



Statement by

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Chairman and Members of the Committee:

Good afternoon, Chairman Hoeven, Vice-Chairman Udall, and Members of the Committee. I am Chris Buchanan, an enrolled member of the Seminole Nation of Oklahoma and currently the Acting Director of the Indian Health Service (IHS). Prior to that I was the IHS Deputy Director, leading and overseeing IHS operations to ensure delivery of quality comprehensive health services. I am pleased to have the opportunity to testify before the Senate Committee on Indian Affairs on our accomplishments in preventing diabetes for Native youth through our work in partnership with American Indian and Alaska Native (AI/AN) communities. I would like to thank you and Vice-Chairman Udall for your leadership on the Committee and for elevating the importance of delivering quality care through the Indian Health Service.

The IHS plays a unique role in the Department of Health and Human Services (HHS) because it is a health care system that was established to meet Federal trust responsibilities to American Indians and Alaska Natives. The mission of the IHS, in partnership with American Indian and Alaska Native people, is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. The IHS provides comprehensive health service delivery to approximately 2.2 million AI/ANs through 26 hospitals, 59 health centers, 32 health stations, and nine school health centers. Tribes also provide healthcare access through an additional 19 hospitals, 284 health centers, 163 Alaska Village Clinics, 79 health stations, and eight school health centers.

Diabetes is a complex and costly chronic disease that requires tremendous long-term efforts to prevent and treat. Although diabetes is a nationwide public health problem, AI/AN people have

been and remain disproportionately affected, with diabetes prevalence more than twice that for non-Hispanic whites in the United States. However, after several decades of intensive efforts by the IHS, Tribes, Urban Indian health organizations, and other partners, we are seeing clear evidence that this epidemic has leveled off.

In AI/AN people, the years of increasing diabetes prevalence stopped in 2011 and it has not risen since that time.¹ In addition, data show that focusing on quality, team-based clinical care has reduced devastating complications from diabetes. According to the January 2017 Centers for Disease Control and Prevention (CDC) Vital Signs report, new cases of diabetes-related kidney failure decreased dramatically (54 percent) among AI/AN adults from 1996 to 2013, a much larger decline than in any other racial group in the United States.² This decrease is especially important given that Medicare spent over \$82,000 per person for beneficiaries of all races with diabetes-related, end-stage kidney disease in 2013.³

As the future of Indian Country depends on the health of its youth, recent data show that there is good news here as well. Although the prevalence of type 2 diabetes in American Indian (AI) youth ages 10-19 is higher than in other racial/ethnic groups, the prevalence for AI youth in this age group did not increase from 2001-2009. However, during that same period, it increased significantly for white, black, and Hispanic youth.⁴ Even better, as it predicts future diabetes

¹ IHS National Data Warehouse. 2016.

² Bullock A, Burrows NR, Narva AS, et al. Vital Signs: Decrease in Incidence of Diabetes-Related End-Stage Renal Disease among American Indians/Alaska Natives — United States, 1996–2013. *MMWR Morb Mortal Wkly Rep* 2017;66:26-32. DOI: <http://dx.doi.org/10.15585/mmwr.mm6601e1>.

³ *Id.*

⁴ Dabelea D, Mayer-Davis EJ, Saydah S, et al. Prevalence of Type 1 and Type 2 Diabetes Among Children and Adolescents From 2001 to 2009. *JAMA* 2014 May 7;311(17): 1778–1786.

risk, the prevalence of obesity in AI/AN youth has also leveled off. Although higher than in US youth overall, obesity prevalence in AI/AN children and youth ages 2-19 years remained nearly constant from 2006-2015.⁵ Several key factors contributed to this significant and ongoing progress, including the Special Diabetes Program for Indians (SDPI).

The SDPI was established by Congress in 1997 in response to the diabetes epidemic that was escalating at an alarming rate in AI/AN people. The SDPI provides grants to Tribal, IHS, and Urban Indian health organizations for diabetes prevention and treatment services. The IHS administers the SDPI grant program to promote evidence-based best practices as well as to ensure accountability for the funds and compliance with grants regulations. The SDPI 2014 Report to Congress documented the continued improvements in key clinical outcome measures since the inception of the SDPI. The SDPI is currently authorized at \$150 million per year through the end of FY 2017.

Since the inception of SDPI, grantees have successfully implemented evidence-based and community-driven strategies to prevent and treat diabetes. There are currently 301 SDPI grant programs in 35 States, 252 Tribal, 20 IHS, and 29 Urban. Grantees collectively served over 782,000 AI/AN people per year, with two-thirds of grantees using at least some of their SDPI funding to work with children and youth. Examples of services that grantees implement to reduce risk factors for obesity and diabetes in youth include school and community-based physical activity and nutrition education, community gardens, AI/AN traditional sports and

⁵ Ogden CL, Carroll MD, Lawman HG, et al. Trends in Obesity Prevalence Among Children and Adolescents in the United States, 1988-1994 Through 2013-2014. *JAMA* 2016;315 (21):2292-2299; IHS National Data Warehouse. 2016.

dancing, cooking classes, sports leagues, and obesity-management clinics. The innovative programs they have developed honor and incorporate their unique and diverse tribal cultures.

In addition to the SDPI, the IHS has established many partnerships to advance the health of Native youth and families. The IHS provides \$1 million per year to support obesity prevention at Boys & Girls Clubs (Clubs) in Indian Country through a cooperative agreement with the National Congress of American Indians (NCAI). NCAI conducts an annual grant process to awards funds to Native Clubs so they can implement the Together Raising Awareness for Indian Life (TRAIL) program. TRAIL uses a comprehensive curriculum that includes educational, nutritional, and physical activities to promote healthy lifestyles, obesity prevention, and self-esteem for AI/AN youth. Over 14,000 AI/AN youth, ages seven through 11 years, have participated in the TRAIL program since 2003.

As important as it is to work with school-aged children, recent science has shown that risk factors for obesity and diabetes start in the earliest days and years of life. IHS has a Memorandum of Understanding with Johns Hopkins University's Center for American Indian Health to promote implementation of their evidence-based Family Spirit home visiting intervention. Working with pregnant women and young families, Family Spirit has been proven to reduce risk factors in American Indian children that are associated with later development of obesity and substance abuse.⁶

⁶ Barlow A, Mullany B, Neault N, et al. Paraprofessional-delivered, home-visiting intervention for American Indian teen mothers and children: 3-year outcomes from a randomized controlled trial. *Am J Psychiatry* 2015;172:154–162

Although it takes many years to turn around an epidemic like diabetes, this is happening in AI/AN communities, with significant improvements in childhood obesity, diabetes prevalence, and diabetes-related kidney failure. Thank you for your commitment to Native youth as well as your vision and leadership for diabetes prevention and treatment among AI/AN people. I look forward to continuing to work with you, our communities, and other partners to ensure the health of our Native youth and families. I will be happy to answer any questions the Committee may have.