for being here this morning, and being a part of this hearing. I am going to begin with Chairman Rolin. Let me indicate that we are asking to have you summarize your testimony and your entire statement will be made a part of the permanent record.

Chairman Rolin, thank you for being with us. Why don't you proceed.

STATEMENT OF BUFORD ROLIN, CHAIRMAN, POARCH BAND OF CREEK INDIANS, COCHAIR OF THE TRIBAL LEADERS DIABETES COMMITTEE, AND COCHAIR OF THE NATIONAL STEERING COMMITTEE FOR THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

Mr. ROLIN. Thank you, Senator Dorgan.

It is a pleasure to be here today to discuss with you the Special Diabetes Program. This important program is making a critical difference in the prevention and treatment of diabetes and cardiovascular disease for American Indians and Alaska Natives.

As I am sure you are aware, and as you have heard already, the rates of diabetes for American Indians and Alaska Natives are the highest in the United States, with rates of diagnosed diabetes in adults as high as 60 percent in some of our communities. Earlier you mentioned the fact that Congress had appropriated in 1997 the special diabetes funding because of the alarming rate of diabetes in the American Indian and Alaska Native communities.

The Special Diabetes Program emerged in the wake of increasing public concern about the human and economic costs of diabetes in the United States and its growing prevalence among the American Indian and Alaska Native population. In 2002, Congress reauthorized the Special Diabetes Program for $150 million per year for fiscal years 2004 and 2008. The IHS was directed to expand this program to implement competitive grants. The competitive grants are awarded to reduce cardiovascular disease and data improvement.

Earlier, it was noted that there are 333 programs within the IHS, bringing the total number of grants to Indian country to 399 programs. The Special Diabetes Fund is set to expire in October

2008. The American Diabetes Association [ADA] and the Juvenile Diabetes Research Foundation [JDRF] and the National Indian Health Board [NIHB] hosted a meeting on June 13 and 14, 2006 to bring tribal leaders and key stakeholders together to discuss how to approach the reauthorization of the Special Diabetes funding. In October 2006, the TLDC, with the consensus of the NIHB, mailed a letter to all tribal leaders seeking input as to the future funding of the Special Diabetes Program. This letter specifically asked the tribal leaders whether they would support an increase of the amount of $200 million a year for 5 years, and I am happy to report that the tribes responded unanimously in that.

The ADA and JDRF have been great partners with the NIHB in an effort to secure appropriate funding for diabetes research and the Special Diabetes funding.

The NIHB was recently informed that two young members of the Choctaw and Chickasaw Tribes will join 150 other children from across the United States to participate in the JDRF's Children's Congress to be held June 17–20 in Washington, DC. These young people will be walking the halls of Congress and meeting their lawmakers in discussing type 1 diabetes. Desiree Cameron of the Choctaw Nation and Erica Rosebush of the Choctaw and Chickasaw Nations were elected from over 1,000 applicants. In a letter to Members of Congress, Erica writes:

> I wish there were a cure for type 1 diabetes so I could live a more normal life like my friends and family. A cure would allow me to eat and drink without checking my blood sugars and counting carbs for insulin. Finding a cure would mean my parents wouldn't have to pay for my supplies that cost a lot. Me, my parents and my brother would not have to worry about sleeping all night because my blood sugars would be too low or go high and make me sick.

As chairman of my own tribe, the Poarch Band of Creek Indians, I wish that more people had an opportunity to come to Washington, DC to express those same concerns. Some of the samples of the prevention screening and treatment services that are provided by IHS tribal and urban diabetes programs are clinical annual examinations of eyes, teeth, and feet, newer and more effective medications and therapies, laboratory tests to assist diabetes control and consultation, 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 from our provincial programs for children and families, community-based health eating programs, and area schools and nursing homes and community physical fitness activities.

As chairman of the Tribal Leaders Diabetes Committee, I have had the unique opportunity to work very closely with Dr. Charles Grim, director of IHS, and Dr. Kelly Moore, director of the IHS Division of Diabetes Treatment and Prevention Program, to oversee the development of the culturally sensitive and appropriate diabetes programs throughout Indian country.

The Fort Berthold model diabetes program, located in New Town, ND is an example of teaching and cooking classes and menu planners for local schools. The Fort Totten model diabetes program located in Fort Totten, ND, organizes several community activities such as diabetes walk and run, and various other programs. The Whirling Thunder Wellness Program operated by the Winnebago

Tribe of Nebraska is a multi-disciplinary program. The IHS service unit program in Zuni, NM has identified 25 percent of those ages 29 and older, and 50 percent of those ages 49 and older as having diabetes.

While these are just some of the examples of the model diabetes programs located throughout Indian country, all of the programs continue to face many challenges. There is a lack of staff and staff turnover, lack of data, case management systems, and a lack of adequate facility space to provide basic service to the community and educational and fitness activities.

An overall concern, Senator, of these programs is that if this funding is not kept in place, a lot of this will not continue to be achieved. The vision of the TLDC is to empower our American Indian and Alaska Native people to live free of diabetes through healthy lifestyles, while preserving cultural traditions and values through tribal leadership, direction, communication, and education.

I appreciate the Senate Committee on Indian Affairs scheduling this oversight hearing on diabetes in Indian country, and especially the Special Diabetes Program. I invite the committee to schedule field hearings in Indian country for diabetes.

Thank you for inviting me to testify.

[Prepared statement of Mr. Rolin appears in appendix.]

The CHAIRMAN. Chairman Rolin, thank you very much. Thanks for being with us today and presenting your testimony.

Next, we will hear from Dr. James Brosseau, the director of the Altru Diabetes Center in Grand Forks, ND, a member of the American Diabetes Association Native American Committee.

Mr. Brosseau, thank you for joining us.

STATEMENT OF JAMES BROSSEAU, DIRECTOR, ALTRU DIABETES CENTER, MEMBER OF THE AMERICAN DIABETES ASSOCIATION NATIVE AMERICAN COMMUNITY

Mr. BROSSEAU. Thanks, Senator Dorgan and other members of the committee. It is an honor to be here.

I have been connected with the IHS since back in the early 1970's, and for that entire time I have worked as a practitioner dealing with diabetes in the clinic on a day to day basis, so that is the perspective I bring to this.

In addition, I have been involved with the Awakening the Spirit Committee of the American Diabetes Association, with Dr. Kelly Moore, who is in the room, too.

I would just like to say that I think the IHS and the Special Diabetes Program for Indians have just done wonderful things, and I certainly hope that they can be continued on. I won't go any further into a description of those programs.

I brought me today about 1 dozen testimonials from people living on reservations in North Dakota. I wanted to share some of their feelings about what it is like to be diabetic and living in Indian country right now.

First of all, many of them are frustrated with things such as lack of services in the evenings or on the weekends, and are frustrated by having long waits in the clinic, a short visit with the doctor, and then leaving with a prescription.

The CHAIRMAN. Dr. Brosseau, could you move the microphone just a bit closer to you and speak up just a bit. Thank you.

Mr. BROSSEAU. Okay. Is that better?

The CHAIRMAN. That is better.

Mr. BROSSEAU. Okay. I was just listing some of the frustrations of people who are served by the IHS, including lack of services in the evenings and on weekends, long waits to see the doctor, and then the sense that you were just given a prescription and sent out the door.

There are manpower shortages and patients complain about having to see different providers each time, availability of new treatments in the sense that rationing is going on, such as you alluded to at the beginning of the hearings. And then many people also feel that they are less valued as people because they are Indian people living in rural reservations in places like North Dakota.

We also see frustration with contract care, where people come to a larger center for treatment and then are given prescriptions for newer medications which are not yet available in the IHS facilities. And then there is also frustration on the part of providers, too, who want to do a much better job, but are handcuffed by shortages.

So these complaints sound a lot like what I hear from patients in my clinic in the non-Indian communities, too. When I started working in the IHS back in the 1970's, things weren't so complex and the magnitude of the problem was not nearly as great. So I think that we have to think about new ways of doing things.

First of all, I think all of us agree our medical care system, our health care system needs and overhaul right from the top down. But for rural clinics and for Indian country in particular we can make some changes now which I think make some sense. For example, medical schools, I think they need to be more selective in taking admissions not just on the basis of what the grade point average is, but they should be looking at people who have ties to their communities. The INMED program at the University of North Dakota started out this way, and probably still does that, but we need to be doing this for people from all backgrounds who have ties to communities and are more likely to stay there.

Perhaps there could be some accelerated programs, since primary care is a problem all across the country, maybe accelerated programs for people who already have a pretty good education. I think access problems needs to be remedied, and chronic disease, we have to change the way we deal with a chronic disease. A 10-minute visit is not going to work for a person with diabetes. There are too many aspects of diabetes to cover in a short clinic visit.

So we have to look at more of a team approach, and I think something like group medical visits, which have been developed in managed care programs, would be very ideal for many IHS settings, worksite wellness programs where we actually go to the places where people are working to do preventive care.

There definitely has to be better collaboration between tribal health programs and the IHS. I know others might want to speak to that also. We should be having programs for pre-diabetics, people that have not yet developed diabetes, because we know that over a 10-year period, we could probably prevent about 50 percent

of those people from progressing to diabetes just by implementing lifestyle change.

School programs, which address primary prevention, are very important and many of these have been developed under the Special Diabetes Program for Indians and need to be continued. And then also alluding to something the first panel talked about, research in diabetes has been fantastic, and the developments over the past 10 years or so have been just unbelievable, but now we have to find a way to translate those developments to the clinic setting, and that is where I would like to see the attention placed.

So in summary, I would say that the Special Diabetes Program has been great, and I hope it can be continued. We do need some fresh thinking to solve manpower problems. Medical schools really have to find new ways to get people out into the rural communities and then new approaches to access and treatment of chronic disease in the clinics would be a great help in dealing with the problems of diabetes, where we have the whole team present and all members of the health care team present also.

Thank you very much.

[Prepared statement of Dr. Brosseau appears in appendix.]

The CHAIRMAN. Dr. Brosseau, thank you very much.

Senator Smith, the next witness, I believe, is from Oregon. Would you like to introduce the next witness?

Senator SMITH. Thank you, Mr. Chairman.

I did remark earlier that Sam McCracken is with the Nike Corporation. They are doing some great things, as you will soon hear, on this issue. I applaud them. I thank Sam for being here representing the great efforts they are making.

The CHAIRMAN. Mr. McCracken, thank you for being here. You may proceed.

STATEMENT OF SAM MCCRACKEN, DIRECTOR, NIKE NATIVE AMERICAN BUSINESS PROGRAM

Mr. MCCRACKEN. Hello. My name is Sam McCracken. I am a member of the Fort Peck Tribes and I am manager of Nike's Native American Programs.

[Phrase in native tongue.] Loosely translated, I am named after my grandfather, Thomas Duck, a provider for the Assiniboine people. My clan is the Red Bottom clan, after my grandmother.

Chairman Dorgan, Senator Smith, Vice Chairman Thomas, and other committee members, thank you for the opportunity to testify today on this vital topic facing the Native American community. Nike applauds this committee for holding this hearing, and we look forward to continuing our public-private partnership under your leadership.

Senator Smith, thank you for the kind words and overall support. Native American tribes in Oregon and across the country have benefitted from your stern leadership and are grateful for your role on this powerful committee.

The impact of diabetes in my community is a topic very close to my heart. Raised on the Fort Peck Indian Reservation in Montana, I have seen first-hand the needs and opportunities facing my community. I personally experienced the tragedy of diabetes. In 2001, I lost my mother to type 2 diabetes. Her passing has renewed my

passion to speak directly and find ways to combat this deadly disease.

I happen to work for a company that lends its powerful voice to get my community active. As the manager of Nike's Native American Program, I have had the opportunity to work with government officials and community leaders in the creation of Nike's Native American Community Program, which is a multi-tiered initiative to support and encourage physical activity on Native lands to combat diabetes.

The program has served several key components, and I would like to take this opportunity to highlight some of our achievements today. First, Indian Health Service's memorandum of understanding. Under the leadership of Indian Health Service's Director, Dr. Charles Grim, Leo Nolan, Senior Policy Analyst, the Nike Native American Community Program helped forge the unique partnership with the Indian Health Service's with the signing of the historic memorandum of understanding in 2003.

The goals of the memorandum of understanding helped those communities gain a better understanding of the importance of exercise at any age, particularly those individuals with diabetes. With these goals, and with our research with the Indian Health Service, Nike has developed an innovative shoe that offers increased comfort and a new design fit that helped fit the needs of the Native American foot. With this hope of a new design, we will encourage and motivate Natives to be more physically active. The shoe is still in development and it will be offered through a limited distribution to qualified Native American community partners.

Second, the Native American Incentive Program. It was created in 2000 while working closely with diabetes program coordinators with some 100 tribal agencies. In this program, Nike provides product, mentoring and recreation for tribal populations. Nike is also partner with several national stakeholders and government officials, and some of those agencies were included in testifying today. Working with the Boys and Girls Clubs, we have introduced NikeGO on Native lands. Today, there are 67 sites across the country. NikeGO provides a culturally relevant physical activity curriculum and equipment all designed to help Native youth between the ages of 8 and 15 discover the joy of movement and physical activity. Nike has also donated more than $1 million in product to support this program.

Third, Nike always listens to the voice of the athlete to inspire and motivate. One such athlete is Notah Begay, III, a four time PGA Tour winner and Native American golfer. Notah has played a central role in helping Nike educate Native Americans about the benefits of exercise in combating the spread of diabetes. In 2004, Mr. Begay joined Dr. Grim and myself at the annual session of the National Congress of American Indians. Mr. Begay was instrumental in kicking off the first-ever National Native American Health and Fitness Day.

In May 2006, Nike announced the 5 year partnership with the Iroquois National Lacrosse Organization, providing the Iroquois Nationals with footwear and apparel. The partnership was developed out of Nike's commitment to working with Native commu-

nities, and another means to inspire physical activity among Native youth.

In closing, Mr. Chairman, the mission of the Nike brand is to bring inspiration and innovation to each and every athlete in the world. We believe our program is true to its mission. I am fortunate to have the opportunity to work for a company that strives to make a difference, but more can be done. Expanding innovative public and private partnerships, and this committee support, is crucial.

I want to thank you for this opportunity to share the Nike story.

[Prepared statement of Mr. McCracken appears in appendix.]

The CHAIRMAN. Mr. McCracken, it is quite an interesting story, and an admirable one as well. We appreciate very much your being here today. Thank you.

Mr. MCCRACKEN. Thank you.

The CHAIRMAN. Next, we will hear from Dr. Biron Baker, who is a primary care physician at Med Center One in Bismarck, North Dakota. Dr. Baker, thank you for joining us. You may proceed.

STATEMENT OF DR. BIRON BAKER, PRIMARY CARE PHYSICIAN, MED CENTER ONE

Mr. BAKER. Thank you, Mr. Chairman, members of the Committee.

My name is Biron Baker. I am a board-certified family practice physician currently working in Bismarck, ND. My tribal affiliation is I am a member of the Mandan and Hidatsa Tribes. My Hidatsa name is Ah Gu Ga Naha Naish. The literal translation, or the loose translation, would be "Stands Above." It is based on the educational things that I have achieved.

I care passionately about what happens to the health care of American Indian people, because I was groomed from early on to work for the Indian Health Service. My mother, her two sisters, and her two brothers combined had over 150 years between them of working for the Indian Health Service. Now, that being said, I will go into some other issues here that explain why I am not an Indian Health Service employee.

In my statement, I have the usual statistics and so forth, but I think those have been gone over to a great degree this morning, and I don't think I will belabor that. When we think about the effectiveness of the Special Diabetes Program, I think if we want to investigate the rates of increase and whether or not the rates of increase have slowed, we might compare the rates of increase between Canadian Indians and American Indians, since the Canadian Indians would not be beneficiaries of this program.

Our diets are high in processed foods and fatty foods, and I think rapid modernization of diet has led to some of the problems that we have had. Some researchers have postulated that, and research has been bearing it out.

I wanted to talk about the severity of complications of diabetes in Indian people. It is something that is readily apparent. It is something that we can see almost just at a glance. My former boss, before I became a physician, I was a jailer for the BIA. My boss, this vital man 15 years older than myself, through the years we became great friends. He has congestive heart failure. He is blind. He

has lost parts of his feet. He has had bypass surgery. He is essentially living on borrowed time. He retired early from the BIA. I helped him do this. It saddens me to think of my friend this way.

My youngest patient that had problems with complications from diabetes was a 22-year old man from Standing Rock who came to see me in the clinic one day. His creatinine, a measure of kidney function that we take through the blood, was already 1.6. When I told him he had lost essentially half of his kidney function, he continued joking with me and continued trying to pass everything off. He didn't necessarily want to hear what was going on.

Finally, in 1 moment of inspiration, I guess, I suggested that he and I go visit the kidney dialysis unit and together we can pick out a chair for him. That finally seemed to get my point across, but this is just evidence of some of the resistance we can face as clinicians, particularly in Indian country.

One of the things that I have used that maybe other people don't necessarily use, is a sense of humor, which at times can be morbid. The thing with that is, a lot of elder people have explained to me, well, we have two choices. We can laugh or we can cry. I choose to laugh. And if I laugh with my patients, sometimes I get the point across a little bit better.

One of the other things that has always concerned me, continues to concern me, is the quality of care available at Indian Health Service facilities. Now, nationwide, I am not necessarily aware of how that goes, but I do understand how it works in the Aberdeen area. The Aberdeen area in particular has had more than its share, I think, of substandard providers. I mention this because I think standardization of care of diabetes is important. The Special Diabetes Program is important. However, the implementation of anything that is recommended in standardized care practices has to be understood by the clinicians who are delivering the care, or it is not effective.

One of the things that just happened to me recently was I had a diabetic patient from Standing Rock who fell down the steps at her home, had three days worth of knee pain. He right knee was swollen. She went to the Indian Health Service clinic and saw a locum physician there, a temporary physician at the Indian Health Service facility. He instructed her to wrap her knee in cabbage leaves. It sounded made up, but from my past experience, unfortunately, I know it wasn't.

I obtained an MRI of her knee and she had a torn anterior cruciate ligament, something that clearly wasn't going to be fixed by cabbage leaves.

I think that the Special Diabetes Program for Indians has done a lot of good, but I think that the quality of the administrators and the clinicians in the Indian Health Service has not followed suit. It saddens me to think that the Aberdeen area Indian Health Service seems to attract the worst of the lot. I am not sure how that happened. I am not sure why that is, but I think it leads to frustration in the ranks of otherwise qualified clinicians, which then leads to an exodus of the skilled clinicians and retention of the substandard clinicians.

I observed during my time with the Indian Health Service what I termed an "any warm body" philosophy. We had a nurse practi-

tioner in McLaughlin, SD who was somewhat less than effective, to put it diplomatically. In my attempts to get her either reassigned or terminated, I was reminded several times that if that were to happen, who would see the patients in McLaughlin?

It never seemed to quite sink in to my administrator that we are doing some harm here, more than we are doing good. I thought about that for awhile, and I tried to reconcile that within myself, why is this the way that this is? It occurred to me then that it was because my administrator wasn't necessarily a health care administrator. Rather, this was somebody who had just been with the system for so long that it was assumed by people higher up that truly this person must have learned something about health care in all the years that they worked for the Indian Health Service; let's try him as an administrator.

Pharmaceutical options remain a problem for American Indians. What I see is a disparity because I am in a private setting, so I get American Indian patients who have insurance, who have Medicaid, who have options other than Indian Health Service. So my patients that come to see me off the reservation actually get the standard of care that that anyone else would receive with their insurance, because what I see is that in the Indian Health Service, we see older insulin preparations. We see older oral medication preparations. And we see things being done that typically we don't think work anymore.

In my clinical practice, there isn't any reason to treat a known diabetic with diet and exercise alone. The research indicates that with early intervention, with a combination of TZD and biguanide medications, you can actually recover some of the pancreatic function that has been lost. At the time of diagnosis, we estimate one-half the pancreatic function is gone at diagnosis.

So if we can do something that is going to recover some of that function, we are going to. Unfortunately, in some providers, we are still seeing diet and exercise alone as monotherapy. Sometimes we are seeing some of the older medications used first line as monotherapy.

Even with the standardization of care, then, we have to have clinicians who understand the standard of care to be able to implement it. These disparities that I am talking about also exist in the frustrations that Dr. Brosseau talked about with contract health services are something that is readily apparent as well. People might ask, what does all this have to do with diabetes on an Indian reservation? It is all so interconnected that you cannot separate one from the other.

I had the dubious honor of being the chief of Medical Staff and having to meet as the chairman of the contract health services meeting every morning where we got together and decided, basically, who was going to get treatment and who was not. My patient who really stands out is a 60-year old rancher who had been waiting 4 years to have a simple rotator cuff replacement and take care of some of the chronic bursitis in one of his arms. He had been waiting 4 years, and I asked the committee, why are we still sitting on this? The answer I got was that it wasn't life or limb threatening.

I was able to successfully argue that a one-armed rancher isn't going to be able to earn enough income to feed himself for very long, which then eventually would threaten his life. Through this process of reasoning, we were able to get a two-armed rancher out of the deal, and he was happy and sent a card of thanks. But he had to wait 4 years and he had to have somebody go to bat for him. A lot of other people with insurance, he got what people with insurance take for granted: Good health care within a reasonable timeframe. He really stands out for me.

The administrators, in particular, within Indian Health Service, has been a source of frustration for myself and for other colleagues for a long period of time now. I worked with an administrator who was an ex-physician's assistant. Any clinician, I think, will tell you that we love what we do so much, we can't imagine doing anything else. So whenever we see someone who is an ex any kind of clinician, the radar goes up and we want to know why they are an exclinician. Pretty soon, I was able to find out. This man made no decisions that I am aware of, with the exception of the one he made to retire. The other administrator I dealt with had been with the Indian Health Service for 20 years and had trouble reading his budget. He couldn't understand that the numbers in parentheses were negative items in his line item budget.

I can't tell you how much frustration this causes when we are trying to get things done and we have a guy in the room who can't read the budget. At an annual meeting of chief medical officers and service unit directors, we had someone stand up and introduce his new service unit director: Here she is; she is a GS–11. The rest of us in the room are GS–15's, and people who understand Government pay scales will see that there is quite a disparity.

Why was she a GS–11? She had 1 year of residency and quit, and she was hired full-time having not completed a full residency. Someone thought that this was perfectly acceptable for care in Indian country. I don't think it is. I think it represents lowering the bar, diminishing the standard. We can't settle for that. But this man didn't see it. He was proud that he had a chief of staff who was a GS–11, and look how much money I saved. That was his impetus.

Eventually, I did have to leave the Indian Health Service. I tried then to work for a tribal health program and I can see that there has to be some better oversight of self-determination efforts of tribes. Tribal chairmen might disagree with me on this, but what I am finding is that political cronyism and nepotism are in force, and every problem that we see becomes magnified.

We had one situation where the tribal chairman's sister was placed in charge of the dialysis unit. She was an RN with no personnel background and no dialysis background. Instantly, she drove a wedge between herself and the staff because she had never worked in a kidney dialysis unit. The staff at the KDU thought she was incompetent. They clearly thought this was a political appointment. They all resigned in protest. For 8 months, our patients were bused between 70 miles and 160 miles away to get their dialysis three times a week, in vans.

This upset me considerably, and other people were upset as well, but I think if we had some sort of an oversight situation there, that

I don't have enough government knowledge about how that would work, but the chairman's response to this, then, was to put his sister in charge of health care and recruitment of physicians. Obviously, that didn't work either.

The CHAIRMAN. Dr. Baker, I need to ask you to summarize, if you would. We are running out of time.

Mr. BAKER. I will finish here. I do have some solutions. I don't want everybody to go away thinking that all I did was come here to complain. I think that the Indian Health Service is funded at roughly 40 percent level of need, and I don't advocate throwing money at a problem, but this is where I make an exception. The area offices seem to provide a layer of administrative capability without real function. I think if the area offices were eliminated, those FTE's could better service Indian people through enhanced contract health service fund availability.

Thank you for the opportunity to present this morning. I will entertain any questions anyone has.

[Prepared statement of Dr. Baker appendix.]

The CHAIRMAN. Dr. Baker, thank you very much for coming.

And finally, Donna Vandall, director of the Whirling Thunder Wellness Center, Winnebago, NE.

Ms. Vandall, thank you very much for being here. You may proceed.

STATEMENT OF DONNA VANDALL, DIRECTOR, WHIRLING THUNDER WELLNESS CENTER

Ms. VANDALL. Good morning, members of the committee and the people who are here in this room. I am known by the people who know me in Winnebago, my Indian name is We-huh-changaga, which means Water Spirit Woman. It is from the Water Spirit clan.

Our program began in 1995, contracted from Indian Health Service. We spent many years doing screenings, which produced a lot of diabetics. Screenings do that. And then we found some startling things. By screening school-age children, we realized that in 10 years if those children grew up, we would have double the diabetics that we had at that time. This was frightening and traumatic to the providers, and to our program.

About that time, SDPI became available. We developed strong activities, strong programs and services. But the most important thing we learned was that we needed to collaborate and network with everybody in the community who would work with us. That translate-s into almost 70 hours of time in the Whirling Thunder Wellness Center that is occupied by community members of all ages, from preschool to senior citizens.

Taking education and nutrition and activities, attempting to change lifestyles, setting up programs that the people themselves want, not the programs that Indian Health Service through the research thought was good, not the programs that providers thought were good, but the programs that the people felt that they could live with and adapt.

We worked for another 5 or 6 years; 18 months ago, we started Ho Chunk Hope, which is dealing exclusively with pre-diabetic people. We have a full plate all the time, with a total of 15 staff people working nonstop to try and achieve the results that we know we

can achieve by changing lifestyles and reducing the diabetic population in our community.

We believe that the efforts we have made are at a critical point right now, and that they need to continue. If other tribes are functioning in the same way, they need to continue, and things get worse before they get better.

Our prevalence in 2000 for diabetics was at 10.8 percent according to the IHS statistics. In 2006, it is at 17 percent. But at the same time, Ho Chunk Hope has shown to us in 18 months of intensive work that you can take people who are ready to convert into full diabetes and back them away from it, so they do not become diabetics. It is very heartening, very exciting work that is being done by the dedicated staff at the Whirling Thunder Wellness Center, and in Ho Chunk Hope.

Many people have come and served and worked through our program and with our program. Many leaders have looked and said, this program works. Whirling Thunder, incidentally, is named for a leader of a band of Winnebago who signed a treaty in 1832 and asked for a doctor. Culture and spirituality have become a major part of our work with Indian Health Service, with our local hospital. That is one of the major partners that we need to have. We are not clinicians. I am not a medical person. We have served as a buffer with our programs between Indian Health Service and the tribal population. Indian Health Service has a need to be able to reach the people that they serve.

We serve as a buffer by bringing them in, treating them very well, getting them to the providers, introducing them, being a pillow that helps them to achieve their health status. We have seen many improvements in our diabetic community. We have had almost no, well no amputations that I am aware of in the past 6 or 7 years, and very few people on dialysis.

The intensive work that is being conducted is being conducted at the tribal level with the funds that come from SDPI and from Indian Health Service Diabetes Program that we have contracted. Indian Health Service still has a vital role in the community, because they have the medical providers and they have the hospitals.

So with that in mind, I want to say that Indian country is very much aware of this committee and its membership. We know your burdens and we appreciate your work. A few months ago, I attended a gathering in the Northern Plains, and a veteran was asked to pray for the evening meal. We prayed for the people. We prayed for the men and women fighting in a war far, far away. We prayed for our tribal leaders. We prayed for the leaders of this Nation. And we prayed for Senator Tim Johnson and his family.

At these kinds of gatherings, and in our ceremonies when the smoke rises, it carries our prayers, and you are there. We hold you close.

Thank you.

[Prepared statement of Ms. Vandall appars in appendix.]

The CHAIRMAN. Ms. Vandall, thank you very much. As you indicate, Senator Tim Johnson is a member of this committee, and cares very deeply about all of these issues. We expect that Senator Johnson will rejoin us here in the U.S. Senate. On his behalf and

the behalf of other members of this committee, let me thank all of you for testifying.

I do want to mention that we have many, many hearings going on this morning here in the U.S. Senate. In fact, I serve on three committees that are now holding hearings even as I am here. It is one of the difficulties of trying to do all that one is required, especially in as many committees and subcommittees on which we serve. So our members are at other hearings, but there is a great deal of interest in this issue in the Congress.

Let me ask a couple of questions. Mr. McCracken, your company, of course, is a for-profit commercial enterprise, but we also recognize that it has been a very public-spirited company in many ways. You described the new shoe design for Native American diabetics. Would you tell us just a moment about that again?

Mr. MCCRACKEN. Sure. I would be happy to. Through our partnership with the Indian Health Service, the memorandum of understanding, we were looking for a tangible outcome of that document. What Nike does best is we innovate. So we took our sports and research lab, we call them "lab rats," out to the field to scan Native American feet across the country, knowing the issues that complicate people with diabetes.

Though the shoe will hopefully motivate and create opportunities for physical activity and promote physical activity, the thought of the shoe was built from the inside out, knowing the complications that come with a person who is pre-diabetic or diabetic in their foot. Those folks took that into consideration as they built it from the inside out, with a seamless inside.

From those scannings, we built a special last that was designed and developed for the Native American foot. If I could give you a brief example, a normal Nike shoe if you were to buy an in-line Nike shoe, in a men's size, it is a D width. From our scientific research we did by scanning 500 plus feet across Indian country, we found that the average Native American male foot was an EE. So when they would try to stick their foot into a normal, which we call an in-line Nike Shoe, we can understand why the discomfort was there.

So we are hopefully going to develop some comfort, which will then encourage physical activity. And with the efforts of physical activity, we are not on the medical side so we don't can't speak on behalf of those, but hopefully we can encourage physical activity with this product because there is going to be a sense of comfort around the product.

The CHAIRMAN. And the size of your shoes?

Mr. MCCRACKEN. What is that?

The CHAIRMAN. The size of your shoes?

Mr. MCCRACKEN. My shoes? I am 11½.

The CHAIRMAN. Double E?

Mr. MCCRACKEN. Double E. I squeeze into those.

The CHAIRMAN. All right. You squeeze into them.

Mr. MCCRACKEN. I squeeze into them. [Laughter.]

The CHAIRMAN. Mr. McCracken, thank you very much for being with us, as I indicated.

Mr. Brosseau, in your experience, are the new medicines that have been available and treating diabetes, are those medicines

available on Indian reservations, or widely available? I think you touched on that just briefly.

Mr. BROSSEAU. Some of them are, and some of them aren't. In the past 10 years, there has just been an explosion of new medications, insulin sensitizers and drugs which don't lower the blood sugar below normal. Metformin was the first of those, and that is available in Indian Health Service facilities, but the newer ones such as the thiazolidinedione and then these new incretin drugs, I am not sure if they are available yet or not. Maybe someone else could answer that question for me.

Then there are these new forms of analog insulins which also have been slow to come to Indian country. They have really also improved our ability to treat people appropriately.

The CHAIRMAN. Dr. Baker, your assessment? Are most of these new medicines available?

Mr. BAKER. Some are not, some of the newer things that have been happening recently. We have used GLP1 analogs and DPP4 inhibitors. These things are probably several years away from being available at the Indian Health Service. Those medications are very exciting in terms of the potential side effect that one of them has for weight loss, and the favorable side effect profile that drug interactions just aren't there. It doesn't drop the blood sugar below normal, and on average you get a 1 or more percent greater reduction in hemoglobin A1C with these drugs. So in my estimation, then, these are very valuable drugs in the arsenal not to have.

The CHAIRMAN. We will do some work to try to evaluate how frequently they are available or not available to those that need them. I think that is an important thing for us to try to understand. Understanding a better treatment regime, understanding the efficacy of new medicines is one thing, but having them available is the most important part of that understanding.

I want to ask about the issue of Indian health generally, and the delivery of health services with respect to clinics and the number of hours clinics are open. Because those with diabetes have lots of complications, and are often showing up for treatment at different hours of the days or nights or weekends. My experience on a number of Indian reservations with the Indian Health Service is they have a clinic, it opens at 8 or 8:30 in the morning, and closes at 4:30 or 5 in the afternoon; not open Saturday; not open Sunday.

So there really is a substantial limited opportunity. I have been talking about trying to develop a new medical model on reservations, very much like some of the commercial sector are trying to do across this country. On the commercial side, they are doing low cost, no appointment, walk-in clinics, in some cases staffed by nurse practitioners or physician assistants and so on, for routine diagnosis, but available 7 days a week at rather extensive hours.

I would ask any of you who wish to answer, is it your experience that on most reservations, there are limited clinic hours available for those who wish to show up at clinics? Does anybody have any experience? Chairman Rolin?

Mr. ROLIN. Yes, sir; that is true. Normal hours are from 8 a.m. to 5 p.m.. In my own clinic, what we have done is certainly we have designated 1 day a week to deal specifically with diabetes. We

begin at 7:30 in the morning with breakfast, and then we monitor the patient's activities during the day. But one of the things that we have taken into consideration is extending the hours and setting up various times, including the weekend, for these very special clinics and all, that we can accomplish and provide the services to our people, Senator.

The CHAIRMAN. Ms. Vandall, do you have a BIA school on your reservation?

Ms. VANDALL. We do not.

The CHAIRMAN. You do not.

Ms. VANDALL. No.

The CHAIRMAN. Does anyone have any knowledge of whether the BIA-run schools have pop, soda, and candy machines on their school premises? I will ask the BIA about that at some point. There is a discussion generally across the country about having machines distributing soda or pop as it is called in my part of the country, and chips and so on, snack foods.

Ms. Vandall, someone else described diabetes bingo. You described a poker walk. Was it you? Okay. Diabetes bingo, I don't know who described that.

Mr. ROLIN. I mentioned that, sir.

The CHAIRMAN. You did. That is instructional? Something people are doing in order to produce information to them that is useful? Can you describe it?

Mr. ROLIN. It is an educational program and I am working with them on it. It is working. Also, what I didn't mention is we have a kids program as well, teaching them about utilizing what the various foods are and all, and how it can affect them. This is also part of that program. It is called "Kids Cafe."

The CHAIRMAN. The reason I asked about what kids are able to access in their schools, in this case the BIA schools because those are the schools over which we have some funding responsibilities, is I wanted to try to understand whether we are trying to educate about fruits and vegetables and diet on the one hand, and then offer advertising as you walk out of a classroom into the lobby of a school for some liquid sugar and some high-fat snacks. I will get information from the BIA about that.

I make that point despite the fact that I was drinking a Coca-Cola this morning. [Laughter.]

Recognizing that I have had other healthy food and drink this morning.

Let me say this, this is I think one of the most important health issues facing Native Americans, the first Americans. We have a lot of health issues facing them. I did not today, but I certainly will the next time I have Dr. Grim here to talk about the Indian Health Service budget, and we will do that soon, I will again inquire to try to find out what part of Indian health is unmet. My guess is it is about 40 percent, 45 percent, based on what I have been able to extract, but getting that information is like pulling teeth.

In fact, there is full scale, I think because of that, full scale rationing of health care. Rationing of health care would be very controversial if people understand what it is going on. It goes on all the time on Indian reservations. I have spoken on the floor of the Senate about the stories that describe it, a woman hauled in, I

mentioned this before at a hearing, a woman hauled into a hospital on a gurney from one of our Indian reservations in our State, hauled into a hospital on a gurney, having a heart attack, with a piece of paper taped to her thigh. And the piece of paper said to the hospital administrator: "Understand now, if you admit this patient, the Indian Health Service will not be paying any of the costs." Understand that, we are out of contract health care money.

She had a heart attack. It is unbelievable that these things go on, and yet they go on.

Mr. Baker, you described the prospect of a one-armed rancher trying to make a living, someone who waits 4 years. You know, when you talk about health care in this country and the system, people say, "Well, we don't want a system like these other countries have because you wait too long." Well, waiting is something a lot of Native Americans understand, unfortunately, and suffering during that wait is something they understand as well.

Contract health, dealing with life or limb, is a circumstance where there is a lot of suffering because someone doesn't meet that test. I had just two Saturdays ago a listening session in Minneapolis and we had 150 Indian leaders and Indian tribal members come. One of the tribal chairmen said, "My tribe runs out of contract health care funding in January," that is the fourth month of the year. That means for eight months of the year, there is no contract health funding left. That is pretty unbelievable.

Another tribal chair testified before this committee and said, "We understand. The refrain on our reservation is, don't get sick after June." If you get sick after June, there is no contract health care money left. That is rationing of health care to a population that is a population at risk. It is unacceptable in this country. We need to find a way using this committee and others to put a magnifying glass up there and tell the American people this is happening, and it is wrong; tell the rest of the Congress it is happening, and it is wrong; and that we have a responsibility to do something about it.

Let me make one final point, because I know, Dr. Baker, your testimony will I am sure raise questions by some people who will say, you know what? The Indian Health Service has some unbelievably wonderful, dedicated people who work across this country in tough situations. They could be making a lot of money elsewhere, but they choose to serve. And God bless them for doing it.

Yes; that is the case. I am sure that is the case, and I have met many of them, and I walk away from them thinking, what a blessing it is they have chosen this career.

It is also the case, I am sure, that there are people unqualified; that there are people who do not have the same motives. We need to work on all of that, and I will in other venues work with Dr. Grim at hearings talking about a range of those issues.

Let me thank all five of you for being present today. This is the first of a series of hearings we will hold on health care. I will be holding a listening session. We are doing a number of listening sessions across the country with Indian tribal members and leaders to talk about a range of issues, especially health care. I mentioned one that we held just recently in Minneapolis for a five-State region. I will be holding one in Phoenix in the next 2 weeks. We are trying to see if we can hold it on the Gila River Indian Reservation,

which is just I believe south of Phoenix. I expect we will probably be doing it on that reservation, which was interesting to me that there was a lot of discussion about the study that ranges from 1965 forward on that reservation. So I will be able to have some information as I hold a regional listening session there with my colleague, Senator Thomas.

At any rate, I appreciate all of you being here. Chairman Rolin, you had a last comment?

Mr. ROLIN. Yes; I would just like to say, Senator, we appreciate this hearing and what is being done, but just a reminder that it took many, many years to achieve the progress that was made to reduce cancer in this country. We have only been working at this now a little over 8 years. We are seeing progress, and the progress is coming through the empowerment that the communities have taken to make sure that we address this deadly disease.

The CHAIRMAN. And I think, what Senator Thomas was asking represents the most important questions for those in Congress who are asked to contribute $150 million toward this priority, and hopefully perhaps even more toward this priority in the future, because it saves lives. What he is asking is not just the empirical evidence, but what is the empirical evidence, and then what are the stories that describe to us that there is real progress? Because you don't know how often agencies come to us, to Senator Thomas and myself and others, and say, well, we have a program. Well, good for them for having a program.

The question we ask is, what is being accomplished with this funding? I think that from my knowledge, there is a very substantial amount of good investment being made that is going to produce substantial results. That is what Vice Chairman Thomas is asking, and it is the question every member of Congress will ask. We have competing needs for limited resources.

But I can't think of a priority that is much more significant than this. If you go to reservations, go to the dialysis centers, go visit with the families who are suffering through these difficulties with diabetes at the root of the difficulties, I can't think of a much higher priority. I think that is the point that Senator Thomas was making as well.

In order for us to do this and continue doing it, we need to be able to tell our colleagues in Congress, here is the achievement; here is the body of achievement. It is substantial. It is impressive, and will continue. And that is what we need from you, and we appreciate your being here today to give us a part of that.

This hearing is adjourned.

[Whereupon, at 11:25 a.m., the committee was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF BIRON BAKER, M.D., PRIMARY CARE PHYSICIAN, MEDCENTER ONE

Greetings Mr. Chairman and members of the committee:

It is an honor to be asked to testify before this distinguished body on an issue of vital importance to Native Americans at risk and diagnosed with diabetes. My name is Biron Baker and I am a Board Certified Family Practice physician. I worked for the Indian Health Service on the Fort Berthold and Standing Rock Service Units in central North Dakota for over 3 years. I am currently employed by Medcenter One in Bismarck, ND. I am an enrolled member of the Three Affiliated Tribes of western North Dakota. My Hidatsa name is Ali Gu Ga Naha Naish. A loose translation of this would be "Stands Above." I've been asked to provide information on diabetes in Indian country.

According to the Center for Disease Control, American Indian and Alaska Natives are 2.6 times more likely to develop type 2 diabetes as non-Hispanic whites of similar age.

Type 2 diabetes is the type of diabetes that the overwhelming majority of American Indians are afflicted with. The problem, in simplest terms, is the inability of the body to utilize its own insulin to regulate blood glucose levels. Data that I've read indicates that the prevalence of type 2 diabetes in American Indians has increased by over 100 percent in the past 15 years, and the complications are worse in American Indians. Greater than 17 percent of all adult American Indians have diabetes and the problem is growing. The total number of diabetics in the United States is at 21 million and another 41 million are "pre-diabetic."

Comorbid conditions in Indians with diabetes outpace that of all other minority groups. When I think of health problems of our country as a whole, I can magnify those problems in Indian country without much effort. Our use of tobacco (not in the religious sense) is near 50 percent. We know that diabetics face the same risk of heart attack as someone who has already experienced a first heart attack. This is compounded by tobacco use disorder. Our rates of alcoholism and alcohol related disorders far outpace the rest of the country and this can prevent standard of care practices for diabetics. Our diets are high in processed and fatty foods and the obesity rate is staggering. Rapid modernization of diet is implicated by several researchers as part of the problem. Primary prevention is relatively new in Indian country and it's had some success. This is area that holds great potential.

The severity of complications associated with diabetes in Indian people is readily apparent. I once worked for a man 15 years older than me and now because of complications related to diabetes he is a very ill man. He is blind, his kidneys are shutting down and he is approaching dialysis, he has lost parts of his feet, he had cardiac bypass surgery and now has congestive heart failure. At 56 years of age, this once vital retired police officer is living on borrowed time. My youngest patient with complications was a 22-year-old man from Standing Rock who had lost half his kidney function before he was diagnosed with diabetes. I was having trouble impressing upon him the need to change his lifestyle. I finally asked him to accompany me

to the kidney dialysis unit so we could pick out a chair for him to dialyze in three times a week for 4 hours each session. That seemed to get my point across, but this is evidence of the type of resistance clinicians can face.

Quality of care at Indian Health Service facilities has been a documented problem. I have seen this problem from the time that I worked with the Indian Health Service in 1997 until today. I had a diabetic patient from the Standing Rock Reservation see me in the clinic in Bismarck with fluid in her knee joint. She had gone to the Indian Health Service facility for evaluation and was told by the physician to wrap her knee in cabbage leaves for several days. I obtained an MRI of her knee and found a torn anterior cruciate ligament. While enhancing funding for the Special Diabetes Program for Indians and standardization of care has shown some benefit, the quality of clinicians and administrators in the Indian Health Service has not followed suit. The Indian Health Service has become a haven for administrators and clinicians who would otherwise never be able to maintain employment. Sadly, the Aberdeen Area Indian Health Service seems to attract the worst of the lot. This leads to frustration in the ranks of otherwise qualified clinicians, and an exodus of skilled clinicians inevitably occurs. It is the principal reason that I no longer work for the Indian Health Service. During my time with Indian Health Service, I observed what I termed an "any warm body" philosophy. Even if clinicians were inadequate, they were kept on staff because to remove them would overwork the rest of the medical staff. hi the long run, this created more problems than it solved, but administration never seemed to recognize this. Perhaps it's because the administrators I dealt with were not healthcare administrators, but rather they were people who were promoted simply because they were still with the system after many years, and surely must have learned something.

Pharmaceutical options remain a problem for Indians accessing care at Indian Health Service facilities. Many of these patients are using older insulin preparations and older oral medications because that is what the pharmacy budgets allow. Typically, Indian Health Service pharmacies run significantly over budget, and disparities still exist. Diabetes programs can purchase glucometers, but not medications. Prevention and early intervention related to diet and exercise is not used as a standard of care on the reservation. Sulfonylurea medications are now third line oral agents, but we see patients on them as monotherapy, first line agents. Part of this is limited pharmacy budgets, but part of it also lies with medical staff ability. Even with standardized "cook book" approaches to the treatment of diabetes, the clinician must be aware of standard of care practices. Otherwise, we see an example of "the eye cannot see what the mind does not know."

Significant care disparities exist between insured and uninsured American Indians. The insured population will often seek medical services at an off reservation private practice type of environment, and care follows what typically happens for every other insured American. Medical, diagnostic and therapeutic interventions are more readily available. The uninsured population will seek care at an Indian Health Service facility and will have that care rationed. Any procedure, test, consultation or intervention that is not deemed "life or limb threatening" will not happen. Direct care or care available at the Indian Health Service facility, is provided. Contract Health, or offsite care, is doled out by the Contract Health Service committee that meets Monday through Friday mornings. Most requests for referral are impossible after May or June of each fiscal year because of depleted funds. Patients are not unintelligent, and recognize this disparity at once. One patient stands out for me. While at Fort Berthold, I was informed during a Contracted Health Service meeting that a particular patient had been waiting for a shoulder repair for 4 years, but that we couldn't approve it because it wasn't "life threatening." I asked what he did for a living, and was informed he was a rancher. I successfully argued to the committee that a one-armed 60-year-old rancher was unlikely to be able to earn enough to eat, thus eventually threatening his life. His surgery was approved, and the now two-armed rancher sent me a note of thanks. He waited 4 years for something that insured Americans take for granted: Good care within a reasonable timeframe. Serving as the chair of the Contracted Health Service committee was one of my most distasteful duties as a clinical director with the Indian Health Service.

Administrative ineptitude within the Indian Health Service is a glaring problem. During a budget meeting, I met an administrator who did not understand his line items. It was explained to him that the numbers in parentheses were negative, and represented a deficit in that particular line item. He had been with the Indian Health Service for 20 years at that point. I worked with another administrator who was a "washed up" physician's assistant. To my knowledge, the only decision he ever made was the one he made to retire. I knew administrators from other service units within the Aberdeen Area Indian Health Service as well. At an annual meeting of chief medical officers and service unit directors [CEO's], one of the clinic CEO's an-

nounced that he had just hired a physician with only 1 year of residency as his chief medical officer. He was very proud of this, and announced her salary as a GS–11. The rest of us chief medical officers in the room had completed 3 year residencies, and we were GS–15's. People familiar with government pay scales will recognize this as a significant disparity. That the Indian Health Service will even hire physicians who haven't completed residency training boggles the mind. It represents setting the bar lower for the future, and encourages misfits and miscreants to apply for work with the Indian Health Service. His statement also opened a rift between medical staff present and administrators in the room, and a lively discussion ensued. Never tell an Indian Health Service physician he's overpaid; he makes one-half to two-thirds of what his peers in private practice make. That's just for primary care. That gap is wider with specialties. The fact that the administrator was so out of touch with reality was what saddened me. All he could see was that he saved money in his medical staff budget.

There must be better oversight of self-determination efforts of tribes. Political cronyism and nepotism were in force where I worked. We once were forced to work with a dialysis unit with an unqualified nurse placed in charge. She was the tribal chairman's sister, so we tried to make do. All the staff nurses resigned in protest, and for 8 months our 18 dialysis patients were bussed to dialysis units 70 to 160 miles away, several different locations, so the chairman's sister could ran the dialysis unit. The chairman's solution to all this was to place his sister in charge of tribal healthcare. The dialysis unit eventually reopened, but our dialysis patients paid for it for 8 months. All too often, unqualified personnel are placed in charge of self determination efforts, to the detriment of the populace. With better oversight, self determination could work. It could be mandated that such a venture not take place until qualified personnel with a plan are in place.

As bad as things seem, there are solutions. The Indian Health Service must make it a priority to hire and retain competent administrators and medical staff. The scholarship program currently in place could be expanded to include healthcare administration as well. It would seem that strong leaders in these positions would be able to eventually recruit and retain competent physicians. If those two areas were addressed seriously, quality of care would improve immeasurably. This would impact diabetes and other health issues in Indian country. While I don't usually advocate throwing money at a problem, this is a case where I make an exception. The Indian Health Service is funded at roughly 40 percent of the level needed. In some areas, the Indian Health Service has done well. With administrators and medical staff, they have not. Increased funding for enhanced and expanded training programs would make a world of difference.

The Area Offices seem to provide another layer of administration without real function. All area offices should be eliminated, and service units should have the autonomy and authority to tailor their needs to fit the needs of the population they serve. During my time with Indian Health Service, at no time was the Area Office any help; in fact, they were a constant hindrance. Any real problems I had as a clinical director or chief of staff were sent to headquarters, and I worked with them to resolve issues. Many times I found myself wondering how much more Contracted Health Service funds we would have at the service unit level if all those FTE's at the Area Office simply didn't exist. I wondered how many more patients would have "optional" joint replacement surgery, "optional" CT scans, "optional" consultations with a specialist, and so on. With completely qualified leaders of the reservation clinics, the Indian Health Service wouldn't need Area Offices for anything.

Tribal governments and Indian Health Service administrators must work together. Poorly planned tribal ventures are based directly on poorly ran Indian Health Service clinics. With qualified administrators who are real leaders, the tribal governments will learn to trust their counterparts in the Indian Health Service. I don't believe this is actually anyone's job presently. No liaison currently exists, simply mutual dislike and distrust. Cooperation would enhance patient care by preventing duplication of services, and coordination of resources.

Thank you again for allowing me to participate this morning. I would welcome the opportunity to work with any of you on these issues, and I invite your questions.

PREPARED STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR FROM HAWAII

Thank you, Mr. Chairman. I commend the committee for holding this oversight hearing on diabetes in Indian country with an emphasis on the Special Diabetes Program for Indians.

The statistics are alarming. We are here today because American Indians and Alaska Natives have a higher incidence of type 2 diabetes than any other racial or

ethnic group in the United States. I am told, among Indian children and young adults, there has been an increase of 80 percent in type 2 diabetes. These data underscore the importance of the Special Diabetes Program for Indians, which provides grants to nearly 400 Indian Health Service, tribal, and urban Indian programs in 35 States. In 2005, approximately 116,000 individuals received services from these programs. One thing is clear. This program is addressing the critical health needs in Indian country.

In Hawaii, Native Hawaiians also experience similar disparities in diabetes incidence and mortality. In 2004, Native Hawaiians had the highest mortality rate associated with diabetes in the State—a rate which is roughly 119 percent higher than the statewide rate for all racial groups.

Our examination of the Special Diabetes Program for Indians is a crucial step toward our larger goal of assuring that American Indians and Alaska Natives attain some parity of good health comparable to that of the larger U.S. population.

Thank you, again, Mr. Chairman for holding this much needed hearing today.

PREPARED STATEMENT OF WILLIAM C. KNOWLER, M.D., DR.P.H., CHIEF, DIABETES EPIDEMIOLOGY AND CLINICAL RESEARCH SECTION DIVISION OF INTRAMURAL RESEARCH NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES NATIONAL INSTITUTES OF HEALTH DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and members of the committee: I am William Knowler, chief of the Diabetes Epidemiology and Clinical Research Section of the National Institute of Diabetes and Digestive and Kidney Diseases [NIDDK]. Our Institute has primary responsibility for diabetes research at the National Institutes of Health [NIH] of the Department of Health and Human Services [HHS]. I am accompanied by Dr. Judith Fradkin, who is the director of the NIDDK's extramural Division of Diabetes, Endocrinology, and Metabolic Diseases.

I am pleased to testify today regarding NIDDK's efforts to combat diabetes in American Indians, the population with the highest known rates of type 2 diabetes in the world. In addition to hitting American Indians the hardest, type 2 diabetes has become a very significant and increasing health problem nationwide. Both type 1 diabetes and type 2 diabetes are major causes of blindness, kidney failure, and cardiovascular death, and the combined economic cost of type 1 diabetes and type 2 diabetes in the United States is over $130 billion annually. Reducing the incidence of diabetes would clearly reduce suffering and benefit our society.

For the past 31 years, I have conducted research on diabetes with the Gila River Indian Community at the NIDDK's Phoenix Epidemiology and Clinical Research Branch in Arizona. This Branch is a major component of NIDDK's intramural research program, and is located in Phoenix because of its emphasis on research in American Indian populations. The Branch develops and applies epidemiologic, clinical, and genetic methods in the investigation of diabetes and its complications, which are particularly common among southwestern American Indians.

Through basic and clinical research, we can gain greater insights into the genetic and environmental factors that lead to the development of type 2 diabetes, develop effective treatments, and perhaps most importantly develop strategies and programs to prevent or delay the onset of the disease. My particular research focuses on the risk factors for type 2 diabetes and its complications [especially diabetic kidney, eye, and heart disease], obesity and its relationship to diabetes, and diagnostic criteria for diabetes.

GILA RIVER INDIAN COMMUNITY LONGITUDINAL STUDY

Most of the research of our Branch is conducted in collaboration with the members of the Gila River Indian Community [most of whom are Pima Indians] near Phoenix. Some of our programs also include other American Indians in Arizona and New Mexico. In our longitudinal population study in the Gila River Indian Community, begun in 1965, we examine community residents at regular intervals. The examinations focus on diabetes and its risk factors and complications. This study has contributed much to the world's current understanding of the causes and consequences of type 2 diabetes and its complications, for which we are all indebted to this community. The study has led to other research on obesity and physiologic problems such as insulin resistance and defects in insulin secretion that play a major role in type 2 diabetes. By carefully evaluating the relationships between plasma glucose concentrations and the specific signs of diabetes, we established criteria for diagnosing diabetes and identifying non-diabetic persons at high risk of developing diabetes. These criteria have been adopted for worldwide use. The study

also led to recognizing the importance of control of high blood glucose and high blood pressure in diabetes. These are now standard components of diabetes care throughout Indian country and the entire world.

I am happy to report that these improvements in standards of care have directly benefited members of the Gila River Indian Community. Over the last 30 years there has been a rise in the percentage of people with diabetes receiving medical treatment to control blood 2 glucose, coinciding with a fall in average blood glucose. There has also been a marked increase in the use of blood pressure medicines accompanied by a fall in average blood pressure. The sharp increase in the use of both aspirin and cholesterol lowering agents in recent years may reduce the risk for heart disease in people with diabetes. The rates of attainment of American Diabetes Association treatment goals for diabetes are better in this community than in the Nation as a whole, thanks to the diligent efforts of the tribal health program in implementing research-based standards of care.

Finally, the research has contributed to understanding the serious long-term consequences of childhood obesity and type 2 diabetes, the importance of obesity on the development of type 2 diabetes, and the concept that type 2 diabetes and its complications can be prevented or delayed by modifying or treating factors that put people at high risk. These results stimulated the development of the Diabetes Prevention Program [DPP].

THE DIABETES PREVENTION PROGRAM [DPP]

The findings of the DPP are among the most encouraging and valuable to come from diabetes research in the past decade. I would like to tell you briefly about this clinical trial. Our Branch, along with 22 university sites, participated in the DPP to examine the effects of a lifestyle-based weight-loss intervention and pharmacologic interventions on the development of type 2 diabetes in adults with pre-diabetes. These interventions were tested because our previous research findings suggested that reducing weight or improving insulin resistance might prevent type 2 diabetes. About half of the nearly 4,000 DPP participants were from minority groups. The lifestyle intervention, that included modest weight loss and increased physical activity, resulted in a dramatically reduced risk—by 58 percent—of developing type 2 diabetes. The intervention with the drug metformin reduced diabetes risk by 31 percent. The lifestyle and metformin interventions worked well in both men and women and in all ethnic groups studied, including the American Indians. This significant finding conveys an important message to American Indians and other people at high risk for type 2 diabetes: By adopting a moderate, consistent diet and exercise weight-loss program, diabetes can be prevented or delayed. The importance of translating these results into practice is paramount. The American Indian and other DPP participants continue to be followed in the DPP Outcomes Study to assess the durability of the effects of the DPP interventions on preventing type 2 diabetes and determine their impact on development of diabetes complications.

The DPP, primarily funded by the NIDDK but also with substantial support from the Indian Health Service [IHS], has had a large impact on many IHS and tribal health programs to prevent diabetes, as I will describe later. The DPP is an outstanding collaboration between NIDDK and the IHS in a research study testing ideas that came from population research and, in turn, greatly influencing and benefiting clinical practice in Indian country and throughout the world.

COMPLICATIONS OF DIABETES

Diabetes is associated with many complications that affect the eyes, kidneys, heart, feet, gums, and blood vessels. The kidney complications of diabetes often lead to heart attacks or to the need for dialysis or kidney transplantation. Poor control of blood glucose and blood pressure, long duration of diabetes, and genetic factors increase the risk of diabetes complications such as those affecting the kidneys. We recently discovered an additional treatable factor: Periodontal disease, an infection of the gums that is very common in American Indians with diabetes. It is the major cause of tooth loss, but the risks of periodontal disease extend well beyond the mouth. Periodontal disease also increases the risk of kidney disease and is associated with higher death rates from kidney disease and heart attacks in those with diabetes.

The rate of progression to kidney failure among diabetic Gila River Indian Community members who are at least 45 years old has declined since 1990, suggesting that newer treatments for diabetic kidney disease are slowing its progression. Since 1999, a similar decline in the rate of diabetic kidney failure has been seen nation-

ally in American Indians but not in other racial or ethnic groups. Unfortunately, the frequency of kidney failure is increasing among younger Gila River Indian Community members because of the increasing rate at which diabetes develops in youth; 5 percent of Community members 15 to 19 years of age now have diabetes, and many of them will develop kidney failure or die of diabetes complications by their forties or fifties.

Death rates from heart disease have doubled among Gila River Indian Community members with diabetes in recent years, while deaths attributed to diabetic kidney disease have declined. These changes are due primarily to improvements in dialysis care that have reduced deaths from kidney disease, while the risk of death from heart disease remains high. On the other hand, death rates from heart disease remained very low in non-diabetic Community members and have not changed over the past 40 years. This finding points to the importance of preventing diabetes and its kidney complications as a means of reducing the risk of heart disease.

LOOK AHEAD [ACTION FOR HEALTH IN DIABETES]

American Indians are part of a major NIDDK diabetes treatment clinical trial, called Look AHEAD [Action for Health in Diabetes], which is a multicenter randomized clinical trial examining the long-term effects of a lifestyle weight-loss intervention on the development of cardiovascular disease and other complications of diabetes. A Southwest American Indian Look AHEAD clinical center at our Branch includes participants from American Indian communities in Arizona and New Mexico.

OVERWEIGHT AND OBESITY

Because obesity is an important and modifiable risk factor for the development of type 2 diabetes, we seek to understand in more detail why some people become overweight or obese. We also conduct research on better ways of preventing or reversing these conditions. Much of this research is conducted in our inpatient clinical research unit in the Phoenix Indian Medical Center. Specifically, we are studying genetic and other causes of why some people overeat and exercise too little, because these are the major factors causing obesity, not "slow metabolism" or abnormalities of resting energy expenditure. We are also studying factors that predict which people respond best to weight-loss interventions by achieving and, more importantly, maintaining weight loss.

GENETICS RESEARCH

Most of the research I have described has had large and immediate impacts on the prevention and treatment of type 2 diabetes. To achieve even greater progress or to eliminate the disease altogether, we believe that a more fundamental understanding of its causes and biological mechanisms is needed. To this end, we have also pursued research in the genetic susceptibility factors for obesity, type 2 diabetes, and its complications, including diabetic kidney disease.

There is a large body of scientific evidence that obesity and type 2 diabetes have major genetic determinants, and there have been considerable advances in technologies to identify genes for such complex health conditions. These new methods need to be applied across various populations and individual American Indian communities, because different genes, or different variants within the same gene, may increase the risk of these conditions in different groups.

In the past year a major type 2 diabetes susceptibility gene was identified in Iceland, and it appears to be a major gene for diabetes in Whites around the world, but not, for example, in the Pimas of the Gila River Indian Community. We are testing the possibility that polymorphisms [that is, common variations in the sequence of DNA among individuals] in other genes in the same metabolic pathway increase the risk of diabetes among the Pimas. Conversely, a genetic polymorphism, that is unique to the Ojee Cree Tribe in Canada was found to greatly increase their risk of diabetes. By contrast, our previous discovery of a region on chromosome I that contains a gene or genes involved in diabetes susceptibility in the Pima Indians has been widely replicated around the world. We work with an international consortium of scientists to precisely identify this gene.

THE NATIONAL DIABETES EDUCATION PROGRAM [NDEP]

To disseminate the important findings of the DPP to people at risk for diabetes, the NDEP developed the "Small Steps, Big Rewards, Prevent Type 2 Diabetes" education campaign. The NDEP is sponsored by the NIDDK, the Centers for Disease

Control and Prevention [CDC], and over 200 partners. The campaign, which includes material tailored to American Indians, emphasizes the practical application of the DPP findings and includes lifestyle-change tools for those at risk, patient education materials for healthcare providers, web-based resources for healthcare providers and consumers, and public service announcements. In addition to educational material on diabetes prevention, the NDEP has developed culturally specific messages on the importance of controlling blood glucose levels to prevent life-threatening diabetes complications for American Indians already diagnosed with diabetes. The NIDDK is committed to continuing these types of educational efforts to disseminate the positive results of its clinical trials to benefit public health.

NIDDK–IHS PARTNERSHIPS

Mr. Chairman, I'm pleased to tell you that the NIDDK works closely with the Indian Health Service to improve the health and quality of life of American Indians. The NIDDK's extramural Division of Diabetes, Endocrinology, and Metabolic Diseases, which Dr. Fradkin heads, has worked closely with the IHS' Division of Diabetes Treatment and Prevention in the development of the "Special Diabetes Program for Indians Competitive Grant Program," which has developed a DPP-like lifestyle intervention program for American Indians diagnosed with pre-diabetes, for implementation testing at 36 tribal grantee sites. Since the awarding of the 36 grants, including one to the Gila River Indian Community, NIDDK has participated in the Steering Committee for this program. In addition, the director of the IHS' Division of Diabetes Treatment and Prevention and its National Diabetes Program, Dr. Kelly Acton, serves as a member of the statutory Diabetes Mellitus Interagency Coordinating Committee, which is chaired by the NIDDK. This committee serves an important function by coordinating activities of all Federal programs related to diabetes and its complications.

In addition, the NIDDK, IHS, CDC, Tribal Colleges and Universities, and the Tribal Leaders Diabetes Committee Joined together to develop "Diabetes-Based Science Education in Tribal Schools," which is an educational curriculum development program to enhance understanding and appreciation of diabetes, and within this framework, to increase knowledge of the biomedical sciences in Tribal elementary, middle, and high schools. One goal of the program is to enhance awareness and understanding of diabetes among students, families, community members, and teachers to prevent the disease and to help affected Tribal members better manage their diabetes. Another objective of the program is to increase the numbers of American Indians who enter the health research professions. The IHS continues to make critical personnel and financial contributions to the successful and influential prevention research program, the DPP and the DPP Outcomes Study.

CONCLUSION

Mr. Chairman and members of the committee, I hope that these few examples convey the firm commitment of the NIH and NIDDK, in partnership with our sister agencies, to combating diabetes in American Indians. The central mission of the NIH is to conduct and support biomedical research aimed at decreasing the burden of disease in the United States. In diabetes, I believe that the NIH's mission is being well served and that the future is encouraging for the ultimate control and prevention of diabetes in American Indians and all Americans. Let me conclude with a note of special thanks to the members of the U.S. Senate on behalf of the community of scientists who work in diabetes. Thank you for the continuing encouragement of biomedical research through which we hope to improve the health of all Americans.

I appreciate the opportunity to address the committee on behalf of the NIH and NIDDK and would be pleased to respond to any questions you may have.

BIOGRAPHY

Dr. William C. Knowler has worked with American Indians in the Southwestern United States for the last 31 years as a research physician with the National Institute of Diabetes and Digestive and Kidney Diseases [NIDDK]. He is chief of the Diabetes Epidemiology and Clinical Research Section of NlDDK in Phoenix, AZ, where he conducts research in type 2 diabetes, complications of diabetes, obesity, and other health concerns of American Indians. He also serves with two national diabetes clinical trials evaluating the best ways to prevent the development of type 2 diabetes and the occurrence of cardiovascular complications of the disease and in a national study of the hereditary factors in the development of diabetic kidney disease.

Dr. Knowler was born and educated in Iowa City, receiving his BA in mathematics from the University of Iowa. He then received doctoral degrees in medicine and public health from Harvard University and further clinical training in Boston before moving to the NIDDK in Arizona in 1975. He is widely recognized for his research in the causes and prevention of type 2 diabetes and its complications. His research findings have been widely implemented in clinical practice, in particular in Indian Health Service and tribal programs serving American Indians.

Dr. Knowler is widely sought as a lecturer and teacher, has published over 400 medical research articles and book chapters, and serves as a reviewer or editor for several medical journals. He is recognized as one of the world's 250 most highly cited researchers in clinical medicine and in biology and biochemistry. He has been honored for his research and its clinical applications with many awards, most notably the Kelly West Award for Epidemiology from the American Diabetes Association, the Tribal Leaders Diabetes Committee award for research in treatment and prevention of diabetes in American Indians, and the NIDDK Director's Award for national leadership in diabetes prevention.

PREPARED STATEMENT OF SAM MCCRACKEN NATIVE AMERICAN BUSINESS MANAGER, NIKE, BEAVERTON, OR

Committee Chairman Dorgan, Vice Chairman Thomas and other members of the committee on Indian Affairs, thank you for the opportunity to speak to you today in support of diabetes prevention and the overall health of Native American communities and the important role that corporate commitment can play in addressing these issues.

At Nike, diversity is celebrated. In that spirit, Nike actively supports the Native American community through a variety of initiatives, programs and grants that seek to increase physical activity of young people on Native lands to help improve their lives and aid in the prevention of prevalent health issues such as diabetes.

Like of all of you, we at Nike are very aware and concerned about the mounting diabetes epidemic among Native Americans and the high percentage of cases among Native American youth.

I am named after my great grandfather Thomas Duck a provider for the Assiniboine and my clan is the red bottom clan. Today I am the Director of Nike's Native American Business Program and a proud member of the Ft. Peck Tribes [Sioux and Assiniboine Tribes] in northeastern Montana. In 2001 the tragedy of diabetes struck my family when I lost my mother to type 2 diabetes. I am committed to forging a healthier future for all Native Americans, a future where diabetes is a thing of the past and physical fitness among youth is at an all-time high. Together, as public and private partners, I believe we can overcome anything.

The Problem

Diabetes strikes 13 percent of the Native American population. Even more concerning is the 80 percent increase of diabetes among Native American children and young adults. Complications from diabetes lead to major causes of death and health problems in Native American communities including an amputation rate that is three-to-four times higher.

Nike's Approach

Through my passion and Nike's commitment to the community we have worked with government officials and community elders in the creation of Nike's Native American community program which is a multi-tiered initiative to support and encourage physical activity on Native American lands to combat diabetes. The program has several key components that are detailed as follows.

Indian Health Service [IHS] and Nike Memorandum of Understanding

Under the leadership of Indian Health Services director, Dr. Charles Grim and Leo Nolan, Senior Policy Analyst for External Affairs for IHS, the Nike Native American community program helped forge a unique partnership with IHS, with the signing of an important Memorandum of Understanding [MOU] in November 2003. Nike and IHS signed the MOU to collaborate on a promotion of healthy lifestyles and healthy choices for all American Indian and Alaska Natives. The MOU is a voluntary collaboration between business and government that aims to dramatically increase the amount of health information available in American Indian and Alaska Native communities. The goal of the MOU is to help those communities gain a better understanding of the importance of exercise at any age, particularly for those individuals with diabetes.

The MOU supports the President of the United States' "Healthier U.S. Initiative," the Secretary of Health & Human Services' Preventative Initiative "Steps to a Healthier U.S." and the Indian Health Services' "Health Promotion/Disease Prevention Initiative."

In 2003, Dr. Grim offered this perspective on the new Indian Health Service partnership: "The mission statement of Nike shares a common basis for collaborative activities with the IHS and other Federal agencies. That basis is the improvement of the health and fitness of every American."

Continued Grim, "Overweight and obesity are the fastest-growing causes of preventable disease and death in America and are contributing factors in diabetes, heart disease, high blood pressure, stroke and poor cholesterol levels. Nearly 13 percent of the Indian population is affected by diabetes, and this campaign can help promote positive changes in the health issues associated with these and many other illnesses and diseases in American Indian communities."

"Regular physical activity contributes to better health by reducing obesity and the many chronic conditions associated with it, including increased diabetes and heart disease," said Health and Human Services Secretary Tommy G. Thompson at the time of the MOU signing in 2003. "This new partnership will serve American Indian and Alaska Native communities by expanding the information available on the importance of physical activity."

Nike stands by the words of co-founder Bill Bowerman who said that if you have a body, you are an athlete. Applying this thinking in conjunction with the goal of the MOU and through deeper understanding in working with the IHS, Nike is developing an innovative new shoe that offers increased comfort through a uniquely designed fit for the Native American foot. Nike's goal with this new design is to increase comfort among Native Americans in the hopes that it will encourage and motivate these citizens to exercise and maintain their physical fitness. The shoe is still in development and will be offered through limited distribution to qualified Native American Business partners.

Native American Incentive Program

In 2000, Nike began the Native American Incentive Program. Working closely with the diabetes program coordinators of some 116 tribal agencies, Nike provides product for their fitness promotion programs and partners with these tribes to provide mentoring and recreational events for the tribal population.

The White Earth Reservation Tribal Council, in White Earth, Minn., for example, began its Diabetes Project with one center and a total of 45 participants. With help from Nike, the program has grown to five Fitness/Wellness centers, 1130 participants, 350 participants in a 100-Mile Walk program, 275 diabetes camp participants, and 40 attendees a month in its water-aerobics classes. Ages of the participants range from 10 to 92.

Nike's U.S. Community Affairs program has also partnered with several national stakeholders and government officials. These key partners include the Indian Health Services, the Department of U.S. Health and Human Services, FirstPic, and the Boys & Girls Clubs which introduced the NikeGO on Native Lands program at six Boys & Girls Clubs sites on Indian reservations. Through this pilot program, NikeGO provides a culturally relevant physical activity curriculum, training, equipment and incentives, all designed to help Native American youth ages 8–15 discover the joy of movement and the fun of physical activity. Since 2004, NikeGO on Native Lands has expanded to include grants to 67 Boys and Girls Clubs on Indian Reservation across 20 states. Fifteen of those grants were awarded this year. Last year, Nike donated more than $1 million in product to support this program.

Listen to the Voice of the Athlete

Nike has always listened to the voice of the athlete to inspire and motivate both within its organization and within the community. Nike has applied this philosophy to the Native American community, as well.

Native American golfer Notah Begay III, a 4-time winner on the PGA Tour, has played a central role in helping Nike educate Native Americans about the benefits of exercise. In fact, Mr. Begay's efforts off the golf course specifically focus on preventing the continued spread of diabetes in the Native American community. In 2004, Mr. Begay joined Dr. Grim and me at the annual session of the National Congress of American Indians. Mr. Begay was instrumental in kicking off the first ever National Native American Health and Fitness day.

In May 2006, Nike announced a 5-year partnership with the Iroquois National Lacrosse organization, providing the Iroquois Nationals with footwear and apparel, including team uniforms, warm-ups and casual sports apparel. Nike designed the new uniforms to pay homage to the Iroquois Nation's rich history in the sport. They

debuted last summer at the 2006 World Lacrosse Championships in London, Ontario, Canada.

The Iroquois Nationals today are the only indigenous nation worldwide participating in international sports competition, meaning that the Iroquois Nationals compete for the world title alongside the United States, Canada and other qualifying countries at each World Lacrosse Championship.

The partnership developed out of Nike's commitment to working with the Native American community and as another means of inspiring physical activity among Native American youth.

"We are proud to have Nike support us at this exciting time in our history," said Chief Oren Lyons of the Iroquois Nationals at the time of the partnership announcement. "The Iroquois Nationals Program has had a significant impact on the youth of our confederacy providing an international showcase for our players and our culture. With Nike's support, we will be able to continue to send our best athletes to compete and promote lacrosse to the world, sharing the game and our history."

Historically, the game of lacrosse may be one of the oldest team sports in the world, and the roots of modern day lacrosse can be traced back to the Iroquois. For over 500 years, lacrosse has played an integral part of the Iroquois Confederacy well being. As lacrosse continues to grow in popularity around the world, Iroquois Nation leaders are committed to promote its heritage and drive broader participation in healthy physical activity among its people.

Late in 2006, the Native American Basketball Invitational [NABI], the largest all Native American basketball tournament in North America, announced Diana Taurasi as its first Honorary Commissioner through its partnership with Nike.

"Nike has been a sponsor of NABI since the tournament's inception in 2003. Our national tournament, organized for the sole purpose of creating college scholarship opportunities for Native American high school athletes, will feature 80 tribal teams from the United States and Canada. Nike's willingness to stand beside our efforts to make NAB[successful has been instrumental in our rapid growth" said GinaMarie Scarpa-Mabry, co-founder of NABI, at the time of the announcement.

Since its inception, NABI has created numerous opportunities for Native American students to receive college athletic scholarships by showcasing high school athletes from Native American communities from throughout North America in one location. NABI's goal for the July 2007 tournament is to become a NCAA certified summer event, which will make NABI the first all Native American tournament certified by the NCAA.

Conclusion

The mission of the Nike brand is to bring inspiration and innovation to every athlete in the world. Also, one of the company's celebrated maxims is to "Do the Right Thing." On behalf of Nike, I believe that our program designed to provide diabetes prevention and overall improved health to Native American communities is true to both its mission and key maxim.

A future rid of diabetes within the Native American community can only be realized if we inspire and instill healthy lifestyles in our youth today. Nike and its partners in the corporate, nonprofit and government arenas have an opportunity to shape these kids' lives now, and help them form positive habits and attitudes that last a lifetime.

I am very fortunate to have the opportunity to work for a company that is thriving to make a difference, but we will only be as successful as the partnerships we forge along the way. Your leadership on this issue is critical, and we look forward working with you.

TESTIMONY OF NEAL D. BARNARD, MD

PRESIDENT, PHYSICIANS COMMITTEE FOR RESPONSIBLE MEDICINE

BEFORE THE SENATE INDIAN AFFAIRS COMMITTEE

OVERSIGHT HEARING ON DIABETES IN INDIAN COUNTRY

FEBRUARY 08, 2007

I would like to thank Chairman Dorgan and Vice Chairman Thomas for affording me the opportunity to submit testimony to the Committee on behalf of the Physicians Committee for Responsible Medicine (PCRM).

My name is Neal D. Barnard, MD, and I am president of PCRM and an adjunct associate professor of medicine at the George Washington University School of Medicine and Health Sciences, a Life Member of the American Medical Association, and a member of the American Diabetes Association. Founded in 1985, PCRM is a nonprofit organization that promotes preventive medicine through good nutrition, conducts clinical research, and encourages ethics and effectiveness in medical research.

I thank the committee for holding this oversight hearing on "Diabetes in Indian Country" and for the Committee's longstanding interest in the dire health problems posed by diabetes to Native Americans and the U.S. population generally. As this Committee knows all too well, diabetes rates have climbed rapidly in recent years, and more than 20

million Americans now have the disease, which is linked to kidney failure, blindness, and cardiovascular disease.

PCRM recently met with staff from this Committee about the growing prevalence of diabetes among Native Americans and ways to address this epidemic. In addition, we had a conference call last fall with Dr. Kelly Acton, head of the Indian Health Service's Diabetes program, and Dr. Acton's staff. We discussed the groundbreaking results from PCRM's recent clinical trial assessing the value of diet changes on type 2 diabetes, and the value these findings can have for Native Americans suffering from type 2 diabetes and for the Indian Health Services' Special Diabetes program. I would like to share these results with this Committee as well.

In 2006, PCRM completed a randomized, controlled trial in cooperation with the George Washington University School of Medicine and the University of Toronto. The trial was funded by the National Institutes of Health's National Institute of Diabetes and Digestive and Kidney Diseases, as well as the Diabetes Action Research and Education Foundation. The results of the study were published in the August 2006 issue of *Diabetes Care*, a journal published by the American Diabetes Association.

The study found that a low-fat vegan diet is a remarkably effective tool to treat and reverse the complications of diabetes. The study compared individuals with type 2 diabetes who were randomly assigned to either a low-fat vegan diet or to a more typical diabetes diet following ADA guidelines. For control purposes, neither group was allowed to make any changes in their current exercise routine, and both were provided with

guidance and support, which included ongoing classes, nutrition education, and cooking demonstrations.

Both diets were associated with clinical improvements, as indicated by reductions in A1c (a marker of blood sugar control over an extended period of time), body weight, plasma lipid concentrations, and urinary albumin excretion. However, among medication-stable participants, changes in A1c, weight, BMI (body mass index), waist circumference, total cholesterol, and LDL cholesterol were significantly greater in the low-fat vegan group. In fact, the magnitude of A1c reduction in medication-stable vegan group participants compared favorably with that observed in single-agent therapy with oral diabetes drugs and was a significantly greater reduction than that seen in the ADA diet group.

A low-fat, plant-based diet positively influences nutrient intake and body composition in several ways that may, in turn, improve insulin sensitivity. First, because this diet is low in fat and high in fiber, calories are decreased while food volume is increased. Research suggests that fat interferes with insulin's ability to move glucose into the cell. Therefore, following a low-fat diet increases insulin sensitivity and is most likely responsible for the improvement in glucose control. Evidence that fat intake contributes to diabetes comes also from numerous other studies, for example a study comparing Pima Indians in the United States, Pima Indians in Mexico, and non-Pima Mexicans. This study measured levels of activity and dietary components. Fat in the diet appeared autonomously responsible for a prevalence of diabetes in US Pima Indians that

was five times higher than that of the Pima Indians in Mexico who ate a traditional plant-oriented diet.

Changing eating behavior is vital to solving the growing incidence of type 2 diabetes in the Native American population, and researchers have long lamented the difficulties in adhering to diets for diabetes. Our study showed that the acceptance of a plant-based diet was far easier than a diet requiring portion restrictions and measuring requirements.

The ADA diet focuses on limiting the portion sizes of carbohydrate foods. For overweight individuals, the ADA recommends a 500 calorie deficit per day, though all foods fit into this model of restriction and measuring. Individuals who exceed their prescribed energy intake limits with overly large portions, even sometimes, can, as a result, easily exceed recommended limits on calories and fat.

In contrast, the vegan diet includes no animal fat, so variations in food quantity are less likely to result in substantial increases in saturated fat intake. Because the vegan diet simply focuses on plant foods, it is also easier to understand than regimens that require limiting unhealthy items through portioning and measuring. Most of the study's participants, as well as most people with diabetes generally, can benefit from weight loss. It was presumably easier for participants to change the food shopping list and eat as much as they want, rather than restricting themselves to small amounts of less-than-healthful foods.

Page 5

Changing eating habits may be facilitated with diet that is natural, healthy, and variable. A vegan diet consists of endless varieties of fruits, vegetables, whole grains, beans, and the many foods that are made from them. These healthful foods are traditional to many cultures, including Native American cultures.

Current federal food policy unintentionally increases the risk of diabetes. Diets are easily distorted by when commodity surpluses are sent to reservations, a policy that continues today under the Food Distribution Program on Indian Reservations. Federal policies currently encourage poor eating habits that predicate and exacerbate chronic diseases, including diabetes.

There is a direct link between diet and type 2 diabetes. Scientific studies show that that those who eat a diet high in animal-derived foods have a significantly higher risk for type 2 diabetes and other health problems including heart disease, risk of overweight and obesity, and cancer. Those who eat a diet rich in plant-based foods are at significantly lower risk.

Given these facts, the Committee should closely examine food policy from a health perspective. The Indian Health Service should make it as easy as possible to eat a low-fat, vegan diet. Accomplishing this shift toward healthier food policy requires two basic steps. First, the IHS food policy should cease dumping commodity surpluses, especially meat and cheese, on Indian reservations. Dumping high-fat animal products is contributing to the diabetes problem on reservations, illustrated by the study comparing Pima Indians on US reservations with the much healthier populations of Pima Indians

Page 6

living in Mexico. Second, if policy is to continue to promote certain foods by making them cheap and available, it should make cheap and available the foods that are healthful for everyone: fruits, vegetables, whole grains, and legumes.

In conclusion, a person diagnosed with type 2 diabetes may be facing kidney failure, blindness, amputations, and a shortened lifespan, not to mention the use of medications to control the disease and concomitant conditions. Altering eating behavior is a simple way to help prevent and control diabetes. Our study and many others indicate that an optimal diet for diabetes prevention and management is a healthful diet built from plant foods. It is my hope that this study will spark interest in altering food policies to ensure better health.

Thank you for your time and consideration. We have been honored to work with the Committee and look forward to continuing to do so on these critical health issues.

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SEARHC health beat
January/February 2007
SouthEast Alaska Regional Health Consortium
a bi-monthly newsletter from your partner in health

Lifestyle Balance Program rejuvenates Carol Feller Brady's health

Carol Feller Brady has been a health advocate for years, but it took joining SEARHC's Lifestyle Balance Program last January to rejuvenate her own health.

"I don't know where the energy comes from," said Brady, who turns 80 on Jan. 1.

Joining the Lifestyle Balance Program —part of a national campaign for Alaska Natives and American Indians with prediabetes —showed Brady the importance of good nutrition and physical activity. She said the program gave her enough endurance to dance with several groups during Celebration 2006 and to keep up with two grandchildren during a trip to New Jersey and Washington, D.C., that involved a lot of walking.

"I've never felt better. It got me feeling just right," said Brady, a writer whose autobiography *"Through the Storm, Towards the Sun"* recently was reprinted.

Brady drank a lot and smoked when she was younger, but not anymore. She has Grave's disease (a thyroid disease) and partial blindness. Recently she found out she has prediabetes, a condition that comes before diabetes where blood sugar levels are higher than normal but not at diabetes levels.

Making a few simple lifestyle changes can help people with prediabetes delay or avoid getting diabetes. The Lifestyle Balance Program holds two 16-week classes a year to teach Natives with prediabetes to be more physically active and to eat healthier food. Rocky Plotnick and Sarah Paddock lead the Lifestyle Balance Program in Juneau, and Brady still consults with them even though her class ended in May. SEARHC dietitian Lisa Nicklow refined Brady's diet and Brady walks 30 minutes a day to stay active.

"I wake up in the morning and I feel good, my stomach feels good," Brady said.

Brady has a long association with wellness and SEARHC. She was Wrangell's community health representative and later Wrangell's representative on the SEARHC Board of Directors. Now in Juneau, Brady is involved in several SEARHC health promotion events and this summer she helped rekindle the Eagles vs. Ravens Wellness Challenge. On top of everything else, she's very involved with ANS Camp 2.

"There are too many people not taking care of themselves," Brady said. *"What you eat is important. Prevention is even more important. I'm a big-time advocate of prevention now. It's how I improved my health."*

An important message from the President

Over the years much has been said about patient rights. But little has been said about patient responsibility.

About 70 cents of every dollar spent on health care in the United States goes toward illnesses and chronic health conditions that could be prevented. Roughly half of all deaths are due to preventable illnesses.

That's why SEARHC encourages people to commit to small lifestyle changes — such as quitting tobacco, eating a healthy diet and getting 30 minutes of physical activity each day — that can mean major improvements to your health. Your best health care provider is yourself.

At SEARHC, our health promotion staff has been working with local businesses to create employee wellness programs, which help employees feel better and be more productive workers while saving the businesses and employees significant costs on health care. We're also working with local school districts to create school wellness plans, so our youth learn healthy habits that will last them a lifetime.

SEARHC endorses these workplace and school wellness programs because they give people the tools to be healthy. As we enter a new year, I encourage you to use these tools to take charge of your own wellness. This simple effort will return a lifetime of benefits.

Ken Brewer

Alternate health resources help SEARHC provide improved services

It's a myth that the funds supplied by the Indian Health Service cover all of the costs of Native health care. That's why patients are asked if they qualify for alternative health resources when they visit SEARHC facilities.

Some SEARHC patients may have private insurance from work or their spouse. Others may qualify for federal and state assistance programs such as Denali KidCare, veteran status, Medicaid, Medicare or workman's compensation. If a patient is eligible for one of these programs, but hasn't applied, SEARHC can help with the application process.

SEARHC reinvests the money it receives from alternate health resources into providing more services or new infrastructure, such as the MRI machine in Sitka, a pediatrician in Juneau, specialty clinics and new clinics where older ones needed improvement. If a pediatric patient gets hurt and needs a medevac to Anchorage, SEARHC can save several thousands of dollars by billing Denali KidCare for the flight.

SEARHC reinvests the money it receives from alternate health resources into providing more services or new infrastructure ...

"If we can bring that money back into the system it means we can use the money for other services," Patient Access Manager Bill Anderson said. *"It can mean continuing programs or adding to them. In some cases, because of alternate health resources we've been able to expand services."*

Patients with questions about alternate health resources can call their local clinics, Crystal Mitchell in Sitka at 966-8307 or Charlene Sykes in Juneau at 364-4465. ✣

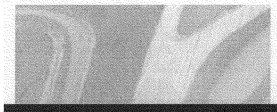
Privacy regulations allow patients to opt out of directory

Whenever a patient checks into Mt. Edgecumbe Hospital, federal privacy regulations — called the Health Insurance Portability and Accountability Act (HIPAA) — allow the patient to opt out of the hospital's directory. Each patient is asked if he or she wants to be included in the directory when admitted to the hospital.

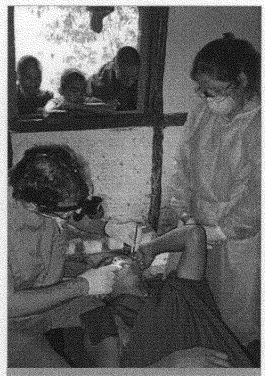
If you, as the patient, decide to be included in the directory it means your family and friends who call the hospital and ask for you will be transferred to your room, your family and friends visiting the hospital will be directed to your floor, your family and friends who call and ask will be told your general condition (stable, guarded, critical), and your family and friends call and ask they will be told you are a patient in the hospital.

However, if you decide to opt out of the directory your family and friends who call or visit the hospital will be told you are not listed as a patient. It also means any flowers and/or cards sent to you will not be delivered.

For family and friends of patients who opt out of the directory, please do not be upset if you call Mt. Edgecumbe Hospital and are told an individual isn't listed as a patient. Mt. Edgecumbe Hospital staff are complying with federal privacy regulations because that individual decided not to be included in the directory. ✣



Dental mission provides services to Himalayan villages



Chuck Hazen inspects a Buddhist monk teeth while Linda Moonan assists and other monks watch and wait for their turn.

Four current or former SEARHC employees recently spent three weeks providing dental services to remote villages in the Himalayan Mountains of India.

The group included SEARHC Director of Dental Services Dr. Tom Bornstein, DDS, of Juneau; Dr. Chuck Hazen, DDS, of Haines; dental assistant Linda Moonan of Haines and recently retired George Figdor of Haines, who last worked for SEARHC in Corporate Communications. They traveled in October and November as part of a medical team with the nonprofit Himalayan Health Exchange.

Working conditions were primitive for the group, and Dr. Bornstein said they worked by headlight, *"without the benefit of electricity, running water, suction, x-rays or adjustable chairs."* But he also said *"the trip was a wonderful and wonder-filled experience."*

The group treated up to 50 patients a day, often working until darkness forced them to stop. In addition to treating problem teeth, the group distributed toothbrushes and taught the villagers flossing, using embroidery thread because no dental floss was available.

"The dental surgery was tough enough, but without the hard work and effort on the part of Linda and George we never would have been able to complete the work we faced," Dr. Hazen said. *"They had to set up, clean up and keep rotating our instruments through the 'momo pot' (a Tibetan dumpling cooker used as a sterilizer) so we could keep up with the patients. Their efforts were extraordinary."*

While modern conveniences hadn't arrived in most of the villages, the modern sugar-laden diet had. Dr. Hazen said many of the Himalayans were *"really hooked on sweets"* and the average 10-year-old needed at least one molar removed, a rare occurrence in the U.S.

"Every tooth we took out was abscessed," Moonan said. *"These people were suffering, with no other options. I felt like we were doing really good things."*

"Almost all of the patients we saw had acute dental pain," Dr. Bornstein said. *"Some had walked for hours from surrounding villages to see us. The patients, translators and villagers were so gracious, appreciative and welcoming that the difficult working conditions and almost impassable roads seemed like minor issues."* ✣

Community Wellness Advocate program wins state award

The Community Wellness Advocate program — a cooperative effort of SEARHC Health Promotion and the University of Alaska Southeast-Sitka Campus — in December was honored with the Barbara Berger Award for excellence in health education and health promotion in Alaska. The Alaska Health Education Consortium presented the award.

The CWA program is modeled after the state's Community Health Aide program that trains village health workers, but the CWA program is geared more toward disease prevention and health behavior change than clinical work. Since the program is taught using distance delivery, students are able to remain in their home communities except for two trips to Sitka that last one week each.

"The Community Wellness Advocate program is an ideal example of what excellence in health education and health promotion in Alaska is all about," said Stephanie Allen, President of the Alaska Health Education Consortium and Executive Director of Alaska Health Fair, Inc. *"The CWA program trains community health educators and health promoters who then are able to implement programs in their communities. It has proven to be very successful addressing areas like cardiovascular health, nutrition, tobacco use and injury prevention. It addresses a missing element and fills that need."*

The CWA program began as a regional program in Southeast Alaska in 1998 that offered four three-credit classes over one academic year, but it expanded to a statewide program in 2001. Theprogram now offers a 30-credit certificate that can be applied to an associate degree in health sciences. In addition to the 12-credit core CWA program, there also are two specialty tracks for community nutrition and injury prevention. Currently under development is a third specialty track focused on health promotion with elders.

Community Wellness Advocates (L - R) former students Litia Garrison, Janice Huls, and instructors Kathy O'Gara, Doug Osborne, and Lisa Sadleir-Hart.

"The Community Wellness Advocate training program was the brainchild of Tlingit elder and longtime health promoter Phil Moreno, who passed away this spring," said SEARHC Community and Employee Wellness Coordinator Lisa Sadleir-Hart, who also serves as the CWA Program Coordinator. *"He had the vision of a community health promoter in every Alaskan community who would work alongside Community Health Aides and Community Family Service Workers, and they would provide services focused on the prevention of disease and promotion of community assets that were health-enhancing."*

For more information on the CWA program, contact Lisa Sadleir-Hart at 966-8735 or look on the Web at http://www.searhc.org/cwa/. A list of previous winners of the Barbara Berger Award can be found on the Web at http://www.ahecalaska.org/marketing.html. ✣

Around the Consortium

Prince of Wales Island

◆ SEARHC and the University of Alaska Fairbanks Cooperative Extension Service will be starting a new youth first responder team on POW that's modeled after the Sitka Youth First Responders. In January, a local coordinator will be hired who will organize the program and recruit youth ages 14-18 interested in earning their Emergency Trauma Technician certificates and serving the community as first responders. For information, contact Bill Winslow at 966-8844 or wwill@searhc.org.

◆ Alicia Roberts Medical Center will be offering "A New You: Health For Every Body," a new program designed to promote healthy eating and active living in all people, regardless of size. The program features four four-hour sessions from 10 a.m. to 2 p.m. on Saturdays starting Jan. 27. Registration closes on Jan. 18 and the class size is limited. Participants are asked to pay $20 for a book and supplies, but $10 will be refunded on successful completion of the course. For information, contact June May at 755-4959 or Brenda Isaacs at 755-4983.

Juneau

SEARHC Juneau Health Promotion is teaming up with Bartlett Regional Hospital, the State of Alaska Heart Disease and Stroke Prevention program, KTOO-FM, the University of Alaska Fairbanks Cooperative Extension Service and the SouthEast Regional Resource Center (SERRC-Alaska's Educational Resource Center) to work on a cardiovascular health project targeting women and children of Gruening Park Subdivision. The project kicked off in November with a Thanksgiving feast. SEARHC will provide educational material and training over the next year to help the Gruening Park community take small steps to a healthier life.

Klukwan/Juneau/Klawock

The SEARHC Steps to a Healthier SE Alaska program recently awarded three $15,000 grants to Klukwan School, Klawock School and Yaakoosgé Daakahídi Alternative High School in Juneau so they can make improvements to school nutrition and physical activity programs. Yaakoosgé used its grant to hire an additional PE teacher and offer seven new PE classes and a new school store menu. Klukwan and Klawock both will use their grants to introduce the SPARK PE program, with Klukwan adding a lifelong learning program and Klawock partnering with Alicia Roberts Medical Center to offer a health and wellness fair. Another round of grants will be awarded in the near future. For information on how your school district can apply, contact Tia Patterson at 966-8629.

Regionwide

◆ January is Cervical Health Awareness Month and the SEARHC Breast and Cervical Health Program would like to remind women they should have a Pap test and pelvic exam at least once every year starting by age 21. They also should be screened for the Human Papillomavirus (HPV). For information, contact your local SEARHC clinic or call 1-800-833-8782 (toll-free in Alaska).

◆ February is American Heart Month and the SEARHC WISEWOMAN will be hosting several activities during February about women's cardiovascular health. Each of the SEARHC WISEWOMAN locations will celebrate National Wear Red Day on Feb. 2, and other heart health events will take place during the month. For information, contact your local SEARHC clinic or call 1-800-833-8782 (toll-free in Alaska).

◆ January is New Year's resolution time and many Southeast Alaska residents will choose to quit tobacco in 2007. The SEARHC Breath For Life Tobacco Quit Program can help you quit by offering one-on-one counseling and free nicotine replacement therapy products (such as patches and gum/lozenges). For information, call the SEARHC Breath For Life program during business hours at 1-888-966-8875 (toll-free in Alaska).

Patient Tip: Small steps lead to better health

This is the time of year for New Year's resolutions, and one of the most common resolutions is improving your health.

Taking just a few small steps can make a big difference in better health. Here are 10 to get you started for the new year. Take these and other small steps and you will have more energy and you'll feel better.

- **Walk instead of driving whenever you can.**
- **Avoid food portions larger than your fist.**
- **Grill, steam or bake your food instead of frying.**
- **Make time in your day for physical activity.**
- **Exercise to a video if the weather is bad.**
- **Don't eat late at night.**
- **Use brown rice or whole-wheat pasta.**
- **Try a green salad instead of French fries.**
- **Take your dog on longer walks.**
- **Drink water or diet soda instead of regular soda.**

A longer list of small steps to better health can be found at **http://smallstep.gov/sm_steps/sm_steps_index.html.**

Find it @ www.searhc.org

The SEARHC Foundation changes its name

The organization that helps SEARHC beneficiaries with unmet medical needs has a new name, the Healing Hand Foundation.

The mission of the Healing Hand Foundation is the same as it was when it was known as The SEARHC Foundation, providing small grants for durable medical goods, pharmaceuticals and patient travel that might not be covered by other resources.

The new name will help eliminate confusion with the SouthEast Alaska Regional Health Consortium (SEARHC). SEARHC remains a strong supporter of the Healing Hand Foundation, but the two organizations are separate and have different boards.

For more information about the Foundation, go to **www.searhc.org/common/pages/foundation/.**

HealthBeat is produced every two months by the SEARHC Corporate Communications department. To be added or removed from our mailing list, or to offer comments or questions, please contact the Corporate Communications office at 907-463-6666.

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SEARHC health beat
May/June 2006
SouthEast Alaska Regional Health Consortium
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Lifestyle changes help Cliff Johnson come to terms with diabetes

Four years ago, Cliff Johnson thought he was a goner. He thought he was dying.

Johnson was overweight, his body was bloated and even getting up to use the bathroom was painful because of seven infections and an intestinal blockage. Then Johnson was diagnosed with diabetes and that may have saved his life.

"I thought I was going to go. I really was in bad shape," Johnson said. *"I thought I was slowly dying."*

When he was diagnosed with diabetes, Johnson joined a monthly support group hosted by the SEARHC Diabetes Program and volunteer facilitator, Emma Widmark, a retired home economist. Johnson started making changes to his lifestyle, with the support of his wife, Debbie. He also got a lot of help from Dr. Nandi Than, registered nurse Nicole Hill, registered dietitian Tiffany Andres and others involved in the SEARHC Juneau Medical Center's Diabetes Program.

Johnson cut out the sweets, limited his intake of starches and made other dietary changes. He also started walking a lot and exercising at a gym. Johnson, who is 5-foot-7 1/2, has lost 84 pounds over the past four years (from 290 to 206). Johnson said he went from taking three diabetes pills a day to just one. He said Dr. Than even suggested no medication, since the lifestyle changes seem to have his diabetes under control, but Johnson's not sure if he's ready.

"He has such a good outlook," Andres said. *"It shows that attitude can go a long way in helping someone live a healthy life with diabetes. He's really encouraging for a lot of the others in the group."*

Johnson said he couldn't have made the changes without the support of his wife. He said the other members in the diabetes support group and the workers with the SEARHC Diabetes Program were a big help, too.

"There's such a positive attitude here, I like it," Johnson said. *"They kept making me feel good about myself, and because of the positive feedback that made me keep coming back. Lately, I feel like a 35-year-old man. I can do things I didn't do before. I don't feel 66."* ✣

An important message from the President

As many of you know, April 1 marked the first anniversary of SEARHC's decision to make all 14 of its campuses tobacco-free.

April 1 of last year was a historic date for SEARHC, because it showed our commitment to better health care. By asking staff members, patients and visitors not to use tobacco at our facilities, we created an improved place for healing. Now it's a year later and we already can see the positive effects of this tobacco-free policy.

Tobacco use is not healthy, and we can advise everyone to quit smoking or chewing for his or her own good health. But we also need to walk our talk as a health care organization. If we are going to promote healthy preventive lifestyles among our beneficiaries, then that means restricting tobacco use at our facilities.

As always, SEARHC has taken the lead in promoting preventive lifestyles in Southeast Alaska. The Alaska Native Tribal Health Consortium already has announced that it will follow our lead by declaring the Alaska Native Medical Center tobacco-free starting with the Great American Smokeout in November. Other tribal health organizations plan to follow suit.

SEARHC's tobacco-free campuses are a good start toward creating healthier communities.

Ken Brewer

SEARHC celebrates the first year of its tobacco-free campuses

Ethel Lund, SEARHC president emeritus cuts the cake as Naya Bagby patiently waits.

Patients and employees celebrated the first anniversary of SEARHC's tobacco-free campuses with a gathering April 6 in Sitka. SEARHC decided to take all of its health care facilities tobacco-free starting on April 1, 2005.

"Welcome to our tobacco-free campuses, this is plural. All 14 campuses of SEARHC went tobacco-free a year ago," said Ken Brewer, SEARHC president. *"It's important to recognize that we needed to walk our talk. If we wanted to call ourselves a health care organization, if we wanted credibility, then our campuses needed to be tobacco-free."*

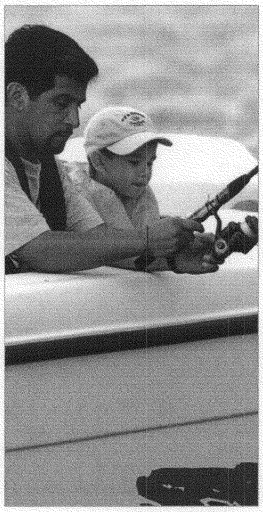
"This makes me feel good," said Ethel Lund, SEARHC president emeritus. *"We tried this several years ago. But now the time was right."*

The tobacco-free designation is for all SEARHC buildings and grounds, including the parking lots and roads running through the campuses. Tobacco use is one of the leading causes of cancer and heart disease, so moving smoke off campus helps promote good health.

"Nothing could have made me prouder than when we decided to go tobacco-free," said Jan Hill, SEARHC's board chairman. *"All of us have been impacted by cancer. This was not something we had to debate. When I got back to Haines after we decided to go tobacco-free, several people asked me how SEARHC is going to pull this off. But now there are a lot of people following SEARHC's lead."*

Several of SEARHC's Community Health Services campuses actually went tobacco-free on Oct. 1, 2004, with all of SEARHC's remaining campuses going tobacco-free six months later. The Alaska Native Tribal Health Consortium plans to follow SEARHC's lead by making the Alaska Native Medical Center in Anchorage a tobacco-free campus starting in November. ✣

Marine safety tips for the Alaska summer



Summer in Southeast Alaska is the perfect time to get out on the water for a nice boat ride. However, it doesn't take much to change an enjoyable boat ride into a disaster. About 18 to 19 Alaskans die each year in boating accidents, one of the highest boating fatality rates in the nation based on the number of registered boats.

"Most of Alaska's boating accidents are predictable and preventable," SEARHC Community Injury Prevention Coordinator Crystal Duncan said. *"By taking the time to learn some basic safety rules, Alaskans can increase their chances of surviving a boat accident."*

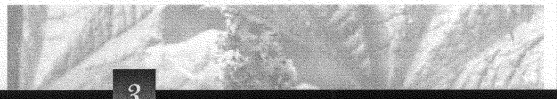
Here are a few safety tips for the Southeast Alaska summer:

- Make sure everybody on your boat wears a personal flotation device (PFD) that properly fits. All children age 13 and younger are required by state law to wear a PFD.
- Never overload your boat. Know what the weight capacity is for your boat and make sure the number of passengers and gear doesn't exceed the weight limit. This especially is important in small open skiffs, which frequently capsize when overloaded.
- Make sure you know how to wear your survival suit, and practice putting it on so you know how to do it in case of an accident.
- Never go boating if you are under the influence of alcohol or drugs.
- Check the weather prior to leaving and be alert for changing conditions. The National Weather Service Local Marine Forecast phone number is **1-907-747-6011** and the Web site is **http://www.arh.noaa.gov/**.
- Always file a float plan before you go out on the water. Make sure someone knows your destination, the route you plan to take and when you plan to return. Also, make sure they have a description of your boat, know how many people are onboard and have a description of your survival gear.
- Carry an emergency kit that includes a handheld VHF radio, first aid supplies, fire starter, flares, snacks (including fresh water), bug repellent, sunscreen, a whistle or horn, fire extinguisher, flashlight, toolbox, spare boat parts, etc.
- Inspect and make sure your boat is in working condition before leaving shore. Make sure your boat is properly ventilated to avoid carbon monoxide poisoning.
- The temperature always is colder over water than land, so make sure you have enough layers of clothing to stay warm.

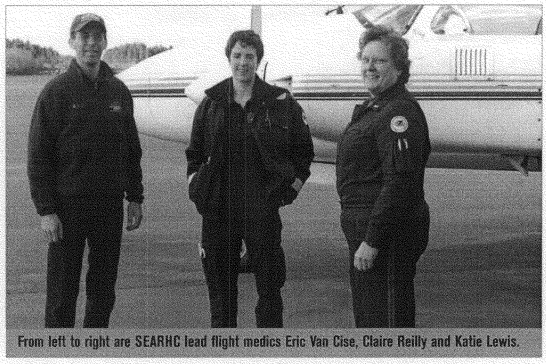
For more information on boating safety, contact the SEARHC Community Injury Prevention Program at **1-907-966-8866** or check out these Web sites:

- Alaska Office of Boating Safety - **http://www.alaskaboatingsafety.org**
- Alaska Marine Safety Education Association - **http://amsea.org**
- U.S. Coast Guard Boating Safety Program for Alaska - **http://www.uscg.mil/d17/d17rbs/d17rbs.htm** ✣

Please note:
This article replaces the normal section "Patient Tip" for this issue only.



SEARHC Air Medical Service celebrates 10th anniversary



From left to right are SEARHC lead flight medics Eric Van Cise, Claire Reilly and Katie Lewis.

Arranging a medevac was a complicated process a decade ago, with more time being needed for coordinating planes, pilots and medics than for the flight itself.

Things are different now, as the SEARHC Air Medical Service celebrated its 10th anniversary with a small gathering March 28 in Sitka. The service flew 1,578 medevac missions from March 23, 1996, to March 23, 2006, the actual 10th anniversary date.

A twin-engine Piper Navajo Chieftain is leased from Harris Aircraft Services exclusively for flying SEARHC medevac missions. A single-engine deHavilland Beaver on floats is available from Harris to fly missions to villages requiring water landings. The medevac team is based in Sitka, with four lead flight medics and six intermittant escorts who make sure there are at least two people on call from 6 a.m. to 6 p.m., the prime times for medevacs The Sitka staffing means local EMTs and health aides can stay in their own communities in case their rural clinics need them.

"The faster response time gets the patient to the definitive care a lot sooner," said Mike Motti, SEARHC's director of emergency medical services and the lead flight medic on the SEARHC Air Medical Service's first flight, which went to Kake. *"That's the purpose of a medevac, the need to get the patient to a higher level of care as soon as possible."*

Besides getting patients to Mt. Edgecumbe Hospital in Sitka or the Alaska Native Medical Center in Anchorage, the SEARHC Air Medical Service is known for the Beanie Babies it gives medevacked patients. Katie Lewis, a lead flight medic/EMS instructor for SEARHC and the EMS escort on that first flight, started the practice when she saw someone give a 65-year-old woman an angel Beanie Baby before her flight. Lewis arranged donations of the toys to pass out to other patients. The vast majority of medevacked patients are adults, but almost all of them are glad to have a Beanie Baby for company.

"I have the best job in Alaska," Lewis said. *"Half my job is helping people learn how to help people, and the other half of the time I get to help people myself."*

Greg Raschick is a teacher at Mt. Edgecumbe High School who has been a lead flight medic for all 10 years of the service. Even though he only works part-time for SEARHC, he was honored for having flown more medevac missions (590) than any other medic.

"Most of the stuff has been pretty routine. What's been the most notable is the scenery and the people I get to meet, and to see the different communities," Raschick said. *"I've been able to see the evolution of safety, with CAPSTONE and better navigation. It used to be there was no organized system for medevacs, and this provides a system for consistent delivery of care to the patient."* ✣

NOTICE

In response to the federal law that pertains to the protection of patient health information, SEARHC developed a Notice of Privacy Practices. This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. SEARHC staff began distributing this Notice in April 2003. Each patient was given this Notice on their first visit to any SEARHC facility since April 13, 2003. This Notice is available from any SEARHC facility, on our website (www.searhc.org) or by calling the Privacy Officer at 364-4466.

Around the Consortium

Klawock/Haines

The Alicia Roberts Medical Center in Klawock and the Haines Health Center each will be undergoing an accreditation survey May 8-11 by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). This is the first accreditation survey for the two SEARHC clinics, although an AAAHC reviewer performed a consultative or "mock" survey of Alicia Roberts in October so clinic workers could learn about the process.

Haines/Klukwan/Craig

SEARHC WISEWOMAN and health promotion staff members have already started planting for the community gardens. The three community gardens enable local residents to grow fresh vegetables for healthy eating. For more information on the Haines and Klukwan gardens, contact Jennifer Potratz of WISEWOMAN at 766-6366 or Mandy Ramsey of health promotion at 766-6317. In Craig, contact June May of health promotion at 755-4959.

Kake

The SEARHC Breast and Cervical Health Program will be taking the mobile mammography van to Kake on April 27 to May 1, Angoon on May 5-9, Haines on May 16-26 and Yakutat on June 14-19. There also will be late summer-early fall visits to Hoonah, Haines and Klawock, with a schedule released in July. The SEARHC Breast and Cervical Health Program provides uninsured, underinsured and income-eligible Southeast Alaska women, ages 18-64, with free annual clinical breast exams and women ages 40-64 with yearly mammograms. To schedule an appointment, contact your local clinic. For information, contact Roz DeRensis at 1-888-388-8782.

Sitka

In May, Tlingit master carver Wayne Price of Haines begins carving the Project Kootéeyaa wellbriety totem pole at SEARHC's Sitka campus. The Project Kootéeyaa's mission is to promote and demonstrate the natural partnership between health and Alaska cultures through the embodiment of wellness, community collaboration and traditional values. SEARHC expects to raise the pole this fall on the grounds of its substance abuse treatment programs in Sitka. For information, contact Project Kootéeyaa chairwoman Roberta Kitka at 966-8603.

The Sitka Diabetes and Lifestyle Balance programs will be hosting a six-week series of Saturday walks from May 6 to June 10 as the national America on the Move program. The walks are open to people on SEARHC's diabetes registry, those taking part in the Lifestyle Balance program for pre-diabetes patients and their family members. The walks start at 10:30 a.m. each Saturday, and transportation is available at 10 a.m. at the Lifestyle Balance program office on walk days. Call the office for a schedule of walk locations. For information, contact SEARHC diabetes grant coordinator Toby Brooks at 966-8915.

Consortium-wide

The SEARHC Breast and Cervical Health Program will be taking the mobile mammography van to Kake on April 27 to May 1, Angoon on May 5-9, Haines on May 16-26 and Yakutat on June 14-19. There also will be late summer-early fall visits to Hoonah, Haines and Klawock, with a schedule released in July. The SEARHC Breast and Cervical Health Program provides uninsured, underinsured and income-eligible Southeast Alaska women, ages 18-64, with free annual clinical breast exams and women ages 40-64 with yearly mammograms. To schedule an appointment, contact your local clinic. For information, contact Roz DeRensis at 1-888-388-8782.

One of SEARHC's first employees passes on

Ida T. James, a longtime nursing assistant for SEARHC, died March 30, 2006, in Juneau at the age of 91.

Ida was born June 12, 1914, on the Navajo reservation in Cove, Ariz. She trained at St. John's Hospital in Santa Monica, Calif. In 1946 she interviewed with the BIA for a job in Alaska and that started her 48-year career as a nursing assistant. She moved to Juneau in 1951 to work at the public health hospital's TB ward at night. Her tenure at the Juneau Native Clinic began in 1964, back when the clinic was located at St. Ann's Hospital, and continued after the clinic became the SEARHC Juneau Medical Center. Ida retired in 1995 at the age of 81.

Ida's claim to fame was that her husband, Fenton D. James, was the first employee hired by SEARHC. But Ida also was one of the first employees hired by SEARHC and she was the first nursing assistant hired.

She is survived by her husband, who lives in Juneau; a sister, Mable Williams of Sitka; two brothers, Danny (Ann) Miller of Albuquerque, N.M., and Frankie Miller of Arizona; two stepdaughters, Gloria (James) Jack of Juneau and Carolyn (Anthony) McIntyre of Sitka; five grandchildren, Kenneth and Renee Southerland, Mark (Alia) Granda of Juneau, George John and Delmer McIntyre of Sitka; seven great-grandchildren; and numerous nephews and nieces in Juneau, Sitka and Albuquerque. ✣

SEARHC
SouthEast Alaska Regional Health Consortium
Your Partner in Health

SEARHC Administration Building
3245 Hospital Dr., Juneau, AK 99801

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HealthBeat is produced every two months by the SEARHC Corporate Communications department. To be added or removed from our mailing list, or to offer comments or questions, please contact the Corporate Communications office at 907-463-6666.

Find it at www.searhc.org

SEARHC five-year strategic plan

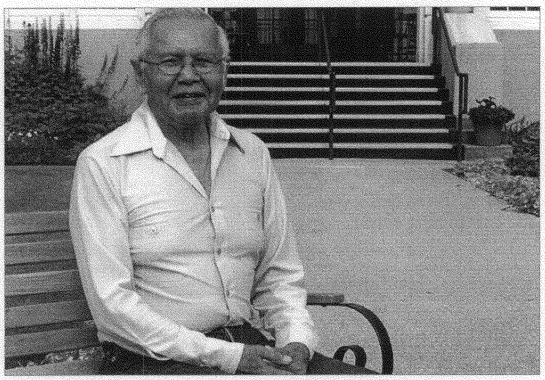
Want to know where your tribal health consortium is headed and how it plans to get there? Then check out **www.searhc.org**, for a link to the SEARHC Five-Year Strategic Plan 2006-2010.

This plan contains many of the ideas and concerns tribal members shared at the Southeast Caucus of the 2005 Tribal Health Summit. The plan lists 17 main strategic goals for the consortium. It also looks at the health care services provided at each of the SEARHC facilities and the projected health needs for each community.

Go to our home page and look for the strategic plan link under the **"Hot Topics"** section. That will open an introduction page, and the complete plan can be seen by clicking on **"Part 1 – SEARHC Strategic Plan" and "Part 2 – SEARHC Community Profiles."**

SEARHC health beat
September/October 2006
SouthEast Alaska Regional Health Consortium
a bi-monthly newsletter from your partner in health

Al Gordon uses diet, walking to take charge of his diabetes



When Al Gordon found out about 12 years ago that he had Type 2 diabetes, he decided he wanted to take control of the disease.

Before his diagnosis, Gordon said he *"ate anything, snacks and sweets, a lot of sugar."* Now 83, Gordon followed the advice of his doctors, nurses and nutritionists and took charge of his diabetes and his health.

"It changed my life," Gordon said during an interview at his room in the Alaska Pioneer's Home in Sitka. *"I benefited more from listening. I don't feel sorry for myself. I'm not looking for pity. I just deal with it. I'm a fighter and I won't give up."*

Once he found out he had diabetes, Gordon changed his diet. Now he keeps cabbage and celery stalks in his refrigerator and he eats those when watches TV. The former cook, cannery worker and World War II U.S. Army Corpsman (medic) also drinks a lot more water.

But his biggest lifestyle change was walking. Gordon makes sure he walks at least 20 minutes a day, and he frequently walks across the O'Connell Bridge to Mt. Edgecumbe Hospital. Gordon is just 5-foot-3, and he said he was 170 pounds when he found out he had diabetes but weighs 149 now.

"I walk a lot," Gordon said. *"I walk anyway, and I'd rather walk than ride a car. I'm lucky I walk. I love to walk."*

"I think the biggest thing is he exercises every day," said Jennifer Henderson, a Certified Diabetes Educator at SEARHC who works with Gordon. *"He walks across the bridge all the time. He has a healthy weight. He really takes care of himself. He is very cheerful and he has a good attitude."*

Gordon's better diet and walking have helped him control his glucose levels so well that he doesn't have to take any medication for his diabetes.

"He isn't on medication, and being able to do that for so many years is quite an accomplishment," Henderson said.

About the only place Gordon has seen a major impact from diabetes is in his vision, which he said is failing.

"The leading cause of blindness in the United States is diabetes," said Dr. Pam Steffes of the SEARHC eye clinic. *"While there is no cure for vision loss due to diabetes, the efforts patients make to control their blood sugar and blood pressure can help them preserve useful vision. Sometimes it's vision changes that motivate patients to be screened for diabetes."*

continued on page 2

An important message from the President

There's an old saying that "an ounce of prevention is worth a pound of cure."

This saying rings true for health care, as prevention and early detection of health problems can be the most effective ways to deal with disease. Many health problems are preventable through healthy lifestyle choices. For example, quitting tobacco helps people avoid many heart and lung problems or several types of cancers. Pre-diabetics can prevent Type 2 diabetes with better nutrition and more physical activity.

SEARHC is committed to providing prevention and wellness programs that help people learn how to take care of the small health issues that grow into major medical problems. These programs are closely linked to clinical care, so our providers and educators can better help people take control of their own health.

As an example, SEARHC's WISEWOMAN program is nationally recognized for the cardiovascular health education and screening it provides women in the region. We also provide innovative programs in tobacco cessation, breast and cervical health, diabetes prevention, injury prevention and community nutrition, among others. These programs are your programs and they are a vital part of SEARHC's strategic plan to provide you with better health care.

Ken Brewer

continued from page 1

One reason Gordon was so motivated to take charge of his diabetes was because of what happened to a couple of his friends. They found out they had diabetes about the same time he did, but Gordon said his friends didn't control their diets and they lost their feet to diabetes complications.

"When my friends lost their feet, they said, "Now I can eat anything,'" Gordon said. *"But that's not so. You still can die of a heart attack."*

Gordon has nine children, eight grandchildren and 21 great-grandchildren, and he's talked to all of them about diabetes and he said it's seemed to help. They're all active and working, and one of his daughters became a registered nurse. Gordon also had some advice for anybody who's just been diagnosed with diabetes.

"Listen to what the doctors and all the nurses and dieticians tell you and do it, even if it's hard," Gordon said. *"We have all the help we need to control our diabetes. The doctors, CNAs, dieticians and kitchen workers, they make sure I don't get sweets and they take care of me. Diabetes doesn't kill you. It's a lack of following the rules that will kill you."* ✣

EARTH Study offices close

The SEARHC EARTH Study has ended its recruitment phase and moved into the data-tracking stage.

EARTH — Education And Research Towards Health — is a national health and wellness study funded by the National Cancer Institute and designed to see how diet, physical activity, and other lifestyle and cultural factors affect chronic diseases, such as diabetes and cancer, in Alaska Natives and American Indians. Nearly 3,800 Natives in three Alaska regions signed up for EARTH Study, including about 900 from Southeast.

The Alaska Native Tribal Health Consortium (ANTHC) in Anchorage will take over the data-tracking component of the study for the three participating Alaska regions, which closed their local EARTH Study offices.

"We want to make sure people know we're not letting them go and there is follow-up," SEARHC EARTH Study coordinator Maybelle Filler said. *"We also want to thank everyone for supporting the project."*

Filler said SEARHC will continue to be involved with its participants, even after ANTHC takes over the data-tracking component. ANTHC will update the communities that invited the EARTH Study to recruit, and make presentations to the SEARHC Board of Directors about the findings. About once a year ANTHC will ask participants to complete a brief questionnaire about their own health, tobacco use and lifestyle changes.

Dr. Cathie Schumacher of ANTHC **(1-907-729-3664)** will coordinate the rest of the EARTH Study, while Diana Redwood **(1-866-896-0482)** will handle most of the follow-up questionnaires. ✣

Edible seaweeds are a traditional way to enhance the diet

For thousand of years, Alaska Natives have gone to sea to find food. But the ocean provides more than fish and marine mammals for the diet. It also provides edible seaweeds, which can be used for seasonings, snacks, main and side dishes.

"The health benefit is undeniable," said Janai Meyer, who is a Ketchikan-based health promotion worker and community nutritionist for SEARHC. *"You have a complete activity. You have the nutrition aspect. You have a built-in physical activity when you spend two hours walking the beach gathering seaweed. And you've got the spirituality benefit because you're out on the beach."*

Meyer and several other SEARHC health educators in June participated in the week-long *"Seaweeds and Environmental Education"* seminar, sponsored by the Organized Village of Kasaan and featuring professors from the University of Alaska Fairbanks Marine Advisory Program. The edible seaweeds part of the program taught health educators and tribal environmental workers how to identify the many varieties of edible seaweeds in Southeast Alaska and also showed them how to responsibly harvest, dry and use the seaweeds.

"The main focus was to create an awareness of the many useful varieties of seaweed, and also how to use them in an education piece," said June May, a Community Wellness Advocate at the SEARHC Alicia Roberts Medical Center in Klawock.

(L) Dolly Garza teaches a class about edible seaweeds during the "Seaweeds and Environmental Education" seminar while June May of SEARHC takes notes.

The edible seaweeds class was taught by Dolly Garza of Ketchikan, a professor of fisheries for UAF and a Haida-Tlingit. Garza is author of *"Common Edible Seaweeds of the Gulf of Alaska,"* the course's textbook and field guide. Garza's book is $10 from the Alaska Sea Grant Bookstore at *http://seagrant.uaf.edu/bookstore/pubs/SG-ED-46.html.*

There are three main groups of edible seaweeds in Southeast Alaska, **"color-coded"** as green, brown and red seaweeds, Meyer said. Within these three main groups are dozens of varieties.

Some seaweeds change color and texture when they dry. So harvesters look at the holdfast, stipe, fronds, midrib and other unique characteristics when they identify seaweeds.

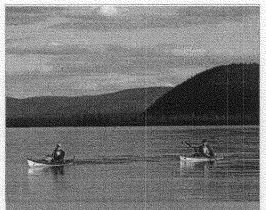
"There are no fatal seaweeds, but there are a couple that may give you an upset stomach," Meyer said.

"There are seven edible seaweeds common to Southeast Alaska that Dolly focuses on in the book," May said. Most people harvest only one or two varieties, Meyer said. Each type of seaweed has a unique taste and nutritional value, which adds variety to the menu.

May and Meyer wanted to remind people about mindful harvest. Federal subsistence laws restrict seaweed harvests in the Juneau and Ketchikan areas (which are considered urban), but personal-use harvesting is allowed just about anywhere else in Southeast. Some types of seaweeds take a long time to reproduce so it's best to always leave the holdfast, stipe and part of the frond behind.

"Seaweed and kelp help regulate the ocean's temperature," May said. *"Some seaweeds provide shelter for smaller sea creatures, so you don't want to overharvest the area where you're gathering."* ✣

Program coordinator races kayak to raise $1,500 for Sitka Youth First Responders



(L) Bill Winslow of Sitka, and (R) Dr. Michael Faughey-Scraggs of York, England

Bill Winslow was worried about his fundraiser when he accidentally sliced his hand the night before the start of the Yukon River Quest.

Winslow, the program coordinator for the SEARHC-sponsored Sitka Youth First Responders emergency rescue team, had entered what's billed as the longest annual canoe/kayak race in the world to raise money to buy equipment for the program. And now he couldn't stop the bleeding in his left thumb and middle finger.

After trying several styles of bandages, Winslow still wasn't able to keep his wound from reopening. But he decided he still could do the 460-mile race in late June from Whitehorse, Yukon Territory, to Dawson City, Yukon. Three days later, Winslow finished in a tie with Dr. Michael Faughey-Scraggs of York, England, for 55th place overall (out of a record field of 74 teams and individuals) and 12th in the solo kayak division. Winslow and Faughey-Scraggs both had an overall time of 76 hours, 51 minutes, 19 seconds.

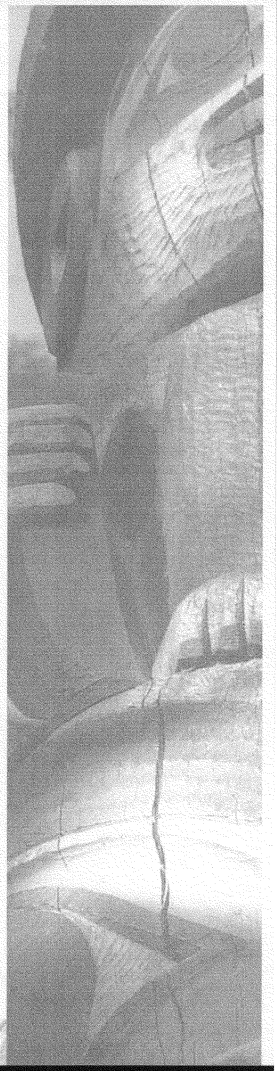
Winslow was slowed during the race because he had to make frequent bandage changes. Then a previously operated-on shoulder became sore.

"This was actually a good thing, because if these things hadn't happened the timing would have been off and I wouldn't have met up with Mike Faughey-Scraggs," said Winslow, who raised more than $1,500 and still has donations trickling in a month after the race.

On the second day of the race, Winslow caught up to Faughey-Scraggs, who was ready to quit. The two kayakers decided to team up and help each other finish. Dr. Faughey-Scraggs is an orthopedic surgeon and he was paddling the race to raise money for his hospital back in England.

"I finished it, despite wanting to give up halfway through. My shoulder was killing me, but Dr. Faughey-Scraggs showed me a different way to paddle that wasn't as hard on my shoulder," Winslow said. *"I didn't want to let the kids down. It is amazing what we can do when we are determined and surround ourselves with people that support us."*

The money raised by Winslow will provide equipment and cover other expenses for the Sitka Youth First Responders. Even though the race is over, Winslow said people still can contribute to the program by contacting him at **966-8844** or by e-mail at **wwill@searhc.org.**



Around the Consortium

Klawock/Craig

Brenda Isaacs, the Community Wellness Advocate for Klawock, is working with several local tribal and community groups to train a youth canoe team so it can take part in the 2007 Inter-Tribal Canoe Journey gathering of the tribes in British Columbia and Washington.

Helping with the team are Mary Kennedy, the AmeriCorps volunteer for the Klawock Cooperative Association; MaryJane Snook of the City of Klawock Boys and Girls Club; and Dennis Nickerson of the Craig Community Association.

Isaacs said the team's goal is "to build community capacity to reduce juvenile delinquency and prevent alcohol and drug abuse in Klawock through cultural revival." The team is using a canoe that was carved by a Seattle alternative high school under the direction of Haida carver Bobby Peele. The team members are carving their own paddles and learning the traditions of the canoe. "We're reviving the canoe," Isaacs said.

The team plans to do a short journey in late August or early September from Klawock to Craig and then out to Clam Island for a night of camping, Isaacs said. She said future journeys will be to Sarkaar, where she hopes an archeologist will be able to teach the young pullers about the history of the old Tlingit fish camp located about 25 miles north of Klawock.

The team already has an invitation to the 2007 Inter-Tribal Canoe Journey, which is sponsored by the Muckleshoot Tribe of Auburn, Wash. It takes place in late July and early August as teams travel toward Seattle along four major coastal routes in British Columbia and Washington.

Haines

Jane Weagant has been hired as a tobacco health educator at the Haines Health Center. She will provide cessation counseling and nicotine replacement therapy, and she also will work on community education about secondhand smoke.

Kake/Sitka

The Kake Healing Heart Team – Frank Hughes, Loretta Gregory and Charlotte Davis – helped SEARHC host the quarterly meeting in July for the Healthy Native Communities Fellowship, a national program sponsored by the Indian Health Service National Health Promotion Initiative. The weeklong retreat at Sitka's Harrigan Centennial Hall featured small wellness teams from 15 communities around the country.

Most of the community wellness teams featured participants from different groups within each community. On the Kake Healing Heart Team, Hughes works for the SEARHC Community Family Services program, Gregory is the SEARHC field office coordinator and Davis is an AmeriCorps volunteer for RurAL CAP (the Rural Alaska Community Action Program). The different teams help each other come up with ways to make healthy changes within their communities.

Angoon

Michelle Kelly, FNP, is the new mid-level provider at the Angoon Medical Clinic.

Douglas/Juneau

The SEARHC Juneau Medical Center is partnering with the Douglas Indian Association to provide free blood tests for lead poisoning to SEARHC beneficiaries and their immediate families. The Douglas Indian Association received two grants from the Environmental Protection Agency, one to test homes for lead and one to test local Native beneficiaries for blood poisoning. For details, contact Douglas Indian Association environmental technician Scott Sloane at 364-3567.

Sloane will provide SEARHC beneficiaries with a form that they will fill out and take with them to the Juneau Medical Center laboratory to get their free blood test. John Perry, the JMC laboratory manager, said the test takes about 10 minutes for the blood-draw and it takes about a week to get the results back from Seattle. The results then will be forwarded to the SEARHC beneficiary's primary care physician and Douglas Indian Association.

Sitka

Mt. Edgecumbe Hospital has added three new providers to its primary care staff. Dr. Suzzanne Blake, M.D., will practice family medicine. Her husband, Terry Blake, is a Physician Assistant. Kathryn Kahler is a Family Nurse Practitioner (FNP).

"With additional staff, we plan to improve access to primary care services, with a special focus on urgent care access and appointments in internal medicine and family medicine specialists," said Dr. Susan Carlson, M.D., the medical director for Mt. Edgecumbe Hospital.

Consortium-wide

The late summer/fall mobile mammography schedule has been announced by the SEARHC Breast and Cervical Health Program. The itinerary is tentative, so double-check the correct dates and times with the local clinics.

The mobile mammography van will be in:

- Haines on Aug. 31 through Sept. 13;
- Skagway on Sept. 18-20;
- Klawock on Sept. 27 through Oct. 10;
- Craig on Oct. 11-13; and
- Metlakatla on Oct. 19-24.

To schedule an appointment, call your local clinic. For information on the mobile mammography program, contact Roz DeRensis at 1-888-388-8782 (toll-free in Alaska). ✣

Correction

An insert page in the July/August 2006 issue of HealthBeat had ommissions in the SEARHC Foundation's donor list for the years 2004 and 2005. Those ommissions for 2004 and 2005 appear here. We apologize for the error.

2004

IN MEMORY OF	GIVEN BY
Albert Paddy	Julia Heinz, MD
Alice Bjorge	Christina Krause
Amy Nelson	Emma Olsen
Anfesia Shapsnikoff	William & Lois Hope
Annie Eldemar	Cheryl Eldemar Weissmuller
Annie Eldemar	William & Lois Hope
Auxenia Mereulief Hope	Norman Sarabia
Barbara Sarabia Casey	Barbara Holian
Bernard Kosher	Nels Lawson
Bessie Jimmie	Edna & Ray Paddock
Bill Breedlove	Edna & Ray Paddock
Bill Patch	Alma Cook
Bruce Cook Sr.	Cyril George
Buddy George	Tom Farquhar
Charlene Farquhar	Melinda Arne
Charlie Jackson, Sr	Marlene Johnson
Charlotte "Lottie" Underwood	Julia Heinz, MD
Chief Johnson	Lily Lidot
Christina Gloria	Robert Mayoue
Christine Mayoue	Jan Hill
Daniel Folletti	Julia Heinz, MD
Daniel Folletti	Lucy W Harrell
Dorothy Quinn	Tom Bornstein
Ed Hubbard	Norman Sarabia
Ed Sarabia, Sr	Corrine Brown
Edith Swan	Mollie Szydlowski
Edrie E Hooten	Genevieve Marvin
Edward W Carle	Myrina Garza
Elizabeth Gardner	Paula Peterson
Ellen Webster	A Millie Stevens
Elwood Thomas	Clara E Garcia
Emily Cool	Tom Farquhar
Esther Farquhar	Harold L Wheaton
Esther Wheaton	Jeanette Ness
Frank Fernandez	Frank Wright, Jr
Frank Wright, Sr	Verna Henninger
George "Chunky" Henniger	Edna Paddock
Harriett Roberts	Ellie Dunlap
Harriett Roberts	A Millie Stevens
Helen Thomas	Jackie Tyson
Helen Todd	Yukie Adams
Henry L Adams, Jr	Wilma R Asnin
James I Asnin	Susan Christianson
James Walton	Deloresa Cadiente
Jennie Marie Rodenberg	Jan Hill
Jim Hill	Robert & Wilma Bennett
Joe Bennett, Sr	Cheryl Eldemar Weissmuller
John Eldemar	Jeanette Strickland
John Eldemar	Robert B Sanborn
John W Hanson Sr	Mitch Spencer
Juanita F Sanborn 'Williams'	A Millie Stevens
Judy Colcord	Mary E Fitzgibbon
Laverne Rousuuu	Susan Christianson
Lawrence H Smith	Wilma R Asnin
Leonard Stark	Deborah & Ken White
Martha Ehlers Claser	Del & Marlene Cesar
Martha Kasko	Tom Bornstein
Mary Cesar	Val Ferguson
Mary Cesar	
Mary Ellis Ferguson	

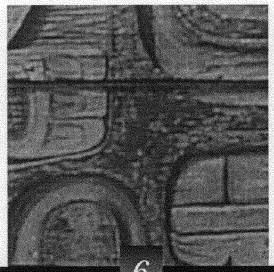
IN HONOR OF	GIVEN BY
Bill Thomas	A Millie Stevens
Erma Lawrence	Constance Griffith
Ethel Lund	Richard Wein
Florence E Brown	Ole & Mary Taug
Gabriel Knight	Sherry Aitken

2004 (continued)

IN HONOR OF	GIVEN BY
Herman Kitka	Richard Wein
Louise D Charles	Janice Rosenthal
Roald Helgesen	Connie Simpson
Sarah Williams	David & Eloise Whitehorn
Theresa M Ballinger	Adria M Ballinger
Vaden Family	Richard Wein

2005

IN MEMORY OF	GIVEN BY
Alice Hillman	Ernest Hillman
All Who Gave Their Lives 9/11	Destiny Sargeant
Angela Bradley	Tonya Moy
Art Willman	Edna & Ray Paddock
Austin Brown	Edna & Ray Paddock
Bruce Cook	Alma Cook
Charles Jack, Sr	Loretta Wallin
Corrine Leach	Douglas W Luna
Dewey Skan, Sr	Dewey Skan, Jr
Dora Jack Williams	Loretta Wallin
Edward Carle	Leonard & Ernestine Kato
Elizabeth Westman	Barbara Searls
Elsie Gunyah	Lizabeth McNeil
Erica Johnson	Karen Orazio
Fenton Dennis, Jr	Roseanne R Coe
Flora Feller	Theresa Brown
George Longenbaugh	Leslie Longenbaugh
George Williams, Jr	Loretta Wallin
George Williams, Sr	Loretta Wallin
Harriett Roberts	Ellie Dunlap
Hazel Bell	Anna Peele
Jack & Emily Cool	Clara E Garcia
Jim Hill & Daniel Folletti	Jan Hill
Joe Bennett	Gayle Wood
Joe Peterson	Ramos Family
John Eldemar	Dianne & Ray Smith
John Eldemar, Annie Eldemar	Katherine Eldemar
Juan and Mary Sarabia	Bill & Clarissa Hudson
Juanita Sanborn "Williams"	Robert B Sanborn
Judy George	Mary & Willard Jones
Judy George	Toni Mallott
Leah Beck	Ethel Lund
Linda Hellerich	Susan Hennon
Lorraine Kunz	Kay & Lowell Barrick
Marie James	Dorothy Owen
Mary McClinton	Cynthia Orie
Mildred Stark	Susan Christianson



Patient Tip: Sports Injury Prevention

Playing sports can be good for you. Sports help people lose weight, stay healthy, relieve stress and they give people an outlet for competition.

But playing sports has risks and people can get injured. This list of eight tips will help you reduce your injury risk from sports, allowing you to enjoy the physical activity.

- Have a medical examination before starting any exercise routine.
- Warm up before beginning activity – at least 3-5 minutes of walking or running and a round of stretching for each of the muscle groups (hold each stretch at least 30 seconds).
- Use protective equipment appropriate to the sport and position played (mouth guard, knee pads, well-fitting athletic shoes, helmet, etc.).
- Vary your exercise routine from day to day (for example, go for a run on Monday, bike on Tuesday and swim on Thursday). Also, when just starting out stick to three times a week until endurance and strength are increased.
- It is important to balance exercise by targeting cardiovascular endurance with strength conditioning and with flexibility.
- Always cool down properly, which includes a round of stretching.
- Please be aware of the different causes for injury – lack of strength, posture defects, poor flexibility, excessive body fat, poor endurance, poor warm-up, uneven playing surface, faulty equipment, bad weather, poor rules, bad lighting or poor refereeing
- Most important, be safe, be cautious, and have fun when you're out playing sports.

Visit these two Web sites for other useful sports-related injury-prevention information:

www.arthritis.org/resources/SIP/sports.asp

http://sportsmedicine.about.com/od/findyourinjurybysport/

Alaska Native Medical Center to go tobacco-free on Nov. 16

The Alaska Native Medical Center and two Anchorage-based Native health organizations that share facilities will follow SEARHC's lead when they go tobacco-free on Nov. 16, the date of the Great American Smokeout.

ANMC, the Alaska Native Tribal Health Consortium (ANTHC) and Southcentral Foundation (SCF) share a health campus on Tudor Road and have other facilities in Anchorage. All three organizations will use the same policy. The policy calls for a tobacco-free environment — both indoors and out of doors — and it applies to all staff, patients and visitors to any of the facilities. According to a press release from ANTHC and SCF, the new policy is modeled after the tobacco-free campus policy adopted by SEARHC in March 2005.

"The goal is to cut the rate of tobacco use among Alaska Native people, who have the highest rate of tobacco use of all ethnic groups in the United States — and cancer is the leading cause of death among Alaska Native people," said Paul Sherry, the CEO of ANTHC. A former smoker, Sherry said he knows how difficult it is to quit, *"but it can be done."*

The Indian Health Service also adopted a national tobacco-free policy for its facilities that takes effect later this summer, said Chris Mandregan, the Director of the Alaska Area Office of the IHS. *"There is no safe tobacco product, so the only logical action is to promote a campus that is tobacco-free,"* Mandregan said.

In Alaska, 25 percent of all adults are regular smokers. For Alaska Natives, 44 percent of adults smoke. Tobacco use has been linked to many types of cancer, cardiovascular disease, respiratory problems and many other health issues. About one in five of all deaths in the United States can be linked to tobacco use.

"There is no safe tobacco product, so the only logical action is to promote a campus that is tobacco-free ..."

"Tobacco has devastating effects on health, so it's a good policy to have a tobacco-free campus," said Andrea Thomas, SEARHC's Tobacco Grant Manager. *"I think SEARHC really set the precedent for Native health consortiums going tobacco-free. I think it sends a clear message. Tobacco use is the leading cause of preventable death in Alaska and we can save lives if we all work together to reduce its use among adults and youth."* ✣

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SouthEast Alaska Regional Health Consortium
Your Partner in Health

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Find it at www.searhc.org

"Gumboot Determination" wins national book award

"Gumboot Determination: The History of the SouthEast Alaska Regional Health Consortium" has been selected as a winner in the 27th annual American Book Awards. The 240-page illustrated book documents Alaska Native health care in the region and was written by Juneau author Peter Metcalfe.

The American Book Awards were established by the Before Columbus Foundation in 1978 as a way to acknowledge the excellence and multicultural diversity in American writing. About a dozen writers are recognized each year for their novels, poetry, collected essays or histories. The 2006 awards will be presented during a late-September ceremony in Oakland, Calif.

"Gumboot Determination" was a project for The SEARHC Foundation, which used the book as a fundraiser to help the foundation fill unmet medical needs for SEARHC beneficiaries.

U.S. SENATE COMMITTEE ON INDIAN AFFAIRS, February 8, 2007

Testimony of James D. Brosseau, MD of Altru Health System, Grand Forks, ND

I. Type 2 Diabetes is a serious problem in American Indians and Alaska Natives

- Overall, American Indians and Alaska Natives (AIANs) have the highest age-adjusted prevalence (percent) of diabetes among all US racial and ethnic groups.
- 17% of all AIAN adults have diabetes (IHS 2003 outpatient data).
- The prevalence of diabetes varies among different tribes and regions, but is increasing in all IHS Areas.
- AIAN mortality from diabetes is three times higher than the general US population.
- Even though type 2 diabetes used to be rare in individuals under the age of 40, the prevalence (percent) of diabetes in AIANs under the age of 35 increased by 133% between 1990 to 2004.
- AIANs suffer higher rates of the complications of diabetes, especially if the onset of their diabetes occurred in their youth.

II. The Indian Health Service (IHS) has created a network to address this growing epidemic of diabetes in AIANs

- In the 1970s, the IHS established its diabetes program as a network of local programs, IHS Area diabetes consultants, and a national office in Albuquerque NM.
- In the 1980s, the IHS established its Standards of Care for Diabetes, and began gathering data to measure rates of diabetes over time and the quality of diabetes care.
- In the 1990s, the IHS documented improvements in diabetes care, implemented updated standards of care and developed a number of clinical resources for diabetes care.

III. Since 1998, the Special Diabetes Program for Indians (SDPI) provided funding to the Indian Health Service for additional diabetes prevention and treatment activities in American Indian and Alaska Native communities

- In 1997, the Balanced Budget Act established the SDPI as a grant program for the prevention and treatment of diabetes in AIANs at a funding level of $30 million/year for 5 years.

- After extensive tribal consultation, the IHS distributed the SDPI funding to over 300 IHS, tribal and urban American Indian and Alaska Native health programs according to a specific formula that included funding for communities with a higher burden of diabetes, communities with a large number of people at risk, and for both large and small programs
- Congress increased the amount of SDPI funding to $100 million/year in 2001, and then again increased it to $150 million/year from 2004 – 2008
- The most recent increase in funding included direction from Congress to improve data and evaluation of this program, and implementation of diabetes and cardiovascular disease prevention demonstration projects

IV. The prevention and treatment of diabetes in AIAN communities has improved greatly over the past decade due to the SDPI funding

- The IHS provided data in its 2000 and 2004 SDPI Interim Reports to Congress that demonstrated significant increases in the availability of diabetes prevention and treatment services for AIANs
- Improvements in diabetes care outcomes include:
  - Significant reduction in the average level of Hemoglobin A1C results in AIANs with diabetes (indicating better diabetes control)
  - Improvements in blood pressure control
  - Improvements in prevention of kidney failure in people with diabetes, including reduction in the percent of people with protein in their urine, and increases in use of recommended medications such as ACE inhibitors
  - Increased use of aspirin to prevent cardiovascular disease
  - Reductions in lower extremity amputation rates
- New prevention activities implemented in communities include:
  - Increased physical activity programs in schools
  - Wellness programs, including fitness centers
  - Community awareness and prevention activities and programs
  - Increased nutrition education, including improved school menus and increased availability of healthy foods
  - Health fairs, classes, and competitive events such as fun runs
  - Traditional activities to promote healthy behaviors and lifestyle changes

V. Reauthorization of the SDPI will help IHS, tribal and urban American Indian and Alaska Native programs continue to build a strong foundation for a diabetes-free future for American Indians and Alaska Natives.

- The current funding has established almost 400 new diabetes treatment and prevention programs in American Indian and Alaska Native communities
- The current funding has provided critical resources, supplies, staff, educational tools, newer medications and therapies, basic clinical exams, screening, culturally appropriate diabetes education materials and resources to prevent complications such as eye, heart, foot and kidney disease
- The current funding has provided new primary prevention activities such as physical fitness programs, medical nutrition therapy, wellness activities, prevention programs targeting children and youth
- The current funding has resulted in many positive outcomes, such as improvements in control of blood glucose, blood pressure, LDL cholesterol and triglycerides
- The experiences of these programs have provided many important lessons learned that will benefit other minority communities and all people affected by diabetes
- The SDPI offers hope for prevention since there is still no cure for diabetes
- The SDPI is needed since obesity rates are skyrocketing in younger and younger people
- We don't want history to repeat itself: Funding increases for alcohol treatment resulted in decreases in mortality rates, but when the funding was discontinued, mortality rates increased again. Please don't let the same thing happen with diabetes
- The federal government has a trust responsibility to provide for the health and welfare of American Indians and Alaska Natives, and must continue to address the epidemic of diabetes in American Indian and Alaska Native communities
- The loss of funding after FY 2008 would be devastating and even more costly because all the gains made with current funding will be lost, and the costs of increased diabetes and its complications will increase again for individuals, families, communities, health programs and staff, and the nation

VI. Disparities continue to exist in AIAN communities.

- Risk factors for cardiovascular diseases are more prevalent and are increasing at a faster rate among AIANs than among the rest of the American population.
- Heart disease and strokes occur with greater frequency among AIANs than among the general US population.
- Health care expenditures for AIANs lag behind those for the rest of the nation.
- Newer and more beneficial medications and treatments are often not available for AIANs served by the IHS until long after they have become standard in non-Native communities.
    - Examples: analog insulins, incretin drugs, insulin pumps, surgical procedures such as gastric bypass
- Contract services for off-reservation care are inadequate to meet the needs of people living on reservations and served by the IHS.

VII. There are many success stories to show that screening, early intervention, and education in prevention pays off.

- On the Spirit Lake reservation in North Dakota prevention and healthier lifestyles are being taught in the schools through a program funded by the NIH.
- The Three Affiliated Tribes of western North Dakota have declared War on Diabetes and have developed a multifaceted program of primary and secondary prevention.
- Group medical visits for pre-diabetic patients are proving to be highly successful in preventing the transition to diabetes in those at highest risk.
- In Montana and Wyoming the State Departments of Health and Human Services have identified "opportunities for improvement" in the delivery of services to diabetic Indian populations and are far along in implementing these programs.
- State health departments in many States are leading the way in developing programs more suited to the special cultural needs of AIAN populations.

Diabetes by the Numbers

1.5 million: The number of new cases of diabetes diagnosed in 2005

20.8 million: The number of Americans who have diabetes

41 million: The number of American who have "pre-diabetes"

33%: The percentage of children born in 2000 who will develop diabetes sometimes in their lives

50%: The percentage of minority children born in 2000 who will develop diabetes sometime in their lives

$2,560: The average annual health care costs for a person without diabetes

$13,243: The average annual health care costs for a person with diabetes

$132 billion: The cost of diabetes to the United States in 2002

1: The world ranking of AI/ANs for the prevalence of diabetes

15.1%: The number of adult American Indians and Alaska Natives with diabetes

106%: The percentage increase from 1990 to 2001 of AI/AN adolescents aged 15-19 years

133%: The percentage increase in American Indians and Alaska Natives under age 35 years from 1990 to 2004

4.3 times higher: The mortality rate for AIAN compared to the general US population

Additional Testimony of James D. Brosseau, MD, MPH
Altru Health System, Grand Forks, North Dakota
Presented before the U.S. Senate Committee on Indian Affairs, February 8, 2007

The Indian Health Service (IHS) and the Special Diabetes Program for Indians (SDPI) have accomplished great things for many people in Indian Country.

- Some of the apparent increase in diabetes prevalence over the past decade is explained by the fact that the criteria for diagnosis have changed. Before 1999 diabetes was defined by a fasting blood sugar of >140 mg/dl. In 1999 the cut-off was dropped to >125 mg/dl. This has resulted in the inclusion of thousands of new cases of diabetes which would not have met the criteria a decade ago.
- Thus the success of SDPI cannot be judged on the basis of increasing prevalence rates, especially after so short a time.
- Progress in diabetes control and prevention takes time.
- Funding for the SDPI should be sustained and increased.
- The IHS needs to be encouraged and funded at a level that will allow them to continue to improve the quality of their work.

I have attached the testimonies of 9 people from Indian reservations in North Dakota who have been directly affected by diabetes. The IHS is their lifeline for care. As their stories show, they appreciate the services they receive, but they are frustrated by a number of things:

- long waits to see the doctor, then short visits
- prescriptions instead of understanding
- scarce service after office hours and on weekends
- manpower shortages, resulting in different providers at each office visit
- lack of availability of newer drugs and treatments
- the feeling that health care is being rationed to them
- continual shortages in contract care services
- a sense that they are valued less as human beings because they are Indians, living on reservations

Providers are frustrated, too. They feel they are being blamed for things over which they have no control, such as drug and contract care shortages.

When I first went to work as a physician and medical officer in the Indian Health Service I heard the same complaints from patients and providers alike. However at that time the prevalence of diabetes was not as great and the treatments not nearly as complex as they are today.

Perhaps even more pertinent to the subject, I hear the same complaints today from patients and providers who have no connection whatsoever with the Indian Health Service.

Most Americans would agree that the whole system of health care in this country needs a major overhaul. But for all rural clinics, and in particular, those in Indian Country, there are simple changes that could be implemented now which could very quickly lead to better access, better care, and more satisfied patients.

For example:

1. The traditional 10-15 minute appointment, which is the standard in most clinics today, works well for acute illnesses, but it is distinctly **unsuited** for chronic disease management. Chronic diseases (such as diabetes) require:

- a **team approach**, with different professionals each applying their special skills to the care of the patient,
- pertinent and timely patient education,
- adherence to evidence-based clinical practice guidelines, and
- a commitment to treat diabetes and associated conditions "to target".

This type of care can best be provided through **group visits**, in which 12 to 15 patients with the same disorder (diabetes) meet together in an interactive session for a period of up to 2 hours with one or more knowledgeable providers. In this setting the dynamics of the group also provide a benefit which is not available in one-on-one encounters.

2. Primary prevention programs, which stress lifestyle change, must be available to all those at high risk for diabetes. Such health promotion programs should be offered at the worksite and in the schools.

3. Research in diabetes has led to unimagined advances in knowledge over the past decade. Now those advances need to be **translated** in an effective manner to patient care. Translation programs must be coordinated by qualified **clinicians.**

In addition, tribal health programs must work in close collaboration with the IHS. There is much waste in the duplication that exists in health care for Native Americans today.

Lastly, medical schools must become more attuned to the needs of rural communities such as the Indian reservations. At present students are selected for admission to medical school primarily on the basis of their academic records. Having served for years on the Admissions Committee of the University of North Dakota School of Medicine, I know that there is a deep pool of applicants. Many smart and dedicated students never get a close enough look because their grade point average or MCAT scores are not near the top. Needed is a process that selects students who have strong

ties to their rural communities and are more likely to return there to live and work. In addition, medical schools should be actively recruiting potential medical school applicants from rural communities in need.

In summary,

- The IHS and the SDPI are doing an excellent job under difficult conditions.
- Fresh thinking and new approaches for accessing services are badly needed. Group visits, better health promotion services, and pertinent translation programs are examples of things that can be done now to improve the situation.
- Medical schools need to demonstrate an understanding of the health problems of rural communities and provide leadership in solving these problems. By not being part of the solution, they have become part of the problem.

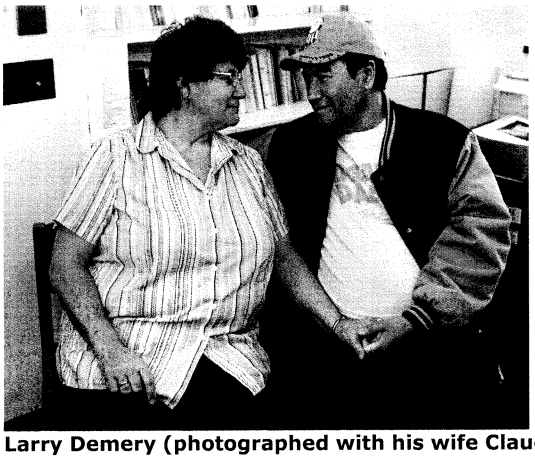
Passing Along Stories...

Health-related experiences of American Indians in North Dakota

These photographs and text are "snapshots" that document health-related experiences of American Indians living in North Dakota. The images and text collected illustrate the extent of health disparities in the state and the conditions and challenges faced by those living with various chronic diseases including diabetes and heart disease, as well as those who are working to lead healthier lifestyles.

Photographer Meg Luther Lindholm of Fargo, North Dakota under contract with the North Dakota Department of Health collected the photographs and interviews during December 2006. The Minority Health Grant and the State Cardiovascular Health Program Grant provided funding for this project.

The views expressed are those of the individuals interviewed.



Larry Demery (photographed with his wife Claudia) Dunseith, ND

Age: 51 Years
Lives: Dunseith, ND. Grew up there
Employment: not currently employed due to illness; formerly a home health aide
Insurance: Medicare/Medicaid
Interviewed at Presentation Medical Center in Rolla, ND, 12/8/06

Health Problems:
Diabetes, diagnosed at age 34.
Arthritis all over, diagnosed 7 years ago.
Heart attack - 4 years ago; an angioplasty uncovered clogged arteries, but the doctors did not operate, considering the procedure too risky given his other health problems.

He thinks he may have a brain tumor. He feels pressure in his head, and a doctor he used to see at the IHS clinic did a blood test on him that indicated a possible tumor, but this has not been confirmed.

He now sees a doctor in Rugby for monthly diabetes checkups and is very happy with this doctor. Feels he really listens/pays attention, and tries to encourage him to eat healthier. He's made some diet changes but says he can't totally give up pasta/red meat.

There's a gym in Dunseith with treadmills, but he's afraid of falling so doesn't want to use it. He has fallen several times at home. The state provides a home health aide who comes to the house to help with chores daily.

Overall he feels his health is deteriorating and is quite depressed about that.

Quality of care:
Most of the IHS doctors who used to be at the hospital/clinic in Belcourt are no longer there. There are only a couple of doctors and an ER doctor.

Larry feels the quality of care at the IHS hospital/clinic has gone downhill, so he doesn't go there anymore. Says if he had to go to the IHS clinic he'd be waiting all day to see someone.

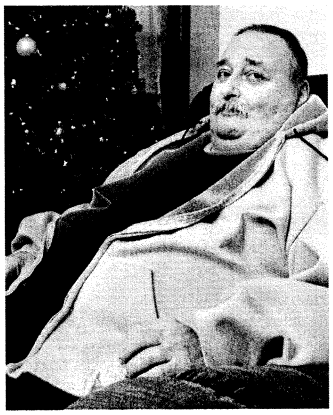
Claudia Demery (photographed with her husband Larry)
Dunseith, ND

Age:	53 years
From:	Dunseith. Grew up in the area.
Employment:	Not currently employed due to disability
Insurance:	Medicare/Medicaid
Interviewed at	Presentation Medical Center in Rolla, ND, 12/8/06

Health Problems:
Epilepsy; diagnosed in 1979; takes medication to prevent seizures.
Irregular heartbeat. Had stent put in.
Asthma since 1996; caused by smoking. She quit.
Arthritis all over. She takes pain pills, rather than shots which might give her seizures.

Quality of care:
She goes to the same doctor that her husband Larry sees, and also likes him very much.

She feels fortunate to have access to doctors other than the ones at IHS, saying "if we had to rely on IHS, we'd probably be dead."



Douglas Manson Rolla, ND
Interviewed at Presentation Medical Center in Rolla, ND, 12/8/06

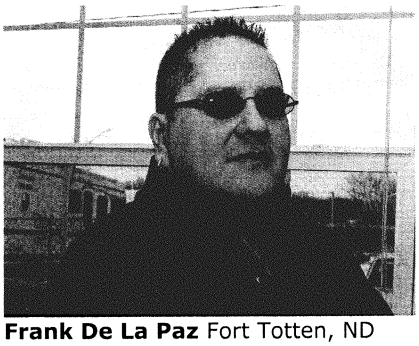
Age:	57 years
Tribal Affiliation:	Ojibwa
Lives:	Rolla. Grew up in Rolla.
Employment:	Retired law enforcement officer
Insurance:	None. He is appealing a rejection from Medicaid, and is also applying for workman's compensation benefits since he was injured on the job.

Health Problems:
Diabetes: diagnosed 20 years ago. Illness runs on his mother's side. He tests his blood sugar level 2x/day.
Eye problems: cataracts that he is waiting for IHS to operate on.
Heart disease: triple bypass heart surgery done in Minot, went well, but the incision got infected.
Arthritis: pretty stiff all over. Has difficulty walking and can't stand up by himself.
Severely overweight.

Quality of care:
Douglas is not happy with IHS. He went to the IHS clinic in Belcourt for an ingrown toenail. There were approximately 25 people waiting in the ER ahead of him, so he left and came to Presentation Medical Center to have the toenail removed. (A community healthcare worker confirmed that a lot of people from the reservation seek care at Presentation Medical Center and the hospital does not turn them away even though they do not have insurance or may not be able to pay).

Feels IHS just doesn't have enough doctors. One used to be able to get an appointment for a checkup, but now the clinic operates on a walk-in basis, so he has to wait up to four hours to be seen.

He goes to IHS 4-5x/year for checkups. They only spend about 10 minutes with him, write prescriptions for medications. They don't really talk with him or seem to care. He is waiting to see when they will operate on his cataracts.



Frank De La Paz Fort Totten, ND
Interviewed in Fort Totten 12/7/06

Age:	46 years
From:	Grew up in Chicago and Veblen, SD. Has lived in Ft. Totten since 1984.
Occupation:	Job placement specialist
Insurance:	Blue Cross Blue Shield/IHS
Children:	8. (Not covered by BCBS)

Health problems:

Diabetes: diagnosed when he was 44.

High blood pressure

He feels he had symptoms of diabetes starting in his late 30's, such as frequent urination. Prior to his diagnosis he was very physically fit, and he loved to work out with weights. After the diagnosis he became very depressed. He also found out about a lot of diabetes in his family. All the men on his mother's side of the family have it. Because of shame people don't talk about it. He only monitors his blood sugar if he's not feeling well. He started noticing problems with his circulation so he's trying to get back into an exercise routine, but the weight room/gym is not open consistent hours. The commodity house on the reservation distributes poor quality government surplus food. Most foods are very high in glucose, and he attributes the prevalence of diabetes on the reservation to the reliance many people have on these foods.

Quality of care:

Frank feels that the IHS only hands out prescriptions. They do not deal with many important aspects of staying healthy, like educating people with diabetes about nutrition and exercise. Nor does IHS help people deal with depression. There are no support groups for people with diabetes.

Also, there is no coordination between the IHS clinic and the diabetes wellness center, which is administered by the tribe. There is no partnering, no referring patients from the His clinic to the wellness center. Services, in his opinion, are very territorial. He goes to IHS for diabetes screenings every 3 months. There is no consistency of care. He sees different doctors who often prescribe different medications.

Zona Loans Arrow Fort Yates, ND

Age:	79 years
From:	Porcupine – Cannonball – Ft Berthold – Porcupine Now lives in Ft. Yates senior housing
Occupation:	Wife/mother. Married 3 times
Insurance:	Medicare

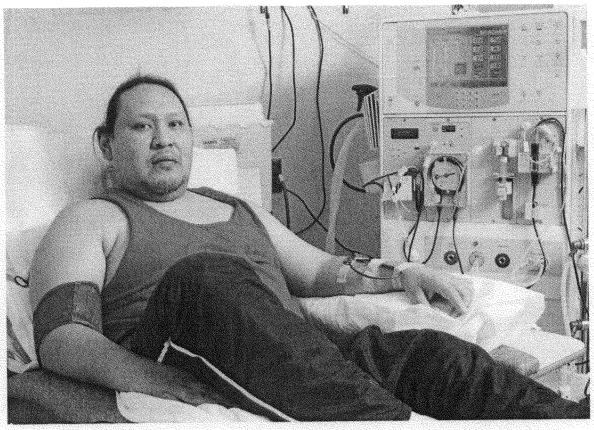
Health Problems:
Diabetes: diagnosed 1964.
High blood pressure, kidney problems, angina,
2 knee replacements
Poor vision from diabetes/cataracts

Zona was healthy as a child. She gained a lot of weight as an adult, weighing 300 pounds at one point. Her diabetes was diagnosed in 1964 and she had diabetes-related heart problems. She also had a burst blood vessel in her brain which was repaired by surgery at a hospital in Bismarck.

She sometimes gets dizzy and falls. She takes 9 medications daily which a Community Health Representative (CHR) separates out for her. She depends on the CHR's to take her to the clinic. She must use a wheel chair to get around her home.

Zona feels the medical care in Bismarck is much better than the medical care on the reservation, where she has to sometimes wait for hours to see a doctors who change all the time and prescribe different medications.

She had cataract eye surgery but needs new glasses. She can't get the glasses because she has to pay out of pocket for those and can't afford them.



David Whitetail Garrison, ND
Interviewed at IHS dialysis unit, 4 Bears District (near New Town) 12/12/06

Tribal Affiliation:	Arikara
Age:	39 years
Lives:	White Shield
Work:	Disability since 3/04. Previously worked in kitchen at casino.

Health Problems:
Diabetes: diagnosed in 1985 when in boarding school in Salem, OR.
He was told of complications that could develop and to watch his diet but "I didn't care...I figured I wasn't going to make it to be that old...I lived a wild life...I was in denial at first, figured I was going to live my life the way I wanted."

The illness caught up with him about 5 years ago. He started getting sick more, not having the energy to do what he wanted.

He wants a new kidney. He's also trying to help other dialysis patients. He helped raise money for a trip with a group of other dialysis patients to Medora.

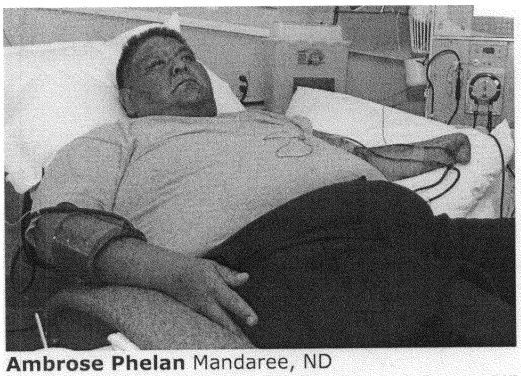
Quality of Care:
He likes everyone on the staff at the dialysis unit. Feels he gets great care.

Philomena Grinnell
(photographed with family members Bernadine and Zaysha)
New Town, ND
Interviewed in New Town 12/12/06

Age:	84 years
Work:	Retired
Lives:	New Town
Insurance:	Government (from her now-deceased husband)

Health Problems
Diabetes: 27 years; takes insulin.
Heart problems: Heart attack in 1994 related to diet and stress from her husband's illness; 2003 – open heart surgery in Minot. 3 valves replaced.

Quality of Care
She has checkups every couple of months. She says many people get frustrated with diabetes and IHS and stop taking their medications and then start losing limbs and their eyesight.



Ambrose Phelan Mandaree, ND
Interviewed at IHS Dialysis unit near New Town, ND 12/12/06

Age:	47 years
Work:	Unemployed due to disability; formerly with gaming commission
Lives:	Mandaree and Watford City
Insurance:	Medicare

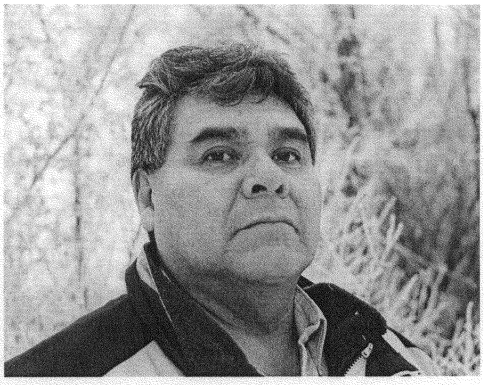
Health Problems:
Type 2 diabetes, diagnosed in 1974. Goes to IHS clinic 4x/week for dialysis, 3-4 1/2 hours each time. When first diagnosed he was in total denial about the illness. "Diabetes was for people who didn't work, who laid around the house watching TV." He had always been overweight and he liked the fact that with the illness he passed a lot of water. It helped him keep his weight down.

He began dialysis in 1996, but kept working until 2 years ago. He used to go to work after dialysis, but "now I have to rest a couple of hours to rejuvenate myself...I'm living on pain pills. I don't like it, but I don't know what else to do... I wouldn't wish this on my worst enemy."

He spoke at a recent diabetes conference because he wants to help "save someone the grief and pain of the last 10 years of my life."

Legally blind in left eye.

Quality of Care:
He has a wife who cares for him, three children and a two-year old granddaughter who he says is his inspiration to keep on living. "Sometimes I feel like throwing in the towel, but then I realize that she needs me as much as I need her."



Bruce Gillette New Town, ND
Interviewed at the Circle of Life Center in New Town on 12/11/06

Age:	53 years
Tribal Affiliation:	Arikara
Employment:	Addiction counselor at the Circle of Life Alcohol & Drug Treatment Center in New Town
Insurance:	Blue Cross/Blue Shield family policy
Children:	2 adult
Lives:	New Town during week, but real home is in Twin Buttes.

Health Problems:
Diabetes: Diagnosed in 9/99. Meds made him sick to his stomach so in 2003 he decided to phase himself off them and focus on diet and exercise. He didn't tell the doctor when he started easing off the meds. Bruce said the exercise and diabetes meds didn't mix: "You can't take diabetes pills and try to diet and exercise because the pills knock you out...A sedentary lifestyle is the most important factor that leads to diabetes."
Alcoholism: Sober since 1999. Began substituting sugary foods for alcohol after he quit drinking which is when his blood sugar started going way up. Because the diabetes pills he was on made him feel bad he ate more.

In 2002, Chairman Hall declared war on diabetes. "I always had a dream about walking." After talking about the idea with others for a long time, Bruce organized a 20 mile walk in 2003 from Bear Den to the Little Shell pow-wow grounds. He got huge blisters from wearing the wrong shoes on this "practice" walk. Now there's an annual *Walk Around the Reservation* that takes place in late May, covering 25 miles/day for 10 days. 600 people signed up the first year, but its dropped off since then. "I've lost every toenail on my feet but none of us have lost our feet…We're so scared of losing our feet that we just sit there and eat our chips."
"Wheaties and beans will drop your sugar, but don't eat them at the same time." (Laughs).

He's very focused on diet because there's a time (during winter) when the exercise stops.

Quality of Care:
IHS relies way too much on handing out meds. He went in for sinus surgery and was given 2 big bottles of pain medications: "Excessive."
He is able to see the same physician at his checkups which are every 6 months.
He feels that Indians have less value than whites in the health care system overall because most Indians don't have health insurance.

SENATE COMMITTEE ON INDIAN AFFAIRS
HEARING ON SPECIAL DIABETES PROGRAM FOR INDIANS

February 8, 2007

Written Testimony
Dr. Sven-Erik Bursell, Joslin Diabetes Center

Introduction

Mr. Chairman and Members of the Committee, I would like to thank you for the opportunity to submit written testimony on behalf of Joslin Diabetes Center and the Joslin Vision Network TeleHealth Program in the Indian Health Service under the direction of Dr. Mark Horton.at the Phoenix Indian Medical Center.

Diabetes is at least 2 to 5 times more prevalent among American Indians and Alaska Natives (AI/AN) as compared to the general US population. Diabetic retinopathy (DR) occurs in almost all individuals with diabetes and is the most common cause of new blindness among adults. Blindness from diabetic retinopathy can be prevented with timely diagnosis and treatment, but historically, only 50% of AI/AN's obtain the recommended annual retinal evaluation needed for this. This is costly both in terms of human suffering as well as medical economics. It is much more costly to care for the blinding complication of this disease rather than properly assess for and treat DR.

The Interior Subcommittee recommended that the Indian Health Service develop in FY 2000 a $1,000,000 cooperative relationship with the Joslin Diabetes Center / Joslin Vision Network (JVN) to address diabetes issues within the Indian Health Service and among the Native American patient population by integrating the JVN and Joslin Diabetes Eye Health Care Model into the care of the Native American population. This IHS/JVN teleophthalmology program has completed its 6th clinical year in FY06. This year was characterized by continued rapid expansion of the clinical program and accomplishment of key development milestones.

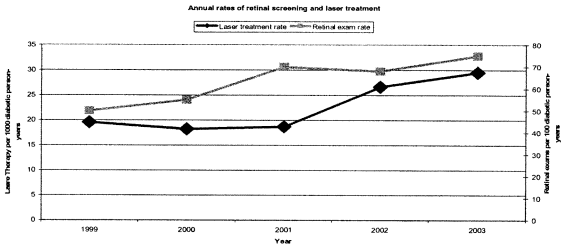
The Joslin Diabetes Center JVN TeleHealth program is a telemedicine initiative designed to facilitate appropriate clinical diabetes management and promote better blood glucose control to reduce the risks of complications such as blindness amongst people with diabetes. The program will and to access all diabetic patients into cost-effective, quality diabetes care and eye care programs regardless of geographic or cultural boundaries.

Joslin has developed the JVN TeleHealth Program through a Cooperative agreement with the Department of Defense and in collaboration with the Department of Veterans Affairs and the Indian Health Service. This telemedicine application was developed specifically to provide the flexibility to integrate with all Federal Agency Electronic Health Record Systems.

Summary of Progress

Nineteen new IHS/JVN sites were deployed in FY06. By the end of the year 50 deployments were completed in 15 states. These deployments have provided an increased opportunity for compliance with the standard of care for surveillance of diabetic retinopathy. By the end of the year, the program completed more than 15,000 studies since its inception. This has been done with a consistent decrease in the incremental costs of deployment and support each year since inception

This clinical activity with the IHS/JVN has had a measurable impact on the visual public health of these patients. A focused evaluation of the four year experience of one of these deployments showed a 50% increase in compliance in the DR surveillance standard of care, with an associated 51% increase in retinal lasers treatments done on the same population. (Fig. 1) Each of those additional laser treatments performed as a result of the IHS/JVN surveillance represent a patient saved from blindness due to DR.



(Fig. 1)

In addition to the clinical success the program sustained in FY06, there were also some notable technical developments. A proof of concept portable JVN system was developed and tested in Selawik, AK in February 06. This site north of the arctic circle in mid winter provided particularly harsh testing conditions that included -20° F temperatures, equipment transport by small aircraft and dog sled, and data connectivity via satellite. Despite the rigors of these conditions, the test was highly successful. Based upon this testing we have continued with the development of the portable system and are currently awaiting software interface development to enable the deployment of this new technology in smaller and more remotely located communities. The same interface will also enable new web based architecture for bidirectional data transport between the IHS/JVN as well as improved secure transmission of images and reports.

Ongoing evaluations and validation studies have broadened the evidence basis for the JVN. The JVN system is currently validated through reports in the peer reviewed literature as being equivalent or superior to the clinical gold standards of dilated eye photography and dilated eye examinations performed by retinal specialists for the purpose of diagnosing the level of diabetic retinopathy and presence or absence of clinically significant diabetic macular edema a major cause for moderate vision loss in patients with diabetes.
Additionally, since individuals with diabetes are at increased risk for eye diseases other than diabetic retinopathy, a validation study was performed to determine the ability of this telemedicine modality to detect non-diabetes related retinal disease. This study showed excellent agreement with dilated ophthalmic examination by retinal specialists in the detection of ocular disease other than diabetic retinopathy.

In another four year study conducted at an IHS facility results demonstrated a 50% increase in DR surveillance and a 51% increase in DR laser treatments as compared to the pre-deployment baseline year. Further review of the data showed that 100% of the increase in both measures were due to the JVN imaging activity.

Finally, a study was performed to evaluate the business model for the IHS/JVN Program that takes into account local cost effectiveness considerations using IHS specific epidemiology and costs of operations in the analysis. This study showed the IHS/JVN to be less costly and more

effective than a live eye examination for detecting diabetic retinopathy and preventing vision loss.

The following goals have been set for the program in FY07

- Deployment of ~20 IHS/JVN Teleophthalmology sites
- Completion and deployment of the portable JVN
- Technical upgrade of the National Reading Center reading workstations
- Development of a vehicle mounted JVN system for mobile operations using improved roads.
- Deployment of the Web based JVN Server with bidirectional communication with the IHS hospital information system and electronic health record

The portable JVN platforms and bidirectional data flow between JVN and the IHS electronic health record data base are pivotal developments from the perspective of patient safety, efficient and cost effective workflow, and compliance with the Presidents Executive Order for movement to an electronic health record.

In a manner similar to the development of the JVN, another telehealth application was developed collaboratively between JDC, VHA, DoD, and the IHS. A web based application called the Clinical Diabetes Management Program was created to allow enhanced management opportunities for individuals with diabetes served by each of these partners. In 2006 the functionality of this technology was expanded to serve as a service delivery platform for the JVN as well as other telemedicine modalities. The IHS is about to join this to its electronic health record for immediate use with the JVN, and eventually with other telemedicine applications such as home telehealth.

Summary

In FY06 the IHS/JVN Teleophthalmology Program produced the largest annual increase in deployments and clinical studies since inception in FY2000. The program continues to increase compliance with the standards of care for diabetic retinopathy at deployed sites in Indian county, resulting in decreased vision loss due to diabetes at these locations. Development has produced new opportunities for this technology in the less populated and more remote locations. Planned development will improve data integration in the IHS electronic medical record, further enhancing safe and effective patient care.

Mr. Chairman, we are pleased to be a part of this Diabetes project with the Indian Health Service and we are grateful for the support from the Indian Health Service and look forward to continuing implementation of this very successful program for Native Americans and Alaskan Indians.

STATEMENT OF THE INDIAN HEALTH SERVICE
HEARING ON THE
SPECIAL DIABETES PROGRAM FOR INDIANS

FEBRUARY 8, 2007

Mr. Chairmen and Members of the Committee:

Good morning, I am Dr. Charles Grim, Director of the Indian Health Service (IHS). Today, I am accompanied by Dr. Kelly R. Moore, Clinical Consultant, National Diabetes Program, IHS. We are pleased to have this opportunity to testify on behalf of Secretary Leavitt on the Special Diabetes Program for Indians.

The IHS provides health services to an estimated 1.9 million Federally-recognized American Indians and Alaska Natives through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our mission is to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

The Diabetes Epidemic

Diabetes has quickly emerged as one of the most serious and devastating health problems of our time. An estimated 20.8 million Americans have diabetes, representing 7.0% of the population. Only two-thirds of those affected have been diagnosed and are being actively treated. Although diabetes occurs in people of all ages and races, some groups have a higher risk than others for developing diabetes. Diabetes is more common in African Americans, Latinos, Asian Americans/Pacific Islanders than in non-Hispanic whites, and in elderly people than in people younger than the age of 65. However, American Indians and Alaska Natives bear the highest prevalence of diabetes in the U.S. population. Addressing this serious disease and its consequences for tribal communities is an important health priority for our nation.

In spite of our best efforts and successes so far in treating diabetes, the epidemic of diabetes continues to increase. Although diabetes is also increasing in the U.S. population as a whole, the increase in the Indian population is far more dramatic. While the prevalence of diabetes in the U.S. population almost doubled between 1980 and 2004, the prevalence of diabetes among American Indians and Alaska Natives was already higher in the early 1980's than in the U.S. population in 2004. Moreover, the

prevalence of diabetes among American Indians and Alaska Natives more than doubled during this time period. Indeed, American Indians and Alaska Natives have the highest age-adjusted rates of diabetes (16.3%) among all U.S. racial and ethnic groups. And, in some communities, the prevalence rate is as high as 60% among adults.

Rates of diabetes in American Indians and Alaska Natives vary across the country. The lowest rates are found among Alaska Natives with the highest rates found among the Nashville Area and Tucson Area tribes. Rates of increase in diabetes also vary across the country. While the Alaska Area has the lowest prevalence rate, data from IHS on the increase among adults from 1997 to 2002 show that Alaska has seen the greatest increase in this time period. Alarmingly, the disease increasingly affects American Indian and Alaska Native youth, threatening the health, well-being, and quality of life of future generations. IHS statistics show that in a 14-year period from 1990 to 2004, an increase of 128% was seen among 15–19 year-olds and a 77% increase was seen among American Indian and Alaska Native children and youth less than 15 years of age.

Special Diabetes Program for Indians

As part of the Balanced Budget Act of 1997, Congress established the Special Diabetes Program for Indians (SDPI) in recognition of the enormity of the diabetes epidemic among American Indians and Alaska Natives. Congress envisioned the Special Diabetes Program for Indians as a grant program that would provide funding for diabetes prevention and treatment services at IHS, tribal, and urban Indian health programs. Almost ten years since its inception, the Special Diabetes Program for Indians is now the most comprehensive, far-reaching diabetes program for American Indians and Alaska Natives, and serves as the foundation for diabetes prevention and treatment efforts for their communities across the U.S.

The Balanced Budget Act of 1997, provided $30 million each year to the Indian Health Service over a five-year period (from FY 1998 to FY 2002) to establish grants for the "prevention and treatment" of diabetes in American Indian and Alaska Natives and stipulated a comprehensive evaluation of the program. Tribes and the IHS worked collaboratively to meet the legislative intent of the Special Diabetes Program for Indians through a process that included formal tribal consultation, developing funds distribution formulas, and establishing grant application and administrative procedures.

In the Consolidated Appropriations Act, 2001, Congress appropriated additional funding for the SDPI in addition to the initial $30 million provided for the program. This appropriation included an additional $70 million in FY 2001, $70 million in FY 2002, and $100 million in FY 2003, thereby extending the program and bringing the funding total to $100 million each year for 2001-2003. Congress encouraged the IHS to implement a best practices approach, continue the ongoing diabetes prevention and treatment activities in tribal communities and to build upon partnerships with other organizations and lessons learned by the Indian special diabetes grant programs.

The SDPI reauthorization for $150 million each year for FY 2004-2008, directed the IHS to expand the program and implement a competitive grant program for eligible entities for the implementation of specific interventions proven to prevent diabetes in people at risk for developing diabetes and reduce cardiovascular risk in people with diabetes, the most compelling complication of diabetes. Funds were also directed towards data improvement. In addition, distribution of funds to original SDPI grantees, now called the Community-Directed Diabetes Programs, for the prevention and treatment of diabetes continued.

IHS Diabetes Network

The IHS Division of Diabetes Treatment and Prevention (DDTP) provides leadership and programmatic administrative oversight to the SDPI grant program. The mission of DDTP is to develop, document, and sustain a public health effort to prevent and control diabetes in American Indians/Alaska Natives. This mission is accomplished by promoting collaborative strategies for the prevention of diabetes and its complications to over 1.9 million American Indians and Alaska Natives through an extensive American Indian and Alaska Native diabetes network. The network consists of a national program office; Area Diabetes Consultants in each of the 12 IHS Areas; 19 Model Diabetes programs in 23 different IHS and Tribal sites, and 333 non-competitive and 66 competitive local IHS, Tribal and Urban Indian SDPI grant programs. The 66 competitive SDPI grant programs, awarded in FY 2004, are comprised of 30 cardiovascular diseases (CVD) risk reduction demonstration projects and 36 diabetes prevention demonstration projects. This extensive diabetes network supports the SDPI grant programs by providing administrative support, training and technical assistance and the dissemination of the latest scientific findings and “best practices” to the programs. Now the most comprehensive rural system of care for diabetes in the U.S., the IHS combines both clinical and public health approaches to address the problem of diabetes and its complications.

Community-Directed Programs

Since 1998, the IHS has provided Special Diabetes Program for Indians funds to 333 IHS, tribal, and urban Indian health programs in 35 states to begin or enhance diabetes prevention and treatment programs. These grant programs make up the Community-Directed Diabetes Program. Each of the grant programs is unique in its diabetes prevention and treatment needs and local priorities. The Special Diabetes Program for Indians allows the grant programs to design and carry out interventions that will best address the problem of diabetes in their individual communities. The result has been the creation of programs that incorporate proven diabetes prevention and treatment strategies such as patient education, quality diabetes care services, and physical activity, nutrition, and weight loss activities in innovative, culturally appropriate diabetes program activities.

Targeted Demonstration Projects

In 2002, Congress extended the funding for the Special Diabetes Program for Indians through 2008 and added an additional $50 million per year to the program (P.L.107-360) for its current total of $150 million each year for 2004-2008.

The IHS set aside $27.4 million of Special Diabetes Program for Indians funding per year from FY 2004 through FY 2008 for a new grant program, called the Special Diabetes Program for Indians "Demonstration Projects." Sixty-six selected grant programs were awarded grants for one of two programs within the Special Diabetes Program for Indians Demonstration Projects.

Diabetes Prevention Demonstration Project

The Diabetes Prevention Demonstration Project focuses on preventing diabetes in American Indians and Alaska Natives at risk for developing the disease. This project adapted, and is currently implementing, the curriculum from the National Institutes of Health (NIH) Diabetes Prevention Program (DPP). The results of this landmark clinical trial, published in 2002, demonstrated that individuals with pre-diabetes could prevent diabetes through lifestyle changes and, to a lesser extent, with a medication called metformin. The DPP included American Indians and thus the interventions were specifically tested on this population.

Many of the Special Diabetes Program for Indians grant programs were already working on diabetes prevention interventions prior to release of the NIH Diabetes Prevention Program study findings in 2002. The Special Diabetes Program for Indians Diabetes Prevention Demonstration Project funds provided the resources to build stronger diabetes prevention programs by translating the promising study findings through implementation of a common, structured diabetes prevention education program in 36 sites.

Healthy Heart Demonstration Project

The Healthy Heart Demonstration Project focuses on reducing the risk of cardiovascular disease in American Indians and Alaska Natives who already have diabetes. This program is currently implementing a clinical, team-based, case management approach to treat risk factors for cardiovascular disease. This approach is based on current models for chronic disease care and the latest cardiovascular disease prevention clinical guidelines.

Cardiovascular disease is the leading complication of diabetes, and the number one killer of American Indian and Alaska Native adults. The Strong Heart Study, an ongoing study of cardiovascular disease in 13 American Indian and Alaska Native communities, has demonstrated that diabetes is a major risk factor and accounts for the majority of risk for cardiovascular disease events in American Indians and Alaska Natives. The

incidence of cardiovascular disease in American Indians and Alaska Natives now exceeds rates in the general U.S. population. The funds for the Special Diabetes Program for Indians Healthy Heart Demonstration Project offer hope that American Indian and Alaska Native communities can reverse these troubling trends by implementing a more intensive, structured case management approach to addressing cardiovascular disease risk in American Indians and Alaska Natives with diabetes.

Evaluation

Pursuant to Public Law 105–33 as amended by P.L.107-260, the IHS conducted a comprehensive evaluation of the SDPI Community-Directed Diabetes Programs. These data have been presented in two interim reports to Congress. In 2000, the IHS submitted the first report, which included descriptions of the Community-Directed Diabetes Programs and their activities to date. The IHS presented a more extensive evaluation of the Community-Directed Diabetes Programs in the second report, which was published in 2004. The IHS used well-established public health evaluation methods to document the accomplishments of the Community-Directed Diabetes Programs.

During the first few years of the Special Diabetes Program for Indians, short-term outcomes included accomplishments related to developing the infrastructure needed to start and enhance diabetes prevention and treatment activities. For example, the Special Diabetes Program for Indians grant programs needed to hire staff, develop their programs, and offer diabetes prevention and treatment services such as foot care, physical activity, and diabetes education services.

As the grant programs gained expertise in diabetes care, the IHS Division of Diabetes obtained information on intermediate outcomes. Intermediate outcomes can be measured to determine if the grant programs' activities and services resulted in measurable changes such as increasing awareness of diabetes and reducing risk factors for diabetes and its complications.

Long-term outcomes, including whether the Special Diabetes Program for Indians results in reduced complications and death from diabetes, eventually, can be measured; however, the current trends in diabetes-related complications and deaths may take years to reverse given the magnitude of the diabetes epidemic in American Indian and Alaska Native communities. Therefore, planning for initial long-term outcome measurements has focused on ensuring that data systems are in place to measure trends over time.

Short-term Outcomes

Compared to their level of services prior to the funding (before 1998), the programs funded under the Special Diabetes Program for Indians achieved numerous improvements (short-term outcomes) in diabetes prevention and treatment services as

of FY 2002 and FY 2005 through increases in the following services:

- Availability of basic clinical exams, newer medications and therapies for diabetes treatment, laboratory tests to assess diabetes control and complications, screening for diabetes and pre-diabetes in a variety of locations, including screening for adults and elders and children and youth
- Use of key elements of quality diabetes care, Multidisciplinary diabetes team staffing, Availability of nutrition education services by Registered Dietitians and Public Health Nutritionists, Conduct of community diabetes needs assessments
- Partnerships between tribal leaders and tribal members on diabetes-related issues, Local community partnerships, Partnerships with outside organizations, Policies addressing diabetes prevention and care
- Availability of organized diabetes education programs and support services, Availability of culturally appropriate diabetes education materials and education approaches, A variety of diabetes education methods, Availability of continuing education opportunities for health care providers
- A variety of traditional approaches
- Funding of primary prevention activities, Diabetes awareness activities, Availability of physical fitness activities, Availability of community nutrition services, Collaborations with the U.S. Department of Agriculture to improve nutrition in communities, Diabetes primary prevention programs for children and youth, Screening and management of overweight and obesity among children and youth, Nutrition education programs for children and youth, Community-based healthy eating programs for children, youth, and families, Physical activity programs for children and youth, Availability of breastfeeding promotion programs.

Intermediate and Long-term Outcomes

A variety of intermediate and long-term outcomes have also been achieved since implementation of the Special Diabetes Program for Indians, including improvements in the following:

- Control of blood glucose, blood pressure, total cholesterol, LDL cholesterol, and triglycerides

- Treatment of risk factors for cardiovascular disease, to prevent and delay the progression of diabetic kidney disease and to detect and treat diabetic eye disease

- Baseline Measures - The IHS improved the accuracy of baseline long-term outcomes measures (prevalence and mortality) so that the ultimate successes and outcomes of the Special Diabetes Program for Indians can be measured accurately. The IHS established a Diabetes Data Warehouse using RPMS

(Resource and Patient Management System) data to measure accurately the long-term complications of diabetes.

Data from the IHS Diabetes Care and Outcomes Audit provide evidence of the Special Diabetes Program for Indians grant programs' success in implementing cost-effective and cost-saving screening and treatment activities for diabetes complications. Since the Special Diabetes Program for Indians began in 1998, the grant programs' activities have contributed to:

- Increasing the number of people with diabetes screened for kidney disease.
- Increasing the number of people with diabetes who are screened for diabetes eye and foot disease.
- Improving blood sugar control with population mean A1C levels decreasing from 8.9% to 7.9%.
- Decreasing population mean diastolic blood pressure by 2 mmHg from 78 to 76 mm Hg.
- Decreasing population mean cholesterol from 206 mg/dl to 192 mg/dl.
- Decreasing population mean triglyceride levels from 260 mg/dl to 230 mg/dl.

The Special Diabetes Program for Indians Demonstration Projects grant programs successfully began implementation of the rigorous Demonstration Project activities in FY 2006. The IHS is conducting a comprehensive evaluation of the program to answer questions on program effectiveness and outcomes based on solid, statistically accurate, and timely data. The final year of this five-year project will be dedicated to disseminating the project results and lessons learned throughout the Indian health system.

Costs of Diabetes

Diabetes costs the United States $132 billion in 2002 in both direct and indirect costs. Yet numerous analyses have demonstrated the cost-effectiveness of delaying or preventing diabetes and its complications. The highest costs associated with diabetes are related to treating and managing its complications such as eye disease, foot disease, and kidney disease. Programs that effectively reduce and manage diabetes complications do, in fact, reduce costs associated with diabetes complications.

In the Diabetes Prevention Program, both the lifestyle intervention and medication intervention that resulted in preventing or delaying diabetes for at least three years were cost effective. Improving delivery of the intervention through a group setting at similar levels of effectiveness would further improve cost effectiveness. When applied to young people at risk (age 25 to 45 years), the intervention is actually cost saving.

The Centers for Disease Control and Prevention (CDC) Diabetes Cost-Effectiveness Study Group found that screening and early treatment of diabetes reduces the lifetime occurrence of kidney failure by 25%, blindness by 35%, and lower-extremity amputation

by 22%. On average, diabetes is diagnosed 5.5 years earlier with screening programs that screen people for diabetes on routine medical care visits. Such screening programs have a greater benefit and are more cost-effective for younger people and minority populations than for the general population.

Many of the activities of the SDPI Community Directed Programs relate to diabetes prevention, early detection of diabetes and its complications as well as improved delivery of care, not only improve quality of life, but also represent an effective utilization of health care system resources. And, in many instances may likely result in cost savings. The new SDPI Demonstration Projects hold great promise to offer similar economically favorable outcomes. A defined economic analysis team is investigating the direct costs of the Demonstration Project interventions in American Indian and Alaska Native communities and this effort will contribute further to our knowledge of how investments in quality diabetes prevention and treatment affect economic costs associated with diabetes.

Summary

The Special Diabetes Program for Indians has brought Tribes together over these past 9 years, working toward a common purpose and sharing information and lessons learned along the way. The IHS has shown through its public health evaluation activities that these programs have been very successful in improving diabetes care and outcomes, as well as in launching primary prevention efforts, on reservations and in urban clinics. Our evaluation of the Special Diabetes Program for Indians and diabetes clinical measures suggests that population-level diabetes-related health is better among our American Indian/Alaska Native patients since the implementation of SDPI. The greatest benefit for American Indians and Alaska Natives with diabetes has likely been in the reduction in microvascular complications—eye, kidney and nerve diseases—due to improvement in long-term high blood sugar levels. Further reducing microvascular and macrovascular complications—atherosclerosis, coronary heart disease, stroke, and peripheral vascular disease—will require continued efforts to improve glucose, blood pressure and cholesterol values. However, the greatest long-term benefit will most likely be from the diabetes primary prevention activities now becoming commonplace in American Indian and Alaska Native communities. In its nine years, the Special Diabetes Program for Indians has demonstrated the positive public health impact that is possible when tribal and Congressional initiatives are focused on a common outcome.

The IHS has demonstrated, through the SDPI, its ability to design, manage, and measure a complex, long-term project to address a chronic disease in partnership with Tribes and other Indian organizations as well as collaborative involvement of other federal agencies and private organizations in a successful manner. What's more, IHS has shown that it can successfully work with tribal partners to help them progress from whatever their starting position—be it a fully functioning clinical diabetes program, a rudimentary community program, or no program at all—along a continuum of diabetes excellence so that all improve in some way. Significant infrastructure has been

established where there was none. Basic programs have become centers of excellence. Innovation has become commonplace in these programs, and the sense of "tribal ownership" is now entrenched. And positive signs such as a decrease in incidence of diabetes-related End Stage Renal Disease among American Indians in the Southwest are starting to be seen.

Mr. Chairman, that concludes my prepared remarks and I would be pleased to answer any questions you or other members of the Committee may have.

NATIONAL CONGRESS OF AMERICAN INDIANS

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February 7, 2007

The Honorable Byron Dorgan
Chairman
Senate Committee on Indian Affairs
836 Hart Senate Office Building
Washington, DC 20510

The Honorable Craig Thomas
Ranking Member
Senate Committee on Indian Affairs
836 Hart Senate Office Building
Washington, DC 20510

Re: Diabetes Programs in Indian Country

Dear Chairman Dorgan and Senator McCain:

On behalf of the National Congress of American Indians (NCAI), I would like to thank you for holding this hearing to address this critical issue in Indian Country. Diabetes is a disease that is increasingly harming our people. I want to take this opportunity to share with you information about one particular program that is being implemented throughout Indian Country to address diabetes within our youth.

The National Congress of American Indians was founded in 1944 and is the oldest and largest tribal government organization in the United States. NCAI serves as a forum for consensus-based policy development among its membership of over 250 tribal governments from every region of the country.

In 2003, the National Congress of American Indians (NCAI) embarked on a journey with several national partners – Indian Health Service, Native American Boys & Girls Clubs across our nation, and Nike, Inc. – to create a program aimed at reducing the onset of diabetes among American Indian and Alaska Native youth. The program—On the T.R.A.I.L. (Together Raising Awareness for Indian Life) to Diabetes Prevention—is an innovative combination of physical, educational, and nutritional activities that promote healthy lifestyles.

Named by one of the pilot Club sites, T.R.A.I.L. is a three-month (12 sessions) incentive-based program that provides youth with a comprehensive understanding of healthy lifestyles that help **prevent diabetes**. Woven throughout the program are self-esteem and prevention activities which offer local sites the opportunity to draw upon their own Tribal traditions and history to learn about nutrition, food choices, and the impact of diabetes.

The program also emphasizes the importance of teamwork and community service. Native youth apply decision-making and goal setting skills in the Physical Activity Challenge and engage in service projects to improve healthy lifestyles in their communities. Community and family members participate in activities as well and benefit from the information provided.

A few examples of what participating T.R.A.I.L. sites have accomplished recently are listed below.

- Boys & Girls Clubs of Greater Scottsdale (Salt-River Pima-Maricopa Indian Community, **Arizona**) has changed all food and beverage vending in all Club units. The vendor is willing to help provide healthy snacks and replace sodas with light juices and flavored waters.

- Boys & Girls Clubs of Central **Oregon**, Warm Spring Unit (Confederate Tribes of Warm Springs) –spent the summer restoring a community garden and starting its own Club garden. Produce is used for healthy Club snacks and cooking classes.

- Boys & Girls Clubs of the **Mississippi** Band of Choctaw Indians held its 2nd Annual Fun Run/Walk with its community health partners, EMTs, and police department. The event involved Club members, family members, and the community.

- Boys & Girls Clubs of Bay Mills, **Michigan** recently held a session where one of the T.R.A.I.L. participants, along with his mother, shared their experiences with diabetes. The boy's father was diagnosed and subsequently died due to diabetes complications. Through a powerful presentation made by this family, T.R.A.I.L. Club members have a greater respect for prevention efforts and are more willing to be active in their daily lives.

- The Boys & Girls Club of Sequoyah County, **Oklahoma** was not any running physical activity programs at the Club until they were awarded funding for the T.R.A.I.L. program and the Nike product grant. The Club now runs 60 minutes of physical activity each day at the Club.

- The Lapwai Boys & Girls Club Unit in Lewiston, **Idaho** (Nez Perce) trained all staff to implement the NikeGO After School program and included the community's local schools and Head Start staff in its physical activity training event.

Each organization receives a grant to support a full-time diabetes prevention coordinator and the operating and travel expenses associated with this initiative. In addition, Clubs receive a Nike product grant for equipment and incentives to supplement the program's physical activities.

FY 2004
In FY 2004, **6** Native American Boys & Girls Clubs were directed to pilot this diabetes prevention program. A total of 250 children, aged 8-10, were targeted. The pilot sites included: Pine Ridge, SD, Mississippi Choctaw, Northern Cheyenne, MT, Green Country (Cherokee), Oklahoma and two communities from the Navajo Nation.

FY 2005
In FY 2005, the program was expanded to **25** Native Club sites in 15 states. Partnership continued between IHS, NCAI, Nike, and BGCA.

Each site received a pass-through grant from NCAI to fund program operations (including a full-time coordinator and program trainings). The sites targeted 1,250 children and their families.

FY 2006
In Fiscal Year 2006, additional funding was obligated to expand the program to 28 Native Club sites in 16 states.

Each site received a pass-through grant from NCAI to fund program operations (including a full-time coordinator and program trainings). The sites targeted 1,400 children and their families.

FY 2007
In Fiscal Year 2007, funding was used to expand the program to 40 Native Club sites in 19 states.

Sites received a pass-through grant from NCAI to fund program operations (including a full-time coordinator and program trainings). The sites are targeting 2,000 children and their families.

Over the course of four years, we have received funding through the Indian Health Service and have seen the dramatic effect this prevention program is having on youth across Indian Country. We are asking the committee to consider direct funding for this program (through IHS) to expand the implementation of T.R.A.I.L. through the network of over 200 Boys & Girls Clubs in Indian Country (located in 25 states and serving nearly 150,000 Native youth). Currently, only 40 of the over 200 Clubs in Indian Country implement this life-changing program.

Sincerely,

Jacqueline Johnson
Executive Director

Senate Committee on Indian Affairs
Oversight Hearing on Diabetes in Indian Country
February 8, 2007

To Whom It May Concern:

Hello, my name is Robyn Zike. I work with the Chickasaw Nation Boys & Girls Club in Sulphur, Oklahoma. I'm the T.R.A.I.L. Coordinator for the Boys and Girls Club. On the T.R.A.I.L. (Together Raising Awareness for Indian Life) to Diabetes Prevention is a program designed for 25-30 kids in the age range of 8-10 years. Two of the concepts that specifically link to the T.R.A.I.L. program are:

1) programs that motivate and support responsible healthy choices, and
2) community initiatives to promote and enable healthy choices.

While T.R.A.I.L. focuses on diabetes, we also cover critical diseases obesity, cancer, heart disease, and stroke. To help reduce such diseases, we also address lifestyle choices such as poor nutrition, physical inactivity, tobacco use and other risk-taking behaviors. The components of the T.R.A.I.L. program are strongly centered on learning to make positive lifestyle choices.

The U.S. Department of Health and Human Services (HHS) notes on the reality of diabetes, that American Indians are about 2 to 3 times more likely than whites to have diabetes. HHS anticipates that diagnosed diabetes cases will more than double by 2050. It also notes that more than one-third of the 17 million Americans who have diabetes don't even know they have diabetes and that diabetes is the sixth leading cause of death.

I feel diabetes education is vital in the lives of adults and kids today. The world makes it to easy to make poor choices regarding nutrition and exercise. Convenience foods are making it convenient for the development of diabetes especially in kids. Diabetes is an ongoing epidemic. I feel that with education and guidance diabetes doesn't have to be a silent killer. I love the T.R.A.I.L. program and urge for the continuation of diabetes prevention programs.

Thank you,

Robyn Zike

Committee on Indian Affairs
Oversight Hearing on Diabetes in Indian Country
February 8, 2007

I am a success story.I had had to control type 2.I am of Lakota and Cherokee descent and my diabetes was weight related. My doctor tried everything and because ea slow thyroid goes hand and hand with this nothing worked till he sent me to a clinic that gives HCG(Human Chorionic Gonadotrophin) shots.I statred their on of all days July 4th.I have lost 65 pounds and have been off all diabetic meds since early October. I was on both Amaryl and Glucophage.I still have to test daily but my fastings remain in the 82 average range and before to me that was a crash with feeling lightheaded,etc.That's how high my highs were.My 2 hour post parangial sugars average 116.My waist line and tha tis the important part went from a 46 inch waist to 33.Once I hit 36 inches my sugars were normal.I firmly believe that many of our people would benefit from these shots .Along with the shots women are on a healthy low sodium,low fat 550 calorie diet.The only exercise is walking until you are thirty pounds from your goal weight.Men get to have a 750 calorie diet.Shots of B12 are also given. The weight just falls off.Over the first two weeks I lost 16 pounds then it levels out to about 4-5 pounds/week,with plateaus every thirty or so pounds.At that time you take maintenance breaks where you do not get shots but only go up to 1250 calories.After maintenance you normally are back to 5 pound /week loss. Mostly you eat lots of chicken breasts,turkey and fish.beef is just once a week but lots of veggies add in to fill you up.Some people use frozen meals like healthy Choice but you can make up your own meals with less sodium and mor emeat. I am thrilled with the weight loss.before I could not walk upstairs without shortness of breath .Now i am bounding with energy and move fast enough to play like a bullfighter with my young bulls in the barn lot(raise bucking bulls).
I really feel that if we can get Indian people on a HCG weight loss program we would see the percent of type 2 fall sharply. And it would be less of an expense medically to treat with HCG diet programs than to treat the disease for years. I have recently spoken with Healthspring who is my Medicare insurer to see if they could okay payment for their customers.My docto rhas many patients who are disabled or on SS and overweight who would benefit from this but cannot afford the costs($59/week after initial $159 for treatment and other expenses).Healthspring is a medicare provider and if they would pick up the cost it would save them money in the long run and medicare because the diabetic supplies they pay out for would not be needed.
I am thirty pounds from my goal weight and size.Currently finding my size 14s getting loose so...Hope this success story helps. I had failed on all other programs.Matrix's HCG injections and counseling and diet plan did the trick that Weightwatcher,South beach,NutriSystem and Atkins,etc could not do.I amreally psyched about this.Also,last week was my birthday and the waitress wanted to know if I was my husband's daughter.I look and feel younger since taking off the weight.My husband is only three years older than I!

Sheila Totten
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Tribal Leaders Diabetes Committee
National Indian Health Board

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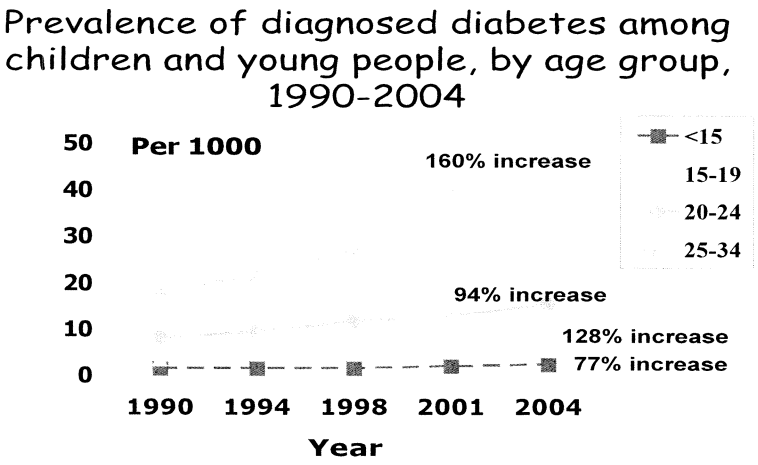
TESTIMONY OF BUFORD ROLIN
Chairman, Poarch Band of Creek Indians,
Chairman, Tribal Diabetes Leaders Committee &
Vice Chairman, National Indian Health Board

BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS
OVERSIGHT HEARING ON DIABETES IN INDIAN COUNTRY
AND SPECIAL DIABETES PROGRAM FOR INDIANS

THURSDAY, FEBRUARY 8, 2007, 9:30 AM
SENATE RUSSELL BUILDING ROOM 485

Good Morning, Chairman Dorgan and Vice-Chairman Thomas, and members of the Indian Affairs Committee. 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). This important 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. The American Diabetes Association (ADA), Juvenile Diabetes Research Foundation (JDRF) and the NIHB hosted a meeting June 13 – 14, 2006 to bring tribal leaders and key stakeholders together to discuss how to approach the reauthorization of SDPI funding during the 110th Congress. It was recommended by the diabetes associations and former congressional leader, Congressman George Nethercut, to seek reauthorization of the SDPI at an increase funding request of $200 million per year for five years.

On October 6, 2006, the TLDC, with the assistance of the NIHB, mailed a letter to all tribal leaders seeking input as to the future of the SDPI. The letter specifically asked the tribal leaders whether they would support the amount of $200 million per year for five years as the amount of funding Indian Country should ask for from Congress. The tribes responded unanimously in support of reauthorization of the SDPI at an amount of $200 million per year for five years.

The ADA and JDRF have been great partners with the NIHB in efforts to secure appropriate funding for diabetes research and the SDPI. At the NIHB Annual Consumer Conference, the ADA and the NIHB participated in a workshop entitled "Advocacy for the Reauthorization of the SDPI: Awakening the Spirit and Working Together to extend the SDPI." The workshop presenters discussed advocacy efforts and the role Indian country could play in achieving reauthorization. The workshop attendees were asked to review "Awakening the Spirit" advocacy kits that will be distributed by the ADA and NIHB to Congressional offices.

The NIHB was recently informed that two young members of the Choctaw and Chickasaw Tribes will join 150 other children from across the U.S. to participate in the JDRF Children's

Congress, to be held June 17 -20th, in Washington, D.C. Delegates to the Children's Congress will converge on Capitol Hill to tell their stories and urge lawmakers to find a cure for type 1 diabetes. Desiree Cameron, of the Choctaw Nation, and Erica Rodebush, of the Choctaw and Chickasaw Nations, were selected from over 1,000 applicants. In a letter to members of Congress, Erica writes:

> *" I wish there were a cure for type 1 diabetes so I could live a more normal life like my friends and family. A cure would allow me to eat and drink without checking my blood sugars and counting carbs for insulin. Finding a cure would mean my parents wouldn't have to pay for my supplies that cost a lot. Me, my parents and brother would not have to worry about sleeping all night because my blood sugars wouldn't be low or go high and make me sick."*

As Chairman of my own tribe, the Poarch Band of Creek Indians, I wish that more Indian people could travel to Washington, D.C. to tell their stories as to how diabetes impacts their lives, the lives of their families and their communities. My mother had diabetes and I still remember to this day how she suffered from the illness.

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. A study published by the ADA in 2002 on the economic burden of diabetes in the U.S., estimated that it costs over $13,000 per year to care for one person with diabetes compared with $2,600 per year for persons without diabetes. Nearly 1/3 of every Medicare dollar is spent on people with diabetes. Individuals with diabetes have more than twice the prevalence of disability from amputation, loss of vision, and other seriously limiting medical conditions. People with diabetes are at greater risk for diabetes-related complications such as stroke, heart attack, blindness, kidney failure, limb amputation, nerve damage, severe dental disease, and complications of pregnancy.

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 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.

As Chairman of the TLDC, I have had the unique opportunity to work closely with Dr. Charles Grim, Director of IHS, and with Dr. Kelly Acton, Director, IHS Division of Diabetes Treatment and Prevention Program, to oversee the development of many of the culturally sensitive and appropriate diabetes programs throughout Indian Country. In 1998, the IHS formally established the TLDC to provide advice and input on diabetes-related issues and its complications for AI/ANs. The TLDC's collaborative effort with the IHS has been an important outcome 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. The TLDC provides that knowledge.

The IHS, tribal, and urban model diabetes programs have developed and implemented a variety of community and education programs that reflect the specific needs of their local communities. While I cannot begin to describe all of the model diabetes programs, I would like to highlight a few:

- The Fort Berthold Model Diabetes program located in New Town, North Dakota, has created community activities such as cooking classes and menu planning for local area schools. The program created educational activities such as a "Diabetes Bingo" game to help educate community members on prevention and treatment of diabetes. While this model diabetes program has developed community and education opportunities for their members, the program faces challenges such as lack of space for an exercise room or to conduct group activities. Funding has been a problem to meet staffing and traveling needs. Excessive travel costs are due to the long distances between communities. Because of limited funding, trips to outlying communities have been reduced. If it were not for the SDPI funding, the program would not have been able to establish a self glucose monitoring program or a diabetic optometry or foot clinic.

- The Fort Totten Model Diabetes Program, located in Fort Totten, North Dakota, organizes several community activities such as a Diabetes Walk/Run, a Diabetes Alert Day, a community blood screening and health fair, and other community awareness events in partnership with the local Headstart program, tribal law enforcement, Elderly meals, Four Winds School, tribal WIC program, and the Expanded Food & Nutrition Education program.

- The Whirling Thunder Wellness Program, operated by the Winnebago Tribe of Nebraska, is a multidisciplinary program with 76 years of cumulative diabetes experience and

includes a physician assistant, two R.N.s, a fitness director, dietician, prevention specialist, two fitness specialists, and an eye care manager. The program has established community activities such as a Healthy Choice Pow Wow Food Stand, a "Bison in Nutrition" intervention, and a Kidz Café offering healthy menus and nutrition education.

- The IHS Zuni Service Unit Diabetes Program, in Zuni, New Mexico, has identified 25% of those ages 29 and older and 50% of those ages 49 and older as having diabetes. A Zuni Wellness Center has been established for individuals at risk of diabetes to exercise and participate in health promotion activities. The Center has earned the reputation for quality advances in fitness and health promotion and cites "community empowerment" as necessary to its success.

While these are just some of the examples of the model diabetes programs located throughout Indian Country, all of the programs continue to face many challenges. There is a lack of staff and staff turnover, lack of data/case management systems, and lack of adequate facility space to provide basic services and to hold community, educational, and fitness activities.

An overall concern of these programs is that the number of known AI/ANs with diabetes has increased due to more accurate data reporting, but the staffing and budget needs have not kept pace. For example, the Blackfeet Diabetes Program identified 331 people with diabetes in 1988, and in 2000, identified over 1,000 people with diabetes; yet the number of staff has been reduced from six to four.

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.

I appreciate the Committee on Indian Affairs scheduling this oversight hearing on diabetes in Indian country, and especially, the Special Diabetes Program for Indians. Thank you for inviting me to testify and I am happy to answer any questions you may have.

Senate Committee on Indian Affairs

Diabetes in Indian Country

Russell Senate Office Building, Room 485

February 8, 2008

Good Morning Honorable Senators of the Senate Committee of Indian Affairs, staff members and others present here today. I am Donna Vandall; I am the Interim Coordinator for the Winnebago Tribal Whirling Thunder Wellness Programs, in Winnebago, Nebraska.

Our reservation is located 20 miles south of Sioux City, Iowa on the West side of the Missouri River it is approximately 120,000 acres on the Nebraska side with 1,800 acres of land on the Iowa side of the river. The tribal population on the reservation is 2,600 people with the same amount of tribal members living off the reservation. A study conducted by our Tribal government after the 1990 census shows that our population was projected to increase from its 1990 level of 2,377 to 5,050 in 2040 due in large part to the high birth rate and population pyramid. With this continuing growth in our community, comes the need for expanded health services, economic development, education and employment. It is for health and diabetes in particular that we have been invited to participate in today's hearing.

Indian Health Service originated the Diabetes Program in 1979. The Winnebago Tribe of Nebraska has contracted the Diabetes Program in 1995. The program was named for Whirling Thunder, a "Head Man" of the tribe who led his own band throughout the treaty time. His signature is on the 1832 Treaty between the Winnebago and the United States. It is this man who expressed his concern for the health of his people. His descendents still reside within our community. He and other leaders after him dreamed a mighty dream of health and wellness for the children.

The Whirling Thunder Wellness Program has received numerous awards and recognitions over the years, for which we are appreciative. There have been many exceptional staff people who carried in the past and who now carry the dream of prevention and wellness for tribal people. We knew that Indian Health Service was involved with the treatment and care of diabetic clients and was not directed nor funded to perform prevention activities.

The Program began screening the youth and adults in our community in 1995. Referrals were made to Indian Health Service for treatment and care. Over the years, we saw a reduction in amputations and loss of sight and other debilitating conditions of diabetes in our patients. Our screening produced results that alarmed us. Early in our program development we saw that the incidence of Acanthosis Nigricans acceleration in school age children showed that in ten years we would have twice the number of diabetics if conditions did not change. This information was frightening and overwhelming.

It is at that time that the Special Diabetes Program for Indians was funded and made available to tribes. We applied, were funded and began a phase of intense community education, with tracking and follow-up of diabetics. We expanded opportunities for physical exercise for all age groups from Head Start children to Senior Citizens. We added weightlifting, circuit training, walking and established personal training programs for individuals.

The collaboration and partnership agreements between tribal programs, the Indian Health Service, Colleges and Universities, the State of Nebraska and - private foundations ensure continuity and mutual support for addressing the needs of diabetics on the reservation and within the Winnebago IHS service area.

The vision of diabetic care was to provide empowerment tools, wellness activities and health education to the tribal community, and to develop a community diabetes prevention team through networking all service areas and service providers of every community discipline with tribally appropriate relationships. This relationship has maximized service and contract resources to improving lifestyle and health status.

The collaboration and cooperative effort between all health care providers has proven to be the most effective way to address diabetes in our community. Surveys, continual screenings and presence at all community events, keep the program in touch with the needs and wishes of the community residence.

The clinical services and records are an integral part of the data follow-up for Indian Health Service and the Whirling Thunder Wellness Program. Our program contributes to the data base of the Winnebago Indian Health Service Hospital through referrals given to our Nurses, Counselor, Wellness Center, and Nutrition Specialist. The medical staff welcomes the tribal diabetes coordinators and staff in their established meetings and work to provide alternatives to care and service when an improvement is identified.

The Whirling Thunder Wellness Program maintains their own data with the services of a contractor from the University of Nebraska. The data collected is Blood Pressure, Blood Sugar levels of the diagnosed diabetics, Hemoglobin A (1)c's and Body Mass index are maintained as an indicator of the potential development of diabetes due to overweight inactivity and other lifestyle contributors. The cooperative partnerships are invaluable for tribes to develop and maintain for the betterment of their citizens and to address the potential devastation of life quality for the total community. Whirling Thunder is a boost to Indian Health Service clinics and services when patients feel welcome return to receive services and become a partner in their own care

The Presidents fitness program goals are a part of our Wellness Center plan as well as the Diabetes Management Standards of the Indian Health Service. Our tribal government is intimately involved with our programs both from a programmatic and administrative stand. Communication is vital and the management of personnel, budgets, supervision of diverse staff and marketing the program locally. Resource management is a must for successful program outcome. Medical personnel are service providers and a support to achieving the program goals. Support staff is the life line we rely on for day-to-day program delivery.

Our services and programs produce a volume of data which is tracked by providers to expedite identity of newly diagnosed and border line individuals and provide immediate tribally appropriate services. The greater vision of the program is to ultimately prevent conversion of all border line individuals to full diabetes by early identification and prevention services.. Family involvement is encouraged and supported to assist the individual in prevention activities.

With the addition of Ho Chunk Hope, a competitive SDPI grant program, in 2005 we began work with the pre-diabetic tribal members. The current results of these activities show exciting preliminary results. Awareness of health, weight and nutrition are proving that people with a strong family history of diabetes can prevent themselves from moving into diabetes. These pre-diabetics are changing their lifestyles and showing their families and relatives that we can live free of diabetes.

At the same time our data from Indian Health Service shows that the prevalence of diabetes in our community has increased form 10.8% in 2000 to 17% in 2006. This factor is determined by the number of new cases of diabetes in one year divided by the number of diabetics in our registry. It tells us the number of new diabetics we are getting per year. More screenings will increase the number as well as other factors. With the identification of the problems and programs of

effective prevention practices, we need continued support to stop the epidemic spread of diabetes for tribes.

Indian Country is very aware of this Committee. We know your burdens and we appreciate your work. A short time ago I attended a celebration in the Northern Plains, and a veteran was asked to pray for the evening meal. We prayed for the People and for the young men and women who were far from home fighting in a war. We prayed for tribal leaders, our elected leaders of the country and for Senator Tim Johnson and his family. In these gatherings and in our ceremonials the smoke carries our prayers and you are there, we hold you close.

We thank the members of this committee for listening to our testimony. We ask for your continued support and funding of these initiatives for the Winnebago tribe, all the tribes within the Aberdeen Area, and all the tribes in the Nation.

I would be happy to answer any questions.

Attachments/ Data from Aberdeen Area Diabetes Audit

Ho-Chunk Hope Success – 39 Prevent Diabetes

The Ho-Chunk Hope Program participants were successful in 2006. Forty-two participants completed the 16-week program. While the average weight loss was 9.4 pounds each, their greatest success was a reduction in their fasting blood glucose (FBG) results. The average reduction in FBG was 11mg/dL. This reduction put 22 participants back into the normal glucose range of less than 100 mg/dL. Another 17 stayed in the pre-diabetes glucose range of 100-125mg/dL. Unfortunately three participants were diagnosed with diabetes at follow-up.

Other measures of success included decreased blood pressure in 24% of participants and decreased cholesterol measurements of an average of 21 points. Almost all participants increased their time exercising with 54% reaching the goal of 150 minutes per week.

The data shows that those participants that lost the most weight and increased their exercise time were the ones who decreased their FBG the most. A Diabetes Free Future is possible as demonstrated by the thirty-nine Ho-Chunk Hope participants.

Submitted by Peg Bottjen, Data Coordinator

HO-CHUNK HOPE

The Ho-Chunk Hope program is a program designed towards prevention. Ho-Chunk Hope first approached the Department Head Directors with a presentation on their program goals and objectives. The presentation was held on October 25, 2005, at that time we were all asked to take a blood test, we all volunteered, each one of us were later contacted for further testing, which entailed taking a fasting glucose test, upon completion I was contacted and was diagnosed as prediabetes. The Lead Recruiter immediately set up appointments with the dietician and a physician who are assisting the Ho-chunk Hope program. I took this very seriously and as a warning to change my lifestyle to prevent diabetes. I was also issued a monitor to test my sugar, which I use on a daily basis.

My meetings with the dietician proved to be the most beneficial; it was explained to me how important it is to maintain and eat a healthy low-fat diet, lose weight and to exercise regularly. There are no symptoms for pre-diabetes, there are risk factors and having a family history, in which both my parents were diabetes; I felt that I too needed to change my lifestyle.

I entered the Ho-Chunk Hope Program on January 10, 2006 in which the first of the 16 classes began, meeting every Tuesday either afternoon or evening. Classes last approximately one hour. I have attended and learned many things through this program, one very important is to take time for myself, I've committed to exercising three times a week after work, monitor what I eat daily, as a result I have lost over 10 lbs., my blood sugar levels are in the normal range.

The thanks go out to the Ho-chunk Hope program and the commitment from the staff and to those that attend classes, we get a chance to share and exchange our war stories. Had I not taken the test and entered the program I would not be where I am today, because after three months on the program and the commitment I made to myself, I was told that I was not pre-diabetes but a diabetic. At first I was upset and little angry, not at the program, but my thoughts were why wasn't I told sooner by the physician. A lot of other thoughts went through my mind but never losing sight of the fact that had I not entered the program and gained the knowledge of preventing diabetes by eating a healthy low fat diet, losing weight and exercising . I am now controlling my blood sugar by following the program, and was informed that I will not have to take any pills as long as I maintain my blood sugar. I owe this all to the Ho-Chunk Hope program.

Carol A. Snow

Hi! My name is Clarissa Hoffman a 34 year old Native American woman who comes from a long line of great people. A people who have had to endure near extinction and yet we are still thriving. We have survived but unfortunately there are still disease and sickness we must overcome, Diabetes is one of them. It has passed down from generations to generations and it can be stopped.

I am very glad, no, happy that I can be part of a change that will help future generations. Ho-Chunk Hope is teaching that change. I love Ho-Chunk Hope and it is a great program. It is life changing program, and a people saving program.

I have learned and re-learned how to take care of myself and fight diabetes. It will be through me that my children will eat and live healthier lives. It is at times hard to find the time to exercise, but if one is determined it can be done. For myself I have had to exercise/lift weights and do reps in between short intervals while cooking… I will have the stove on, my 1 year old in the high chair, and the weights in the kitchen, with my companion being my partner. (my companion has also completed the program and am happy to say is off the diabetic chart in a good way) or when home alone or just being silly I will bust some dance moves to a whole song….exercising while entertaining my little ones. It is hard but it can be done.

Our eating habits have changed also. No more sugary sugar... from white sugar to sweeteners and to light brown sugar and only Diet Soda if need to be. I have incorporated honey & cinnamon into our diet and since I am the one who cooks our meals, it is I who can cook the foods in a healthier way and try different tastes that are better for us.

I know I am responsible for how my children eat and the habits they form, therefore I need to make sure I do what is best for them, by first taking care of myself while, at the same time making permanent healthier choices in all of our lives.

Ho-chunk Hope has helped teach me those ways and has also showed me the way to a healthier lifestyle. I am so thankful for the program and I know it will help others too. It is not only a lifesaver but a limb saver too! And I mean that in a good way because diabetes is in my family, I have had 3 relatives lose limbs. Diabetes needs to be taken seriously and seriously wiped out and it can be.

Since I started this class on January 10, 2006 I've learned a lot more about Diabetes, the reason I am taking this class is because I was tested and my blood sugar was 102 which is a little high for the fasting I did, and being in this class has made me aware of how important it is to exercise and watch the intake on my foods. I have lost weight and I exercise more than I did in the past. I want to thank Ho-Chunk Hope for sponsoring this class and the exercise classes we have with Amber from 4 Seasons. I know the other ladies that are in this class really enjoy it.

By, Lea Cleveland