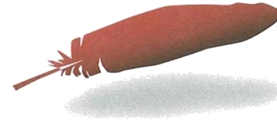


# National Indian Health Board



## SENATE COMMITTEE ON INDIAN AFFAIRS OVERSIGHT HEARING ON “NATIVE YOUTH: PROMOTING DIABETES PREVENTION THROUGH HEALTHY LIVING”

**Testimony on Behalf of the National Indian Health Board**  
**Vinton Hawley, Chairperson**  
**March 29, 2017**

### **Introduction**

Chairman Hoeven, Vice Chairman Udall and Members of the Committee, thank you for holding this important hearing on improving the lives and health of American Indian and Alaska Native youth through preventing diabetes. Thank you for the opportunity to provide this testimony on behalf of the National Indian Health Board (NIHB).

The federal promise to provide for the health of Indian people was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation’s obligations to the Tribes and the special trust relationship between the United States and Tribes. The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace. The Snyder Act of 1921 (25 USC 13) legislatively affirmed this trust responsibility. To facilitate upholding its responsibility, the federal government created the Indian Health Service (IHS) and tasked the agency with providing health services to AI/ANs. Since its creation in 1955, IHS has worked to fulfill the federal promise to provide health care to Native people.

To provide context for this discussion, I would first like to provide you with some health statistics for American Indians and Alaska Natives (AI/ANs). The AI/AN life expectancy is 4.5 years less than the rate for the U.S. all races population. AI/ANs suffer disproportionately from a variety of diseases. According to IHS data from 2005-2007, AI/AN people die at higher rates than other Americans from alcoholism (552% higher), unintentional injuries (138% higher), homicide (83% higher) and suicide (74% higher). Indian Country also suffers disproportionately from diabetes at a rate 182% higher than the general U.S. population.

Chronic poverty, historical trauma, remote locations, and a devastatingly under-funded Indian health delivery system all contribute to these statistics. The United States is too great a nation to stand idly by while AI/ANs, the first Americans, live with these realities.

## Diabetes in Indian Country

American Indian and Alaska Native (AI/AN) youth, children, and families face many disparate adverse experiences and health outcomes compared to the general U.S. population. One of the most prominent health disparities in Tribal communities is the high rate of type 2 diabetes. AI/ANs of all ages are disproportionately impacted by type 2 diabetes and its many chronic complications— whether through their own individual diagnosis or the diagnosis of a loved one. The Gila River Indian Community has reported a 4 year old presenting with type 2 diabetes – and they are not alone. As such, Tribal communities must have the resources and support they need to access fresh and nutritious foods, safe places for physical activity, and quality diabetes treatment and intervention programs.

Because AI/AN traditional subsistence lifestyles have been replaced with federal programs such as the Food Distribution Program on Indian Reservations, the Food Stamp Program, and the Commodity Supplemental Food Program, many Tribal communities have a new reliance on store-bought foods, poor access to fresh produce, and have increased consumption of fast foods. These compounding issues have resulted in American Indian and Alaska Native children suffering from higher rates of obesity and related complications, such as type 2 diabetes.<sup>1</sup> The prevalence for type 2 diabetes in Native children can be as high as 76%, compared to only 6% for non-Hispanic white children.<sup>2</sup>

Even in the general U.S. population, type 2 diabetes is increasingly diagnosed in youth and now accounts for 20-50% of new-onset diabetes case patients. However, type 2 diabetes disproportionately affects minority race and ethnic groups – with the highest rates being among American Indian and Alaska Native youth. While few longitudinal studies have been conducted, it has been suggested that the increase in type 2 diabetes in youth is a result of an increase in obesity in the overall population.<sup>3</sup> The majority of studies that have been done have been conducted on American and Canadian Indigenous populations because of the high rates of diabetes experienced in Tribal communities. Therefore, we know American Indian and Alaska Native youth age 10-19 are nine times more likely to have diagnosed type 2 diabetes compared to young non-Hispanic whites in the same age group.<sup>4</sup> Furthermore, from 1990-2009 AI/AN youth age 15-19 experienced an increase in diagnosed diabetes of 110%.<sup>5</sup> While these statistics are staggering, there are personal stories and real life implications behind each of the Native youth and families that have been diagnosed with type 2 diabetes. People with diabetes diagnosed before the age of 20 years have a life expectancy that is 15–27 years shorter than people without diabetes.<sup>6</sup> Given this, it is more important than ever that Tribal communities work to prevent diabetes and its complications in young American Indians

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<sup>1</sup> Story, M. et al. (2003). Obesity in American-Indian Children: Prevalence, Consequences, and Prevention. *Preventative Medicine*, 37(1), S3-S12, S5.

<sup>2</sup> Kaufman, F. (2008, July 16.). Written Testimony before the Senate Committee on Health, Education, Labor, and Pensions, Subcommittee on Children and Families. *Childhood Obesity: The Declining Health of American's Next Generation—Part I*, 3.

<sup>3</sup> (Dabelea, et al., 2014) (2)

<sup>4</sup> SEARCH for Diabetes in Youth Study (<http://www.ncbi.nlm.nih.gov/pubmed/17015542>)

<sup>5</sup> IHS Division of Diabetes Statistics

([https://www.ihs.gov/sdpi/includes/themes/newihstheme/display\\_objects/documents/factsheets/Fact\\_sheet\\_AIAN\\_508c.pdf](https://www.ihs.gov/sdpi/includes/themes/newihstheme/display_objects/documents/factsheets/Fact_sheet_AIAN_508c.pdf))

<sup>6</sup> (Mayer-Davis, et al., 2009)

and Alaska Natives. One program in particular, the Special Diabetes Program for Indians (SDPI), has been especially successful in establishing and sustaining effective diabetes treatment and prevention programs in Indian Country.

### **Special Diabetes Program for Indians**

Because of the rising rates of type 2 diabetes in American Indian and Alaska Native youth and the U.S. population in general, Congress established the Special Diabetes Program for Indians in 1997. The SDPI was first funded through the Balanced Budget Act in conjunction with the Special Diabetes Program for Type 1 Diabetes (SDP) – a program that addresses the opportunities in type 1 diabetes research. Together, these two programs have become the nation’s most strategic, comprehensive and effective effort to combat diabetes and its complications.

The SDPI is changing the troubling statistics for American Indians and Alaska Natives of all ages with marked and measurable improvements in average blood sugar levels, reductions in the incidence of cardiovascular disease, prevention and weight management programs for our youth, and a significant increase in the promotion of healthy lifestyle behaviors. This success is due to the nature of this grant program that allows communities to design and implement diabetes interventions that address specific cultural approaches identified community priorities. The SDPI currently provides grants for over 300 programs in 35 states.

As a result of intensive data collection and analysis over the past two decades of the SDPI, we are able to demonstrate remarkable outcomes from SDPI programs, including a reduction in A1C levels, reduced cholesterol levels, and weight loss of program participants around Indian Country. Recently, the Centers for Disease Control and Prevention (CDC) published data in its Morbidity and Mortality Weekly Report about the remarkable decline in End-Stage Renal Disease (ESRD) due to diabetes seen in American Indians and Alaska Natives in 1996-2013. During this time period, similar to that of the SDPI, AI/ANs have experienced a 54% decline in incidence rates of ESRD due to diabetes – the steepest decline of any other ethnic group. The CDC report also states, “because of SDPI, the partnership of IHS and I/T/U programs is stronger, and together they provide a comprehensive public health–oriented national program that has demonstrated success in addressing the diabetes epidemic and reducing complications such as ESRD-D.”<sup>7</sup> ESRD treatment costs Medicare roughly \$87,000 per patient, per year, so SDPI is also resulting in significant cost savings for federal health programs.<sup>8</sup>

As the data shows, the diabetes treatment and prevention programs funded by SDPI are clearly improving, as well as saving lives, in Tribal communities and transforming the way diabetes is addressed. For example, the Alaska Native Tribal Health Consortium’s (ANTHC) “Store Outside Your Door” program highlights traditional foods of the Native peoples living within the region and teaches families how to

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<sup>7</sup> (Bullock, et al., 2017)

<sup>8</sup>U.S. Renal Data System: [https://www.usrds.org/2013/view/v2\\_11.aspx](https://www.usrds.org/2013/view/v2_11.aspx), Accessed on March 27, 2017.

harvest and prepare nutritious traditional foods that do not include many of the preservatives and sugars of the processed foods often available at local grocery stores. This model makes nutritious foods accessible to the community and infuses the local Indigenous culture back into mealtime. Another example of the effective, innovative community health programming being conducted in Tribal communities around Indian Country is the “Cherokee Choices” program at the Eastern Band of Cherokee Indians (EBCI). Like many Tribal communities, the EBCI has higher rates of obesity and type 2 diabetes than the U.S. general population. To combat these high rates, the Cherokee Choices program includes three main components: elementary school mentoring, worksite wellness for adults, and church-based health promotion.<sup>9</sup> As a holistic approach to preventing diabetes and obesity in the local AI/AN population, Cherokee Choices also seeks to address racism, historic grief and trauma, mental health, and creates a supportive environment for developing positive policy changes.

These are just two examples of the over 300 Tribal programs nationwide taking an innovative, holistic and community- and evidenced-based approach to preventing diabetes in Native youth, children and families. As one young American Indian from the Klamath Diabetes Program stated after participating in the diabetes prevention program at the Cow Creek Consortium in Oregon, “I truly believe [SDPI] can dramatically improve the health of the Klamath Tribes and bring us *mo ben dic hosintambiek* (“good health” in Klamath). I would have never had the courage or been in the shape necessary to accomplish my goals had it not been for the Diabetes Prevention Program. It is imperative that these types of programs are firmly in place to lead us to the next level of good health”.

Most recently in the long history of the SDPI, in April 14, 2015, the U.S. Senate passed a two year reauthorization of the Special Diabetes Program for Indians (SDPI) as part of The Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act of 2015 (P.L. 114-10). The measure passed the Senate by a bipartisan vote of 92-8. This followed action by the U.S. House of Representatives on March 26, 2015, which also passed the legislation by a bipartisan vote. SDPI is one of many programs in this legislation. However, the reauthorization is set to expire on September 30, 2017. Meaning, over 300 diabetes treatment and prevention programs around the country would no longer be available to the most vulnerable population for this devastating disease. Congress must act swiftly to reauthorize the SDPI and ensure continuity in the successful prevention and intervention efforts being conducted all across Indian Country.

NIHB and Tribes are encouraged by the strong support enjoyed by SDPI in Congress. In September 2016, a letter addressed to Congressional leadership in support of SDPI and SDP garnered signatures from 356 House Members and 75 Senators. We hope that Congressional leaders make the renewal of these programs a legislative priority in the coming months. Failure to enact SDPI swiftly will result in the loss of staff for many SDPI programs living in rural areas and will cause disruptions to patient care.

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<sup>9</sup> Bachar JJ, Lefler LJ, Reed L, McCoy T, Bailey R, Bell R. Cherokee Choices: a diabetes prevention program for American Indians. *Prev Chronic Dis* [serial online] 2006 Jul [date cited]. Available from: URL: [http://www.cdc.gov/pcd/issues/2006/jul/05\\_0221.htm](http://www.cdc.gov/pcd/issues/2006/jul/05_0221.htm)

## **Putting First Kids 1<sup>st</sup>**

The National Indian Health Board, in partnership with the National Congress of American Indians, the National Indian Education Association, and the National Indian Child Welfare Association have created a joint policy agenda for American Indian and Alaska Native children. This agenda, updated in 2015, is intended to be a tool to develop integrated policy approaches and specific recommendations for Tribal governments, policymakers, and local leaders to use when creating and implementing a vision for thriving, vibrant Native communities. The agenda includes a “Healthy Lifestyles” component that outlines policy recommendations that would specifically help policymakers and Tribal communities prevent diabetes in Native youth, children, and families through increasing physical activity, improving access to nutritious foods, and increasing access to health care and public health services.<sup>10</sup> In addition to the swift reauthorization of the Special Diabetes Program for Indians outlined earlier, the NIHB puts forth the following recommendations for Tribes and policymakers to pursue to strengthen diabetes prevention efforts and to make healthy lifestyles more accessible to Native youth and families:

- Ensure that community food programs, especially youth breakfast and lunch programs, incorporate healthy food choices and locally produced or traditional food options.
- Co-locate food assistance programs to serve meals to elders along with Head Start, child care, or school programs to reduce administrative costs and resources.
- Work to improve the Food Distribution Program on Indian Reservations by incorporating more traditional, locally-produced foods as healthier options.
- Provide direct funding to Tribes who want to administer the Supplemental Nutrition Assistance Program (formerly the Food Stamp Program).
- Work to create similar options for the Women, Infants and Children (WIC) program and increase Tribal flexibility in administering this program.
- Advocate for Tribal provisions within the National School Lunch Program and the School Breakfast Program for Tribal schools.
- Work with school nutrition programs to replace junk foods with healthier options in vending machines and school cafeterias. These programs should permit Tribal administration and should ensure that state-administered programs are sufficiently responsive to the needs of Native youth.
- Promote the expansion of retail grocery markets in Native communities.
- Support federal programs that encourage at-home food production, such as backyard gardens and training on planting and maintenance.
- Work to ensure that Bureau of Indian Education (BIE) schools receive funding to build and upgrade sports-related facilities, such as gymnasiums, fields, and tracks to increase safe places for Native children and youth to be physically active.

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<sup>10</sup> Native Children’s Policy Agenda: Putting First Kids 1<sup>st</sup>  
([http://nihb.org/docs/10122015/Aug\\_2015\\_Native\\_Childrens\\_Policy\\_Agenda.pdf](http://nihb.org/docs/10122015/Aug_2015_Native_Childrens_Policy_Agenda.pdf))

- Incorporate wellness programs in health clinics and facilities. While health care addresses disease prevention and treatment, wellness encompasses daily lifestyle choices, environment, emotional and spiritual well-being, and health education. Through wellness promotion, the incidence of health problems can be reduced, along with long term health care costs.
- Improve outreach services and health education. For example, a Tribal diabetes patient education program, which focuses on teaching people how to manage their disease on a daily basis, is an important tool for reducing diabetes-related complications. These programs can also be directed to helping children manage their diabetes from an early age. Similarly, community outreach services can help educate people about the availability of health benefits and teach children to make healthy choices early in life.
- Develop school-based health clinics. Students perform better in class when they are healthy and ready to learn. School-based health centers bring the doctor's office to the school so students avoid health-related absences and get support to succeed in the classroom.

### **Conclusion**

Thank you again for the opportunity to offer this written statement. While Tribes have made important gains in recent years in terms of type 2 diabetes funding, improved health outcomes, and the leveling off of diabetes incidence rates, there is still a long way to go before Native youth, children, and families will no longer be devastated by the impacts of diabetes and its complications.