INDIAN HEALTH SERVICE
SPECIAL DIABETES PROGRAM FOR INDIANS

2011 REPORT TO CONGRESS

Making Progress Toward a Healthier Future

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MESSAGES

A Message from Yvette Roubideaux, M.D., M.P.H.
Director, Indian Health Service

On behalf of the Indian Health Service, I am extremely proud to provide this Report to Congress on the Special Diabetes Program for Indians (SDPI). Using current scientific research and evidence-based best practices, SDPI grant programs have made tremendous improvements in diabetes treatment and prevention in both clinical settings and community-based programs. In this report, you will learn more about how SDPI has changed the diabetes landscape in American Indian and Alaska Native (AI/AN) communities since 1998.

The 66 SDPI Demonstration Projects broke new ground in Indian health diabetes prevention and treatment by implementing rigorous, highly structured interventions with outstanding results.

- The 36 SDPI Diabetes Prevention Programs successfully translated the National Institutes of Health (NIH)-led Diabetes Prevention Program (DPP) lifestyle intervention in their communities. In doing so, they achieved rates of diabetes incidence in high risk AI/AN people similar to that achieved in the NIH study lifestyle intervention group.
- The 30 SDPI Healthy Heart Demonstration Projects successfully reduced cardiovascular disease (CVD) risk in AI/AN people with diabetes. The percent of participants who met target goals for CVD risk factors (e.g., blood pressure and blood lipids) increased significantly after the team-based, intensive case management intervention.

The 338 SDPI Community-Directed Diabetes Programs, now with more than a decade of experience, have implemented and sustained diabetes treatment and prevention interventions—often, where few resources were available before.

- Since 1998, they have dramatically increased access to services such as diabetes clinics, teams, and registries; weight loss programs for adults and youth; infrastructure to promote physical activity; and access to experts in nutrition and physical activity.
- Since the inception of SDPI, many clinical measures for people with diabetes have improved and rates of diabetes complications over the same period decreased—most notably, for end stage renal disease (ESRD). SDPI has certainly contributed to these remarkable outcomes.

SDPI has shown that Indian health programs can treat and prevent diabetes in ways that significantly reduce the burden of diabetes and its complications for American Indian and Alaska Native people. The SDPI programs have accomplished incredible outcomes that will result in a healthier future for the patients we serve.

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A Message from S. Lorraine Valdez, M.P.A., B.S.N., R.N.
Acting Director, Indian Health Service
Division of Diabetes Treatment and Prevention

On behalf of the Indian Health Service Division of Diabetes Treatment and Prevention (IHS Division of Diabetes), I am pleased to present the fourth Report to Congress on the Special Diabetes Program for Indians. This unique program continues to make significant progress in treating and preventing diabetes in American Indian and Alaska Native people.

The IHS Division of Diabetes plays a central role in managing and supporting the Special Diabetes Program for Indians. We strive to improve accountability and excellence in our programs by:

- Translating and disseminating the latest science to Indian Health Service, Tribal, and Urban Indian programs across the country;
- Providing training on diabetes science and SDPI program management;
- Facilitating sharing of information and expertise among health care professionals and Tribal communities;
- Supporting grant program efforts to use best practices in diabetes treatment and prevention; and,
- Providing essential clinical data for program planning and improvement through the Diabetes Care and Outcomes Audit.

Above all, we continue to build strong partnerships with American Indian and Alaska Native communities in a common effort to turn the tide of the diabetes epidemic. Together, we are working to create a healthier future for American Indian and Alaska Native people.

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A Message from the Indian Health Service Tribal Leaders Diabetes Committee

The Indian Health Service Tribal Leaders Diabetes Committee is honored to share in presenting this Report to Congress on the Special Diabetes Program for Indians. Since 1998, we have worked closely with the Indian Health Service to provide Tribal consultation on the program funding and activities. We have witnessed profound changes as this program has become an essential and vital force in our communities.

The Special Diabetes Program for Indians has transformed the overall health and well-being of American Indian and Alaska Native people—in ways far beyond diabetes treatment and prevention. The program's resources have empowered staff and participants to create innovative, effective, and tailored approaches to diabetes and other chronic diseases for our unique, diverse communities.

Today, success stories are replacing stories of fear; despair is being replaced with inspiration and hope. Comprehensive diabetes treatment and prevention activities have resulted in improved diabetes care and clinical outcomes on reservations and in urban clinics. Men and women with diabetes are controlling their blood sugar, blood pressure, and cholesterol. Those with prediabetes are losing weight to prevent diabetes through regular physical activity and healthy eating.

As you read this Report to Congress, you will see the progress we are making on many fronts. We are translating successfully the science of diabetes treatment and prevention into local Tribal communities. We are forming unprecedented Tribal health partnerships to find innovative solutions. We are becoming more accountable and more efficient in what we do—as administrators and as consumers of the services and programs offered through the Special Diabetes Program for Indians. Most important of all, our health is improving.

Yet, the journey is far from over. We are still very concerned about the large disparities in type 2 diabetes and its complications among American Indian and Alaska Native people. We must halt the diabetes epidemic in our youth. We must use the lessons learned from the Special Diabetes Program for Indians to equip all of our communities with efficient and effective strategies.

We welcome your continued support of the Special Diabetes Program for Indians.

Indian Health Service
Tribal Leaders Diabetes Committee

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Nashville Area Representative
Buford Rolin

Federal Co-Chair
Acting Director, IHS Division of Diabetes
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ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

Indian Health Service
Special Diabetes Program for Indians
2011 Report to Congress

With the Balanced Budget Act of 1997, Congress established the Special Diabetes Program for Indians (SDPI) in response to the diabetes epidemic among American Indian and Alaska Native (AI/AN) people. The SDPI is a $150 million per year program that provides grants for diabetes treatment and prevention services to 404 IHS, Tribal, and Urban Indian health programs across the Indian health system. At Congress's direction, SDPI has two major components: the Demonstration Projects (SDPI Diabetes Prevention Program and SDPI Healthy Heart Project) and the Community-Directed Diabetes Programs. (Note: The Demonstration Projects transitioned into the "SDPI Initiatives" in October 2010.)

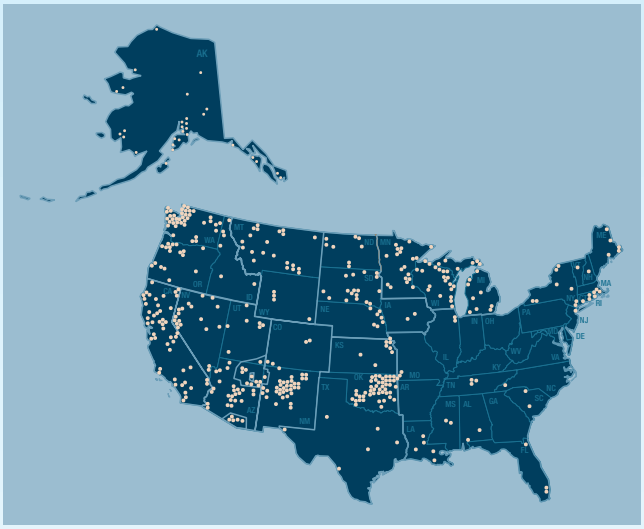


Figure 1. SPDI Grant Program Map

The purpose of this fourth interim Report to Congress on the SDPI is to provide updated information about SDPI activities and outcomes, including results for the Demonstration Projects. This report presents SDPI's outstanding accomplishments in improving the quality of diabetes care and changing the culture of diabetes treatment and prevention in the Indian health system.

The SDPI Demonstration Projects: Successful Translations of Diabetes Science

In 2004, Congress established the SDPI Demonstration Projects to translate research findings on diabetes prevention and cardiovascular disease risk reduction in AI/AN community-based programs and health care settings. The SDPI Demonstration Projects consisted of the SDPI Diabetes Prevention Program and the SDPI Healthy Heart Project. Overall, 66 grants were funded that served 110 tribal communities from 2004 to 2010. The results clearly show that the SDPI Demonstration Projects successfully reduced the risk of diabetes in people at high risk and reduced cardiovascular disease risk in people with diabetes.

SDPI Diabetes Prevention Program (SDPI DP)

The landmark Diabetes Prevention Program (DPP) clinical trial, led by the National Institutes of Health (NIH), was the first study in the United States to show that lifestyle intervention could reduce the incidence (new cases) of type 2 diabetes by 58% in a diverse population of people at high risk for diabetes. The SDPI DP adapted the lifestyle intervention from the DPP clinical trial and translated the Lifestyle Balance program in 36 diverse AI/AN communities. The SDPI DP intervention included group classes and individual coaching sessions. A total of 2,373 participants completed the follow-up assessment conducted within one month after finishing their last lifestyle class.

Following the lifestyle intervention, the SDPI DP participants achieved significant improvements in key diabetes risk factors (Table 1).

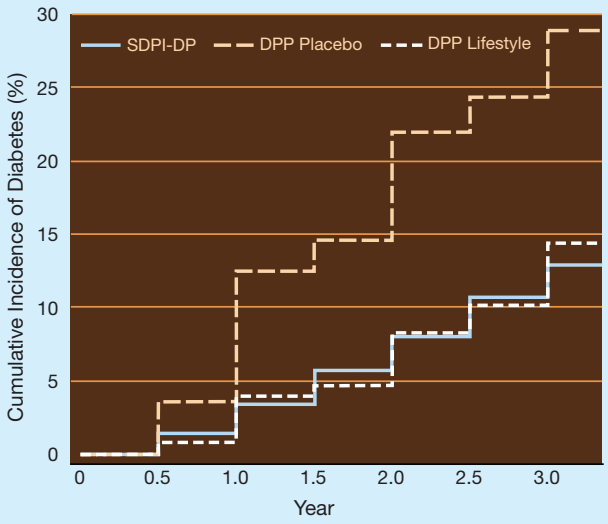
Table 1. SDPI DP Changes in Diabetes Risk Factors

MEASURE	RESULTS	
	Baseline[1]	Follow-up[2]
Weight Loss		
Average Weight (lbs)	218	209
Average BMI (kg/m^2)	35.8	34.3
Lifestyle Behaviors		
Ate healthy foods once or more per week	73%	86%
Ate unhealthy foods less than once per week	54%	82%
Performed 150 minutes or more of exercise per week	23%	57%

[1]Baseline = Before starting the lifestyle intervention classes
[2]Follow-up = Assessment within one month after finishing the lifestyle classes (approximately 5-7 months after baseline)
Source: Evaluation of the SDPI Diabetes Prevention Program

As was shown in the NIH DPP study, improvements in diabetes risk factors result in fewer new cases of diabetes. Modeled after the NIH DPP, the SDPI DP lifestyle intervention did successfully reduce risk factors for diabetes, including matching the weight loss achieved by the AI subgroup in the NIH DPP. As such, NIH DPP results were used as the benchmark for evaluating SDPI DP outcomes (Figure 2).

Figure 2. Cumulative Incidence of Diabetes in SDPI DP and NIH DPP



Note: Results of NIH DPP and SDPI DP are superimposed in the graph for comparison, but participant characteristics and study design were not identical.

Results:

- The diabetes incidence rate for NIH DPP participants in the placebo group was 11% per year.
- The diabetes incidence rate for NIH DPP participants in the lifestyle intervention group was 4.8% per year (a 58% reduction compared to the placebo group).
- The diabetes incidence rate for SDPI DP participants was 4.0% per year—very similar to the NIH DPP lifestyle group.

Source: 1) Evaluation of the SDPI Diabetes Prevention Program
2) Knowler *et al.* and the Diabetes Prevention Program Research Group, 2002

These results demonstrate that the SDPI DP achieved rates of diabetes incidence in high risk AI/AN people at a rate similar to that achieved in the NIH DPP lifestyle intervention group. Reductions in diabetes incidence have significant implications for preserving health and reducing health care costs.

SDPI Healthy Heart Project (HH)

Cardiovascular disease (CVD) is the leading cause of death in AI/AN people, especially those with diabetes. Research has shown that controlling CVD risk factors, particularly blood pressure, LDL cholesterol, and smoking, can substantially reduce the occurrence of heart attacks and strokes. The SDPI HH intervention applied intensive case management, including medical care and patient education strategies, to change CVD risk behaviors and improve clinical measures in people with diabetes. A total of 3,352 participants at 30 diverse Indian health care sites completed the baseline assessment.

Following the SDPI HH intervention, participants made improvements in key cardiovascular risk reduction behaviors from baseline to the third annual assessment (Table 2).

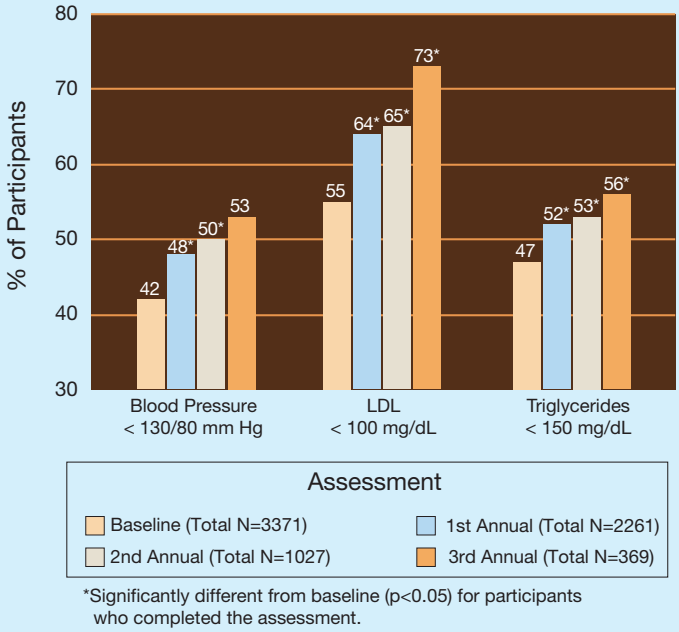
Table 2. SDPI HH Changes in CVD Risk Reduction Behaviors

MEASURE	RESULTS	
Lifestyle Behaviors	**Baseline[1]**	**3rd Annual[2]**
Non-smokers	79%	89%
Ate healthy foods once or more per week	78%	86%
Ate unhealthy foods less than once per week	68%	81%
150 minutes or more of exercise per week	27%	40%

[1] Baseline = Before starting the case management intervention
[2] 3rd Annual = Assessment approximately three years after baseline
Source: Evaluation of the SDPI Healthy Heart Project

These changes in lifestyle behaviors, along with intensive case management, resulted in significant improvements in SDPI HH participants' achievement of CVD risk factor targets (Figure 3).

Figure 3. SDPI HH Achievement of CVD Risk Factor Targets



Source: Evaluation of the SPDI Healthy Heart Project

Results:
At the third annual assessments:

- 53% met the target goal for blood pressure compared with 42% at baseline.
- 73% reached the LDL cholesterol target compared with 55% at baseline.
- 56% reached the triglyceride target compared with 47% at baseline (a risk factor target associated with CVD).

Impact: Controlling blood pressure and blood lipid levels to target goals is essential for reducing risk of CVD in people with diabetes (American Diabetes Association, 2012).

These results demonstrate that SDPI HH succeeded in implementing intensive case management to reduce cardiovascular risk factors in AI/AN people with diabetes and, in turn, reduced their 10-year risk of developing coronary heart disease. Improvements in these clinical measures translate into reductions in health care costs and improved quality of life for people with diabetes.

Just as Congress envisioned, both SDPI Demonstration Projects showed that research-based interventions could be successfully translated in AI/AN communities and, even more importantly, prevented diabetes and reduced cardiovascular disease risk in people with diabetes.

The SDPI Community-Directed Diabetes Programs: 12 Years of Successful Interventions

Since 1998, SDPI funding has made it possible for AI/AN communities to develop and sustain quality diabetes treatment and prevention programs. Based on local needs and priorities, the SDPI Community-Directed Diabetes Programs implement proven interventions to address the diabetes epidemic, often where few resources existed before. These include:

- **Medical care services**
- **Purchasing key diabetes-related medications** (not available on local formularies due to high cost)
- **Diabetes self-monitoring supplies** (e.g., glucose meters and test strips)
- **Diabetes education services**
- **Medical nutrition therapy services**
- **Physical activity programs**
- **Weight management programs**
- **Risk reduction programs for youth**

At the national level, the IHS charged the Division of Diabetes with developing the supportive structures necessary for the SDPI Community-Directed Diabetes Programs to successfully implement these interventions. This comprehensive national diabetes infrastructure includes:

- **National Diabetes Consultants** – to provide expertise on diabetes treatment and prevention to grantees;
- **Area Diabetes Consultants** – to work with individual grantees to improve program implementation and grant program accountability;
- **Comprehensive Diabetes Training** – such as conferences, webinars, online courses, and technical assistance calls;
- **Clinical Tools** – including Standards of Care, Best Practices, treatment algorithms, quick-reference cards;

- **Indian Health Diabetes Website** – as a central information source for all SDPI tools, training, and resources;
- **Information Technology** – electronic health record improvements to enhance diabetes care and data collection;
- **Data Infrastructure** – diabetes surveillance, IHS National Data Warehouse, diabetes care cost analysis; and
- **Diabetes Care and Outcomes Audit** – a required annual patient chart audit of the quality and outcomes of diabetes clinical care.

SDPI funding has enabled staff and programs at the local and national levels to dramatically increase access to diabetes treatment and prevention services throughout the Indian health system (Table 3).

Table 3. Percent of SDPI Community-Directed Programs Reporting Diabetes Interventions

	1997[1]	2010
Diabetes clinics	31%	71%
Diabetes clinical teams	30%	94%
Diabetes patient registries	34%	94%
Nutrition services for adults	39%	89%
Access to registered dietitians	37%	77%
Culturally tailored diabetes education programs	36%	99%
Access to physical activity specialists	8%	74%
Adult weight management programs	19%	76%

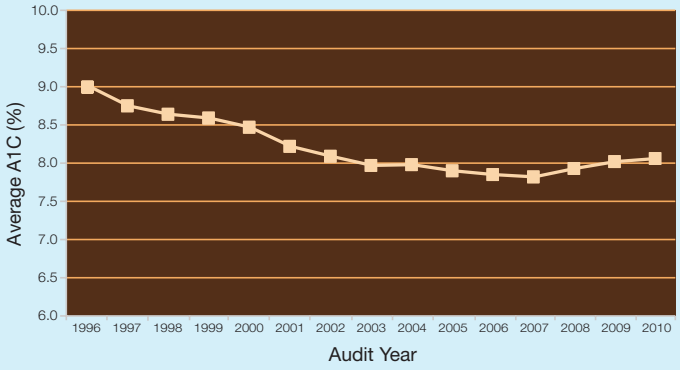
[1] Baseline = Before SDPI funding was available
Source: Evaluation of the SDPI Community-Directed Diabetes Programs

Clinical Diabetes Outcomes During SDPI

At the same time that access to these diabetes services increased dramatically, key outcome measures for AI/AN people with diabetes showed achievement or maintenance at or near national targets. These results have been sustained throughout the SDPI era (Figures 4-6).

Clinical Diabetes Outcomes

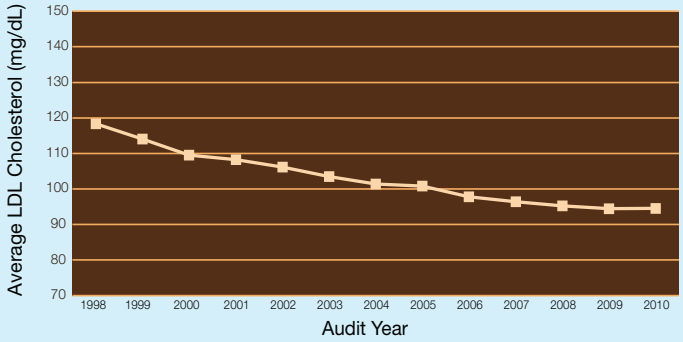
Figure 4. Average Blood Sugar



Source: IHS Diabetes Care and Outcomes Audit

Target: A1C <7% for most patients
Outcome: The average blood sugar level decreased from 9.0% in 1996 to 8.1% in 2010 as measured by the A1C test.
Impact: Every percentage point drop in A1C results can reduce the risk of eye, kidney, and nerve complications by 40% (Centers for Disease Control and Prevention, 2011).

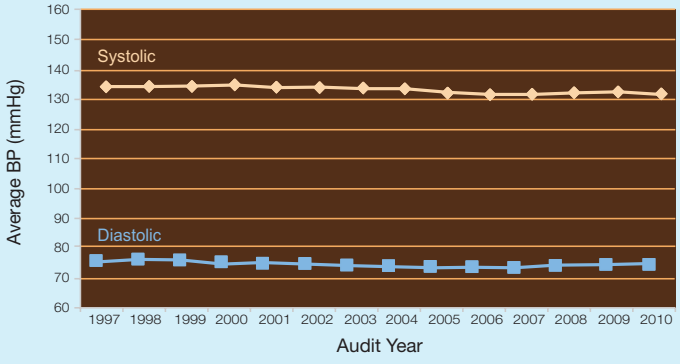
Figure 5. Average LDL Cholesterol



Source: IHS Diabetes Care and Outcomes Audit

Target: LDL cholesterol <100 mg/dL
Outcome: Average LDL cholesterol declined from 118 mg/dL in 1998 to 95 mg/dL in 2010.
Impact: Improved control of LDL cholesterol can reduce cardiovascular complications by 20-50% (Centers for Disease Control and Prevention, 2011).

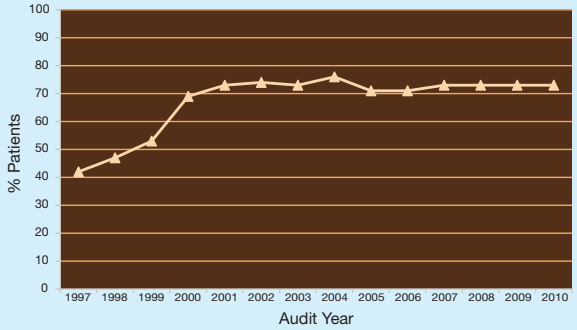
Figure 6. Average Blood Pressure



Source: IHS Diabetes Care and Outcomes Audit

Target: Blood pressure <130/80 mmHg
Outcome: Blood pressure has been well-controlled throughout the SDPI era. The average blood pressure in 2010 was 132/75 mmHg.
Impact: Blood pressure control reduces the risk of cardiovascular disease among people with diabetes by 33-50% and reduces the risk of eye, kidney, and nerve complications by about 33%. Lowering blood pressure in patients with early diabetic kidney disease can reduce the decline in their kidney function by 30-70% (Centers for Disease Control and Prevention, 2011).

Figure 7. Use of ACE Inhibitors and ARBs for Blood Pressure Control



Source: IHS Diabetes Care and Outcomes Audit

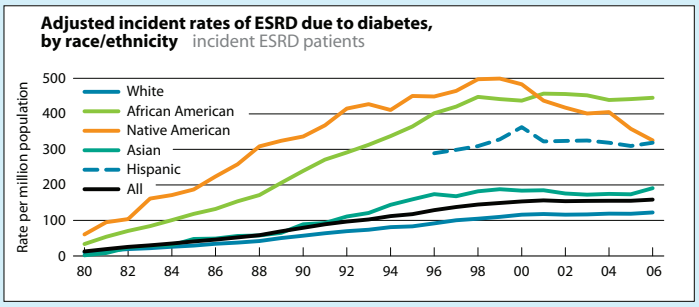
Target: Treatment with angiotensin-converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) is recommended for people with diabetes and hypertension, unless contraindicated.

Outcome: Use of these blood pressure-lowering medications increased from 42% in 1997 to 73% in 2010.

Impact: Treatment with ACE inhibitors and ARBs is more effective in reducing the decline in kidney function than is treatment with other blood pressure-lowering medications (American Diabetes Association, 2012).

Clinical improvements in blood sugar, LDL cholesterol, and blood pressure control, combined with the use of ACE inhibitors and ARBs, are associated with a tremendous impact on reducing rates of diabetes complications. During the time period of SDPI, rates of end stage renal disease (ESRD) in AI/AN people with diabetes markedly declined compared to rates in other racial and ethnic groups in the U.S. (Figure 8).

Figure 8. Adjusted Incident Rates of ESRD Due to Diabetes, By Race and Ethnicity



Source: United States Renal Data System, 2008

According to the United States Renal Data System (USRDS), between 1999 and 2006, the incidence rate of ESRD due to diabetes in AI/AN people fell by 28%. ESRD incidence due to diabetes in AI/AN people rose rapidly until 1999, followed by a significant decline beginning in 2000. This is a greater decline than for any other racial or ethnic group.

The rate of new cases of ESRD due to diabetes among AI/AN people decreased beginning in 2000 after steadily increasing for the previous two decades. This decrease reduced the burden of dialysis costs that would have been incurred by the health care system. Medicare costs per year for one patient on hemodialysis were $82,285 in 2009. Reducing the rate of progression to kidney failure requiring dialysis translates into millions of dollars in cost savings for Medicare, IHS, and other third party payers.

The SDPI Community-Directed Diabetes Programs, now with more than a decade of experience, have implemented and sustained diabetes interventions that have significantly improved clinical outcomes for AI/AN people.

SDPI: Making Progress Toward a Healthier Future

While it is not possible to determine the extent to which the remarkable clinical outcomes described in this Report to Congress are due solely to SDPI, nothing else has impacted diabetes resources across the Indian health system as much as SDPI over the past 12 years. SDPI has provided the funding, tools, training, support, and clinical data to help the Indian health system make tremendous changes in the diabetes landscape in American Indian and Alaska Native communities.

The scope of this nationwide program to address the diabetes epidemic is unprecedented. Guided by Congress' vision, scientific research, and community-driven priorities, SDPI funding has enabled the Indian health system to build one of the most comprehensive and effective diabetes programs in the United States. The challenges ahead remain daunting, but as our understanding of diabetes continues to evolve, we will discover new directions and yet more hope for creating a healthier future for American Indian and Alaska Native people.

"It is rewarding to see the progress that has been made in diabetes prevention and care with the Special Diabetes Program for Indians in Tribal communities.

With SDPI funds, Tribes have shown that we can change the diabetes landscape. Now, we can implement diabetes prevention programs that are as successful as the NIH-led Diabetes Prevention Program clinical trial. Now, we can work closely and intensively with our people with diabetes to lower their risk of cardiovascular disease.

These success stories were unimaginable 13 years ago when SDPI started! With all this progress, we are hopeful and encouraged that indeed, one day we will stop diabetes."

Buford Rolin
Tribal Co-Chair and Nashville Area Representative,
IHS Tribal Leaders Diabetes Committee and
Chairman, Poarch Band of Creek Indians, AL

CHAPTER 1: Introduction
The Special Diabetes Program for Indians

The Special Diabetes Program for Indians was established by Congress in 1997 in response to the escalating diabetes crisis confronting American Indian and Alaska Native (AI/AN) communities. Administered by the Indian Health Service Division of Diabetes Treatment and Prevention (IHS Division of Diabetes), the program provides grant funding for diabetes treatment and prevention services at 404 IHS, Tribal, and Urban Indian health programs across the Indian health system.

This fourth Report to Congress on the Special Diabetes Programs for Indians (SDPI) documents the program's services, activities, and accomplishments. Now in its 13th year, the SDPI is a comprehensive, innovative, and successful initiative to reduce the burden of diabetes in AI/AN people.

"With the support of the Klamath Diabetes Program, I've lost 38 pounds and my blood sugars are no longer in the prediabetic range. The weight loss has helped me to perform Indian dancing without pain. I would never have gotten in shape to run my first 5K race 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."

Taylor David, Klamath
Klamath Diabetes Prevention Program Participant
Cow Creek Consortium
Klamath Falls, OR

The Diabetes Epidemic in American Indians and Alaska Natives

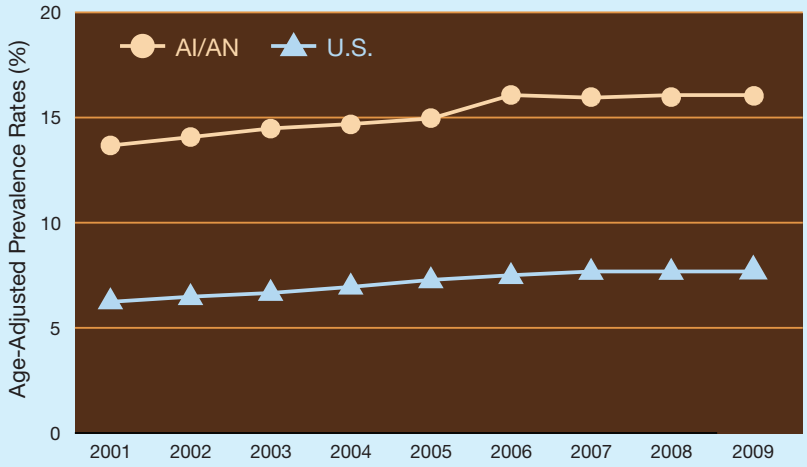
Diabetes is one of the most serious and devastating health problems in the United States, especially for AI/AN people. Diabetes affects the health and quality of life of entire AI/AN communities, causing illness, blindness, pain, disability, and death (American Diabetes Association, 2012; O'Connell et al., 2010).

AI/AN adults (aged 20+) have the highest age-adjusted prevalence rate of diagnosed diabetes compared to other major racial and ethnic groups in the United States (Centers for Disease Control and Prevention [CDC], 2011):

- 16.1% of American Indians and Alaska Natives;
- 12.6% of non-Hispanic blacks;
- 11.8% of Hispanics; and
- 7.1% of non-Hispanic whites.

The diabetes prevalence rate of 16.1% in AI/AN adults is almost twice the rate of 8.3% for the total U.S. adult population (Figure 1.1) (CDC, 2011). Diabetes prevalence rates vary by region, from 5.5 percent among Alaska Natives to 33.5 percent among American Indians in southern Arizona (CDC, 2011). In some AI/AN communities, more than half of adults have diabetes, with prevalence rates reaching as high as 60% (Lee et al., 1995).

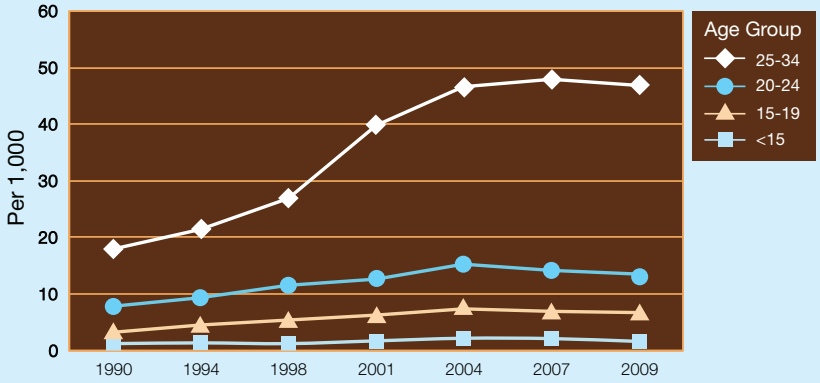
Figure 1.1 Diabetes Prevalence in U.S. and American Indian and Alaska Native Adults (Aged 20+)



Source: 1) IHS National Patient Information Reporting System, National Data Warehouse, 2012 (IHS, NPIRS, NDW, 2012)
2) Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Health Interview Statistics, data from the National Health Interview Survey

Once found mainly in older adults, diabetes increasingly affects younger AI/AN people, threatening the health, well-being, and quality of life of future generations (IHS, NPIRS, NDW, 2012).

Figure 1.2 Diabetes Prevalence in American Indian and Alaska Native Children and Youth



Source: IHS National Patient Information Reporting System (NPIRS)

From 1994 to 2009, prevalence rates of diagnosed diabetes increased by:

- 110% in AI/AN youth ages 15-19 years
- 161% in AI/AN young adults ages 25-34 years

Many factors contribute to the high prevalence of diabetes in AI/AN communities (Alberti et al., 2007). The key risk factors for diabetes include:

- a hereditary predisposition;
- exposure to diabetes while in the womb;
- dramatic increases in the rates of overweight and obesity as a consequence of living in adverse social and physical environments;
- increasingly sedentary lifestyles; and
- inadequate access to healthful nutrition.

"We have too many young people – youth and young adults – developing diabetes. We can turn the tide with continued progress of SDPI in Tribal communities.

We have seen success in reducing risk for developing diabetes. We have seen success in reducing heart problems and improving health for people with diabetes. Now we have the knowledge and the power to move forward in reducing the diabetes epidemic."

Rosemary Nelson
California Area Representative, Tribal Leaders Diabetes Committee (TLDC)
Astariwi Band of Pit River Indians, CA

The interaction among these factors has increased the risk of diabetes among AI/AN people and contributed to the large health disparities in diabetes morbidity and mortality compared to other racial and ethnic groups.

Diabetes Complications

Diabetes complications are among the leading causes of death and disability in many Tribal communities (U.S. Department of Health and Human Services, 2011). These include:

- heart attacks and heart failure;
- stroke;
- kidney disease and kidney failure;
- eye disease, impaired vision, and blindness;
- foot ulcers and lower limb amputations;
- nerve damage; and
- depression.

Historically, the prevalence of cardiovascular disease (CVD) was low among AI/AN people. However, the CVD prevalence rate grew dramatically during the latter part of the 20th century, primarily due to the diabetes epidemic (Howard et al., 1999). **The rate of CVD in AI/AN people with diabetes is 3 to 4 times higher than in those without diabetes** (Wang et al., 2011).

Heart disease, stroke, and diabetes complications such as kidney, eye, and nerve disease, require expensive treatment. As a result, the cost of caring for people with diabetes is 2.3 times greater among people with diabetes than among those without the disease (Fradkin, 2012).

What is Diabetes?

Diabetes is a disease in which blood sugar (glucose) levels are above the normal range. Type 2 diabetes– the most common form of the disease – is a chronic, potentially debilitating, and often fatal disease. Before being diagnosed with diabetes, people develop a condition called prediabetes, when blood sugar levels are higher than normal, but not yet in the diabetic range.

Over time, high blood sugar levels damage the small (microvascular) and large (macrovascular) blood vessels throughout the body. Damage to the small blood vessel system causes eye, kidney, and nerve disease, foot ulcers, and amputations. Damage to the large blood vessel system causes cardiovascular disease (heart disease and stroke), which is the leading complication and killer of people with diabetes. (National Institutes of Health, 2009).

Advances in the Science of Diabetes Treatment and Prevention

While the diabetes epidemic is widespread among AI/AN people, the good news is that diabetes and its complications can be prevented. Intensive use of medications and counseling aimed at achieving and sustaining control of blood sugar, blood pressure, and blood lipids can have a major impact on preventing diabetes-related deaths and disabilities (American Diabetes Association, 2012).

A significant and cost-saving strategy for reducing the burden of diabetes is preventing its onset in the first place. Type 2 diabetes can be prevented or delayed in people with prediabetes through intensive lifestyle intervention or use of certain diabetes medications (Knowler et al., 2002; Knowler et al., 2009).

"Before the [SDPI Diabetes Prevention] program, I was overweight, stressed, and had horrible eating habits. Today, with the knowledge, encouragement, and the support system from the program staff and the Lifestyle Balance program, I have learned to make a healthy balance between what I eat and how to be physically active. I lost 15.4 pounds and my fasting blood glucose decreased from 100 to 90."

Leslie Burbank, Navajo
Tuba City Regional Health Corporation Diabetes Prevention Program Participant
Tuba City, AZ

Responding to the Epidemic: The Special Diabetes Program for Indians

In 1997, Congress established the SDPI to curb the diabetes epidemic and its impact on AI/AN people. Congress envisioned the SDPI as a grant program that would provide funding for diabetes treatment and prevention through Indian Health Service (IHS), Tribal, and Urban Indian health clinics and community diabetes programs.

Congress initially established the SDPI through the Balanced Budget Act of 1997 and augmented support for the program through the Consolidated Appropriations Act of 2001 and Public Law 107-360 in 2004. SDPI funding was reauthorized in 2007, 2008, and 2010, extending it through fiscal year 2013 (Table 1.1).

The SDPI provides grants for diabetes treatment and prevention services to 404 IHS, Tribal, and Urban Indian health programs in 35 states. The SDPI grant programs use evidence-based and community-driven strategies to address diabetes treatment and prevention across the lifespan. The IHS Division of Diabetes and the tribally-appointed Tribal Leaders Diabetes Committee (TLDC) provide leadership and guidance for SDPI implementation. The formula for distribution of funding was developed after national consultation and recommendations from the TLDC for the initial funding distribution in 1998 and with each reauthorization.

Table 1.1: Special Diabetes Program for Indians Legislative Background

PUBLIC LAW	ANNUAL FUNDING	PURPOSE
Balanced Budget Act of 1997 (Public Law 105-33, Section 4922)	$30 million per year (1998–2002)	• Establish the Special Diabetes Program for Indians grant programs for the "prevention and treatment of diabetes" in AI/AN people. • Conduct a comprehensive evaluation of the Program.
Consolidated Appropriations Act of 2001 (Public Law 106-554, Section 931)	Additional $70 million per year (2001–2002) $100 million (2003)	• Continue ongoing diabetes treatment and prevention activities in Tribal communities. • Implement a best practices approach to diabetes treatment and prevention. • Build upon what the grant programs have learned.
An Act to amend the Public Health Service Act with respect to special diabetes programs for Type I diabetes and Indians (Public Law 107-360, Section 1)	$150 million per year (2004–2008)	• Continue ongoing diabetes treatment and prevention activities in Tribal communities. • Strengthen the IHS diabetes data infrastructure. • Develop and implement a new SDPI grant program of Demonstration Projects for: (1) primary prevention of diabetes in AI/AN people at risk for developing diabetes; and (2) cardiovascular disease risk reduction in AI/AN people with diabetes.
Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173)	$150 million per year (2009)	• Continue activities as in 2004-2008.
Medicare Improvements for Patients and Providers Act 2008 (Public Law 110-275)	$150 million per year (2010-2011)	• Continue activities as in 2004-2009.
Medicare and Medicaid Extenders Act of 2010 (Public Law 111-309)	$150 million per year (2012-2013)	• Continue activities as in 2004-2011.

SDPI Grant Program Components

As directed by Congress, the IHS Division of Diabetes established two major components of the SDPI grant program:

- Community-Directed Diabetes Programs; and
- Diabetes and Cardiovascular Disease Prevention Demonstration Projects.

SDPI Community-Directed Diabetes Programs

The SDPI was launched in 1998 when IHS distributed grant funds to IHS, Tribal and Urban Indian health programs to begin or enhance local diabetes treatment and prevention services based on community needs (Community-Directed Diabetes Programs). There are currently 338 Community-Directed Diabetes Programs located at IHS, Tribal, and Urban Indian health sites in 35 states in all 12 IHS Administrative Areas.

Each of the communities served by the Community-Directed Diabetes Programs is unique in its diabetes treatment and prevention needs and priorities. Therefore, each grant program designs and implements culturally appropriate interventions to address the problem of diabetes in their own communities specific to their local needs.

The Community-Directed Diabetes Programs incorporate diabetes prevention and treatment strategies, such as:

- quality medical care services;
- access to key diabetes-related medications;
- diabetes self-monitoring supplies;
- diabetes education and medical nutrition therapy services;
- nutrition, physical activity, and weight management programs; and
- risk-reduction programs for youth.

Now with more than a decade of experience, these programs have dramatically increased access to diabetes treatment and prevention services. Since their inception, many clinical measures for people with diabetes have improved, and rates of diabetes complications such as end stage renal disease have fallen markedly (see Chapter 4).

SDPI Diabetes and Cardiovascular Disease Prevention Demonstration Projects

In 2004, Congress directed the IHS to develop a new demonstration project component of the SDPI. The SDPI Diabetes and Cardiovascular Disease Prevention Demonstration Projects (Demonstration Projects) were to focus on translating research findings to prevent onset of diabetes in high-risk individuals and to reduce the risk of cardiovascular disease in people who already have diabetes.

Congress authorized increased SDPI funding from 2004 through 2008 for the Demonstration Projects, which were funded at $27.4 million per year for 5 years. Congressional reauthorizations of SDPI extended this funding through fiscal year 2013. Beginning in fiscal year 2010, the Demonstration Projects transitioned to implementation and dissemination initiatives (SDPI Initiatives) after having completed the initial Demonstration Projects and their evaluation.

To develop the new demonstration projects in 2004, the IHS Division of Diabetes conducted extensive Tribal consultation to gather input from Tribal leadership. Guidance also was obtained from leading experts in diabetes prevention and CVD risk reduction to help design the demonstration projects.

Two types of SDPI demonstration projects were designed and implemented to translate the latest research findings on diabetes prevention and treatment in IHS, Tribal and Urban Indian health programs:

- The **SDPI Diabetes Prevention Program (SDPI DP)** implemented a scientifically-proven lifestyle intervention program among AI/AN people with prediabetes to prevent onset of diabetes (see Chapter 2). The SDPI DP lifestyle intervention was based on the Diabetes Prevention Program (a clinical trial led by the National Institutes of Health) that showed diabetes could be prevented or delayed in people at high risk for the disease, including AI/AN people (Knowler et al., 2002).

- The **SDPI Healthy Heart Project (SDPI HH)** used intensive one-on-one medical case management, patient education and team-based care to reduce risk factors for CVD in people with diabetes (see Chapter 3). The SDPI HH was based on current models for chronic disease care and the latest evidence-based CVD risk reduction guidelines (Wagner et al, 2001).

Through a competitive grant application process, 36 programs were selected for the SDPI DP and 30 programs were selected for the SDPI HH. The University of Colorado Denver, in partnership with the University of Arizona, was selected to serve as the Coordinating Center. The Center provided training and technical assistance to the grant programs for project implementation and evaluation.

Following a year of collaborative planning, staff training, program development, and evaluation design, the SDPI Demonstration Projects were launched in fiscal year 2005. The grant programs participated in a comprehensive evaluation of their activities and outcomes. This intensive evaluation of the Demonstration Projects was completed in 2010. The SDPI DP and SDPI HH projects and their evaluation results are presented in Chapters 2 and 3, respectively.

Just as Congress envisioned, both SDPI Demonstration Projects showed that research-based interventions could be successfully translated in AI/AN communities and, even more importantly, could prevent diabetes and reduce CVD risk in people with diabetes.

Administrative and Data Support

The IHS Division of Diabetes oversees the SDPI, providing leadership, direction, and administrative and technical support (see Chapter 4). Administrative funding for SDPI supports national and Area level efforts to strengthen the capacity of grant program staff and to improve diabetes outcomes.

For example, ongoing technical assistance and training in program evaluation, clinical care, and diabetes self-management education is provided using electronic communications such as webinars, online clinical tools, and interactive training. Such cost-effective and time-efficient approaches have enabled hundreds of grant program staff members from Alaska to Florida to participate in these educational opportunities without incurring travel time or meeting costs.

"If it weren't for this program, I would very likely be a person with diabetes. I thank God for this program. I really do."

Stephanie Crawford, Sisseton Wahpeton Oyate
Haskell Health Center Diabetes Prevention Program Participant
Lawrence, KS

In addition, as directed by Congress, administrative funding from the SDPI has been allocated to help build and strengthen the diabetes data infrastructure of the Indian health system, including support for development of IHS's Electronic Health Record (Carroll et al., 2011). Program funds have helped to expand the capacity for diabetes surveillance and ongoing monitoring of diabetes care and diabetes-related health outcomes. Data from the IHS Diabetes Care and Outcomes Audit provide evidence of the SDPI grant programs' success in implementing cost-effective and cost-saving screening and treatment for diabetes complications.

Making Progress toward a Healthier Future

The Special Diabetes Program for Indians has succeeded in implementing an innovative, evidence-based, nationwide program to address the diabetes epidemic and to improve the quality of life for many AI/AN people. Guided by Congress's vision, scientific research, and community-driven priorities, SDPI funding has enabled the Indian health system to build one of the most comprehensive and effective diabetes programs in the United States.

The following chapters demonstrate how SDPI's infusion of resources on a sustained basis has changed the diabetes landscape in IHS, Tribal and Urban Indian health programs. Communities at very high risk for diabetes have created the infrastructure to help reduce health disparities. SDPI's evidence-based clinical care and prevention messages are permeating local communities and their health care systems. Thus, the program's impact reaches far beyond the resources that have been invested.

"I have a strong family history of diabetes and heart disease. Now I know I'm not doomed to walk that path. The program taught me that I didn't have to change it all. Small changes add up. I have lost 17 pounds and I have a sense of well being that I didn't have before."

Arne Vainio, M.D., Mille Lacs Band of Ojibwe
Fond du Lac Human Services Diabetes
Prevention Program Participant
Cloquet, MN

CHAPTER 2
SDPI Diabetes Prevention Program: Successfully Reducing Risk for Diabetes

The landmark National Institutes of Health-led Diabetes Prevention Program (NIH DPP) clinical trial was the first study in the United States to show that an intensive lifestyle intervention could reduce the incidence (rate of new cases) of type 2 diabetes by 58% in people at high risk for diabetes compared to a placebo group (Knowler et al., 2002). The NIH DPP included a subgroup of American Indian people who participated in the lifestyle intervention and achieved the same remarkable results. The SDPI Diabetes Prevention Program (SDPI DP) was designed to translate the NIH DPP lifestyle intervention in 36 diverse clinical and community-based settings that serve American Indian and Alaska Native (AI/AN) people.

Each SDPI DP grant program was required to implement certain basic intervention activities, called the core elements (Table 2.1), to ensure consistency in the way the program was delivered and evaluation data were collected.

The SDPI DP evaluation was designed to determine if the onset of diabetes could be prevented (primary outcome) and to answer these two questions:

- Could the results achieved by the NIH DPP's academic research centers with extensive expertise and experience in health behavior change research be replicated in the Indian health system by a diverse group of rural and urban clinics, IHS and Tribal hospitals, and community health programs?

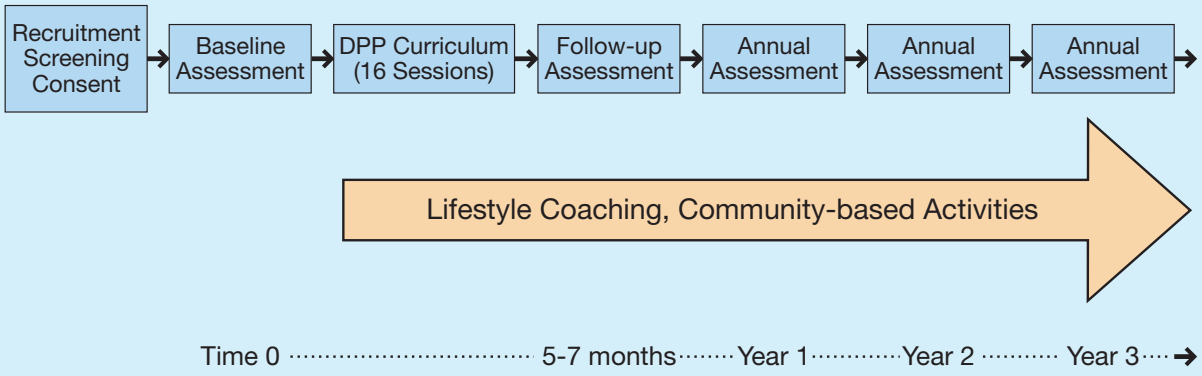
- Could the SDPI DP Lifestyle Balance group classes, combined with a moderate level of individual counseling and follow-up group activities, produce the behavior changes and weight loss to stop the progression of prediabetes?

Table 2.1 Core Elements of the SDPI DP

- Recruit and screen to enroll participants with prediabetes
- Goal: Recruit 48 participants per year
- Teach the 16-session Diabetes Prevention Program Curriculum in group sessions over 16-24 weeks
- Provide monthly individual lifestyle coaching to participants on physical activity, nutrition, and weight loss
- Develop a plan to retain participants
- Hold community-based awareness and prevention activities
- Participate in evaluation and data collection

The SDPI DP evaluation assessed prevention of the onset of diabetes and outcomes of the lifestyle intervention such as changes in participants' behaviors (e.g., nutrition and physical activity) and clinical characteristics (e.g., weight, blood sugar levels, and blood pressure) before they started the lifestyle intervention and at follow-up assessments (Figure 2.1).

Figure 2.1 SDPI DP Evaluation Design



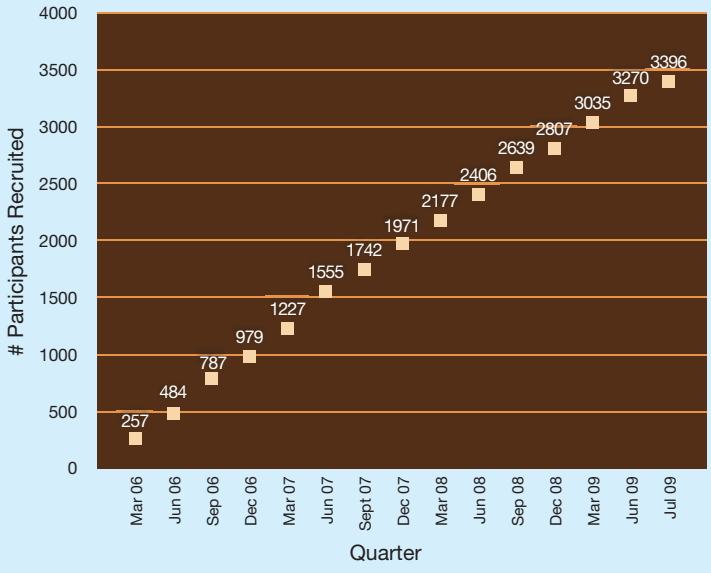
Participant Recruitment

During the planning year for the SDPI Demonstration Projects, the grant programs conducted numerous awareness activities to inform their communities about the new diabetes prevention program. They held events such as health fairs and conducted blood sugar screenings to identify AI/AN people at high risk for diabetes.

The grant programs screened 21,809 AI/AN people from January 2006 through July 2009. The programs identified 4,020 eligible individuals with prediabetes who signed consent forms to participate in the SDPI DP. Of these, 3,396 completed the baseline assessment before they enrolled in the lifestyle intervention classes.

Screening and recruitment at Kaibeto Diabetes Expo, Tuba City Diabetes Program, Tuba City, AZ

Figure 2.2 SDPI DP Participant Recruitment



Source: Evaluation of the SDPI Diabetes Prevention Program

Results: SDPI DP grant programs recruited 3,396 participants by July 31, 2009—about 237 per quarter.

Impact: Successful recruitment strategies helped enroll enough participants to evaluate the demonstration project.

Participant Retention

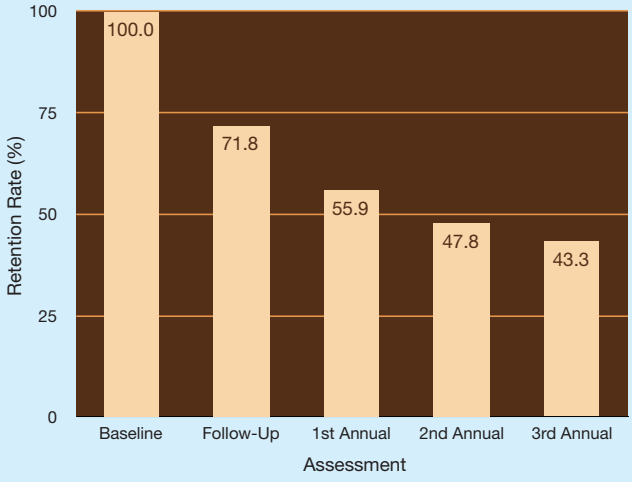
Of the 3,396 participants who completed their baseline assessment, 3,312 went on to start the lifestyle intervention classes. About 72% of this group (2,373 participants) completed the follow-up assessment conducted within one month after finishing their last lifestyle class (usually about 5 to 7 months after their baseline assessment). This retention rate is comparable to other translational studies of the NIH DPP in the United States (Seidel et al., 2008).

Billboard promoting the Fond du Lac Diabetes Prevention Program, Cloquet, MN

The grant programs conducted annual assessments of participants on the anniversary of their first lifestyle class (these are referred to as the 1st, 2nd, and 3rd annual assessments).

Over half (56%) of the 3,312 SDPI DP participants who started the intervention completed the 1st annual assessment (1,826 participants). At the time data were analyzed for this report, not all participants had yet reached the time for their 2nd or 3rd annual assessments. Of those who had reached these anniversaries, the 2nd year assessment rate was about 48% (770 participants) and the 3rd year rate was about 43% (269 participants) (Figure 2.3).

Figure 2.3 SDPI DP Participant Retention



Source: Evaluation of the SDPI Diabetes Prevention Program

Results: About 72% of the 3,212 SDPI DP participants who started the lifestyle intervention completed the follow-up assessment, and more than half completed the 1st annual assessment.

Impact: Retention of participants is important for collecting complete data to evaluate the demonstration project.

Implementation of the Lifestyle Intervention

To implement the core elements of the diabetes prevention intervention, each grant program was required to have a Diabetes Prevention Team that included:

- a diabetes educator or lifestyle coach who taught the classes and met individually with participants;
- a project coordinator responsible for overall coordination; and
- a licensed health care provider who was available for medical consultation.

Other recommended team members included a dietitian, a physical activity specialist, and community representatives.

Lifestyle Balance Classes

Throughout the 3.5-year implementation, SDPI DP grant program staff taught the 16-session Lifestyle Balance Curriculum adapted from the NIH DPP (Wing et al., 1996). Classes were taught over the course of 16 to 24 weeks (Table 2.2, page 32). Unlike the NIH DPP, where the curriculum was delivered to participants mainly through one-on-one counseling sessions, the SDPI DP delivered the information in group classes.

The grant programs delivered a total of 11,690 classes. Over two-thirds (68%) of the SDPI DP participants attended all 16 Lifestyle Balance classes, 17% attended 8 to 15 classes, and 15% attended 7 classes or less.

Lifestyle Coaching Sessions

Following completion of the Lifestyle Balance classes, the SDPI DP participants attended monthly one-on-one lifestyle coaching sessions. At these sessions, the lifestyle coaches evaluated participants' needs and goals, provided individualized nutrition and physical activity plans, and helped to identify and address barriers to participation.

"Being diagnosed with pre-diabetes was the wake-up call I needed to focus on making healthy changes to prevent diabetes."

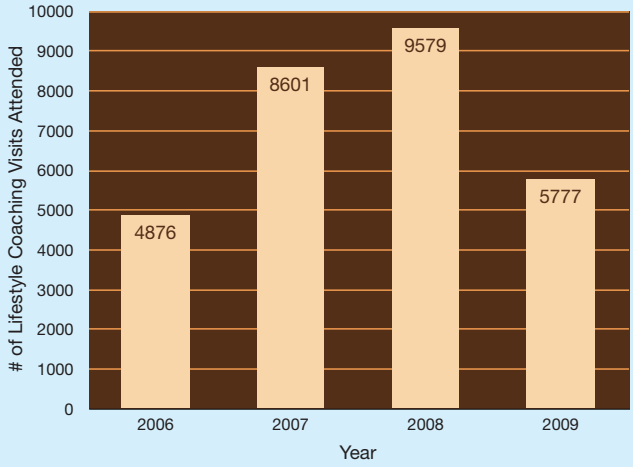
Becky Youngbear-Alvarado, Meskwaki
Meskwaki Diabetes Prevention Program Participant
Tama, IA

Tonya Giger, M.P.H., C.H.E.S.
Project Director, Cherokee Nation Diabetes Prevention Program
Tahlequah, OK

Table 2.2 DPP Lifestyle Balance Curriculum

CLASS	TOPICS COVERED
1. Welcome to the Lifestyle Balance Program	Goals of the program, program materials, lifestyle coach-participant relationship
2. Getting Started Being Active/Getting Started Losing Weight	Self-monitoring of physical activity and setting goals; self-monitoring of foods eaten, weighing and measuring tools
3. Move Those Muscles	Current level of physical activity, developing a physical activity plan
4. Being Active: A Way of Life	Graphing activity, finding time to be active, injury prevention
5. Be a Fat Detective	Graphing and self-monitoring of weight, self-monitoring of fat grams, setting a fat gram goal
6. Three Ways to Eat Less Fat	Three ways to eat less fat, developing a plan to eat less fat, review of self-monitoring skills
7. Healthy Eating	Review of the Food Guide Pyramid, eating grains, vegetables, and fruit, eating lower-fat foods
8. Take Charge of What's Around You	Food and activity cues, identifying positive cues for activity and getting rid of cues for inactivity
9. Tip the Calorie Balance	Healthy eating and being active related to calorie balance, how calorie balance relates to weight loss
Problem Solving	Five steps to problem solving, practicing the steps using a current problem
10. Four Keys to Healthy Eating Out	Four basic principles for healthy eating out, practice selecting meals from a menu
11. Talk Back to Negative Thoughts	Identifying negative thoughts, practice talking back to negative thoughts with positive thoughts
12. The Slippery Slope of Lifestyle Change	Identify things that cause participant to slip from healthy eating or being active, what to do after a slip
13. Jump Start Your Activity Plan	Adding variety to activity plan, learn about aerobic fitness, learn the F.I.T.T. principles
14. Make Social Cues Work for You	Identifying problem and helpful social cues, strategies for coping with social events
15. You Can Manage Stress	Preventing stress and coping with unavoidable stress, managing DPP-related stress
16. Ways to Stay Motivated	Importance of motivation, ways to stay motivated

Figure 2.4 SDPI DP Lifestyle Coaching Session Attendance



Source: Evaluation of the SDPI Diabetes Prevention Program

Results: SDPI DP participants attended 28,833 lifestyle coaching sessions by July 2009.

Impact: The one-on-one lifestyle coaching sessions helped participants to continue practicing healthy behaviors after completing the Lifestyle Balance classes.

SDPI DP lifestyle coaches provided 28,833 coaching sessions. On average, each participant attended 6 lifestyle coaching sessions in their first year in the demonstration project (Figure 2.4).

After-Core Activities

In addition to the required group classes and individual lifestyle coaching sessions, the grant programs conducted "after-core" activities to keep participants motivated and to provide ongoing skill-building and group support. Examples of these activities include: cooking classes, walking clubs, grocery store tours, yoga classes, and hikes. The SDPI DP grant programs held 3,038 after-core activities—about 84 activities per grant program, or two activities per month per program.

Canoe Paddle Camp at K'ima:w Medical Center Diabetes Prevention Program, Hoopa Valley Indian Reservation, CA

The Lifestyle Intervention Improved Participants' Diabetes Risk Factors

SDPI participants achieved significant improvements in diabetes risk factors following the lifestyle intervention (Table 2.3). They lost an average of about 8.4 pounds, or an average 3.9% weight loss from baseline. Along with this weight loss, the average baseline Body Mass Index (BMI) went down from 35.8 to 34.3.

Table 2.3 SDPI DP Changes in Diabetes Risk Factors

MEASURE	RESULTS	
	Baseline[1]	Follow-up[2]
Weight Loss		
Average Weight (lbs)	218	209
Average BMI (kg/m^2)	35.8	34.3
Lifestyle Behaviors		
Ate healthy foods once or more per week	73%	86%
Ate unhealthy foods less than once per week	54%	82%
Performed 150 minutes or more of exercise per week	23%	57%

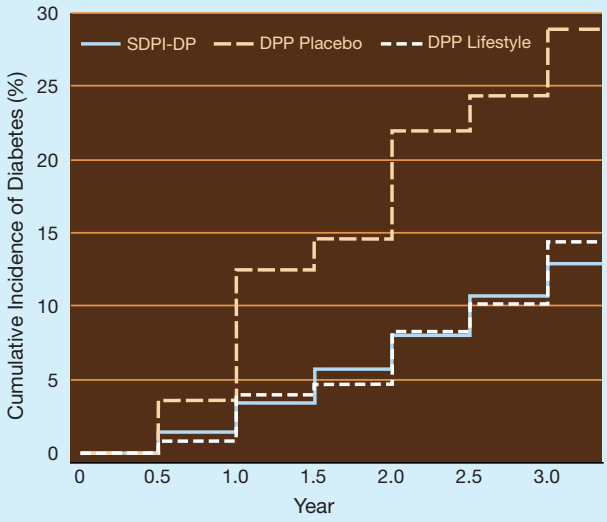
[1]Baseline = Before starting the lifestyle intervention classes
[2]Follow-up = Assessment within one month after finishing the lifestyle classes (approximately 5-7 months after baseline)
Source: Evaluation of the SDPI Diabetes Prevention Program

Many participants indicated they had made important lifestyle changes following the intervention. More people reported eating healthy foods more often and eating unhealthy foods less often. More than twice as many people achieved the goal of at least 150 minutes of physical activity per week compared to their baseline assessments.

"Having learned so much about ways to eat less fat has helped me to change how I cook and prepare my meals. I lost 13 pounds, my blood sugar went back to normal, and my triglycerides went down almost 200 points from 303 to 126! I really like the positive changes that are now evident in my overall health."

Charlotte McConnell, Tlingit
SDPI Diabetes Prevention Program Participant
SouthEast Alaska Regional Health Consortium (SEARHC) Lifestyle Balance and Diabetes Prevention Program Participant
Juneau, AK

Figure 2.5 Cumulative Incidence of Diabetes in SDPI DP and NIH DPP



Note: Results of NIH DPP and SDPI DP are superimposed in the graph for comparison, but participant characteristics and study design were not identical.

Source: 1) Evaluation of the SDPI Diabetes Prevention Program
2) Knowler et al., 2002

Results:

- The diabetes incidence rate for NIH DPP participants in the placebo group was 11% per year.
- The diabetes incidence rate for NIH DPP participants in the lifestyle intervention group was 4.8% per year (a 58% reduction compared to the placebo group).
- The diabetes incidence rate for SDPI DP participants was 4.0% per year—very similar to the NIH DPP lifestyle group.

Impact: Reductions in diabetes incidence have significant implications for preserving health and reducing health care costs.

The SDPI DP achieved rates of diabetes incidence similar to those in the NIH DPP intervention group.

SDPI DP Reduced Risk for Diabetes in AI/AN People at High Risk

As was shown in the NIH DPP study, improvements in diabetes risk factors resulted in fewer new cases of diabetes. Modeled after the NIH DPP, the SDPI DP lifestyle intervention did successfully reduce risk factors for diabetes, including matching the weight loss achieved by the AI subgroup in the NIH DPP. As such, NIH DPP results were used as the benchmark for evaluating SDPI DP outcomes (Figure 2.5).

Lifestyle Class Attendance and Diabetes Incidence Rate

Additional analysis showed that the diabetes incidence rate among SDPI DP participants who attended all 16 Lifestyle Balance classes was significantly lower than that of those who attended 15 or fewer classes. The diabetes incidence rate was 3.6% per year in those who finished all 16 classes, while the rate was more than double (7.7% per year) among participants who did not attend all of the classes.

"The Diabetes Prevention Fitness Program has helped me to prevent diabetes and now, health and fitness are top priorities in my life."

Pastor Thomas Ben,
Mississippi Choctaw
Choctaw Diabetes Prevention Program Participant
Chocktaw, MS

The Lifestyle Intervention and Future Risk of Developing Diabetes

A widely used model for predicting a person's future risk of developing diabetes is the Framingham Diabetes Risk Score (Wilson, et al., 2007). The risk score assigns points to different diabetes risk factors (e.g., fasting blood sugar, BMI, parental history of diabetes) and estimates a person's likelihood of developing diabetes in the next 8 years. The SDPI DP evaluation used this score to assess relative changes in diabetes risk following the lifestyle intervention.

The average Framingham Diabetes Risk Score of the SDPI DP participants decreased significantly from 19.5% at baseline to 16.8% at follow-up assessment, a relative risk reduction of 14%.

SDPI DP Achieved Its Objectives of Translating Scientific Findings and Reducing Risk for Diabetes

The SDPI DP successfully adapted and implemented the NIH DPP lifestyle intervention in 36 diverse AI/AN communities, and in doing so, achieved rates of diabetes incidence in high risk AI/AN people at a rate similar to that achieved in the NIH DPP lifestyle intervention group. In addition, SDPI DP participants improved their diabetes risk factors and reduced their risk of developing diabetes in the next 8 years.

Each case of diabetes that is delayed or prevented means a reduction in diabetes-related complications and in the health care costs required to treat the disease. It has been estimated that Medicare could save between $1.8 to $2.3 billion over the next 10 years if community-based lifestyle intervention programs (such as the SDPI DP) were made available nationwide to overweight people ages 60-64 years who have prediabetes (Thorpe and Yang, 2011). Most importantly, each case of diabetes that is prevented means a better quality of life for American Indian and Alaska Native people, their families, and their communities.

SDPI Diabetes Prevention Initiatives

After completion of the demonstration project, SDPI funding was used to continue these activities and to develop strategies to disseminate the findings and lessons learned from the demonstration project to all IHS, Tribal and Urban Indian health programs.

"My blood sugars are now in the normal range. My blood pressure is good and I feel good. I'm at a high point in my life being diabetes-free."

Pete Fills the Pipe, Oglala Lakota
Pine Ridge IHS Diabetes Prevention Program Participant
Pine Ridge, SD

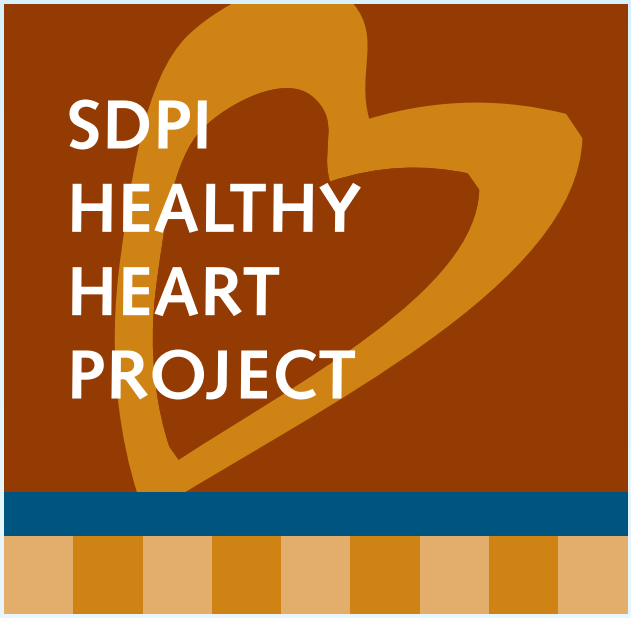
Barbara and Bob Mora, Navajo/Paiute and Tarahumara/Mexican, Bishop, CA

"I lost 16.4 pounds and my blood sugar went back to normal. The thing that impressed me the most was experiencing first-hand the impact of weight loss on blood sugar levels. I already knew that exercise was a real aid in controlling blood sugar, but both of these together are far better than any drug that is out there today."

William "Bill" Hill, Cherokee Nation of Oklahoma Muscogee (Creek) Nation Healthy Heart Project, Okmulgee, OK

CHAPTER 3
SDPI Healthy Heart Project: Successfully Reducing Cardiovascular Disease Risk

Cardiovascular disease (CVD) is the major cause of death and a significant cause of morbidity for people with diabetes. Controlling blood pressure and blood lipid abnormalities is essential to reduce CVD risk in people with diabetes (American Diabetes Association, 2012).



The 30 SDPI Healthy Heart Project (SDPI HH) grant programs implemented an intensive clinical, team-based case management approach to CVD risk reduction. Each grant program was required to implement the core elements (Table 3.1) of the demonstration project to ensure consistency in the way the program was delivered and evaluation data were collected.

The SDPI HH was designed to determine if intensive case management could reduce risk factors for CVD in American Indian and Alaska Native (AI/AN) people with diabetes. The SDPI HH evaluation assessed outcomes of the CVD risk reduction intervention related to participants' lifestyle behaviors (e.g., cigarette smoking, nutrition, and physical activity) and clinical characteristics (e.g., blood pressure and blood lipids) before the intervention (baseline) and at 1st, 2nd, and 3rd year annual assessments (Figure 3.1).

Table 3.1 Core Elements of the SDPI HH

- Recruit and screen to enroll participants with diabetes
- Goal: Recruit 50 participants per year
- Implement an intensive, monthly case management program
- Treat cardiovascular disease risk factors to target goals
- Provide education on diabetes self-management and cardiovascular disease risk reduction
- Develop a plan to retain participants
- Hold community-based awareness and prevention activities
- Participate in evaluation and data collection

Participant Recruitment

In January 2006, the 30 SDPI HH grant programs began recruiting participants and implementing the intensive case management intervention. The programs conducted awareness activities to inform their communities about the new CVD risk reduction program. They also worked with Indian health system facilities to find eligible participants in their diabetes patient registries.

The grant programs identified 6,874 AI/AN people with diabetes in their communities during the 3.5-year period of the demonstration project. Of these, 4,058 people with diabetes were found to be eligible and signed consent forms to participate in the SDPI HH project. By the time recruitment ended on July 31, 2009, 3,373 participants had completed their baseline assessments. On average, 78 participants enrolled in the SDPI HH each month from January 2006 through July 2009 (Figure 3.2).

Figure 3.1 SDPI HH Evaluation Design

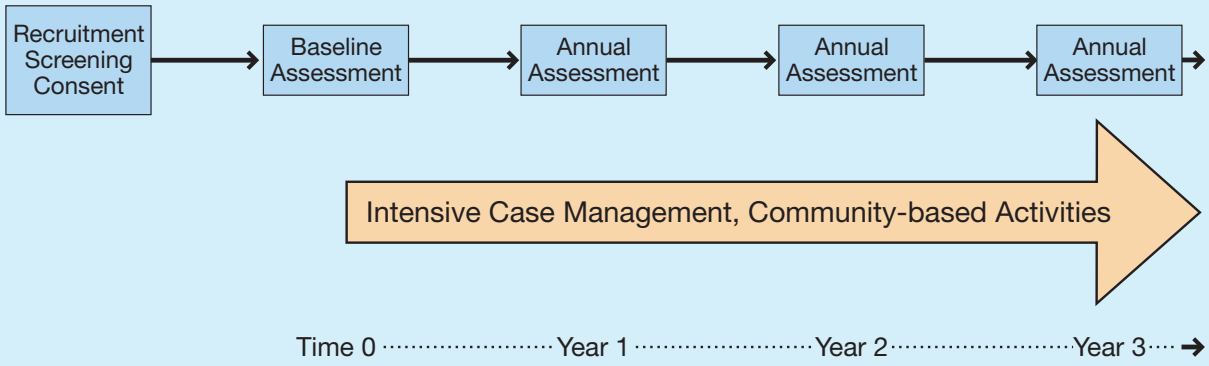
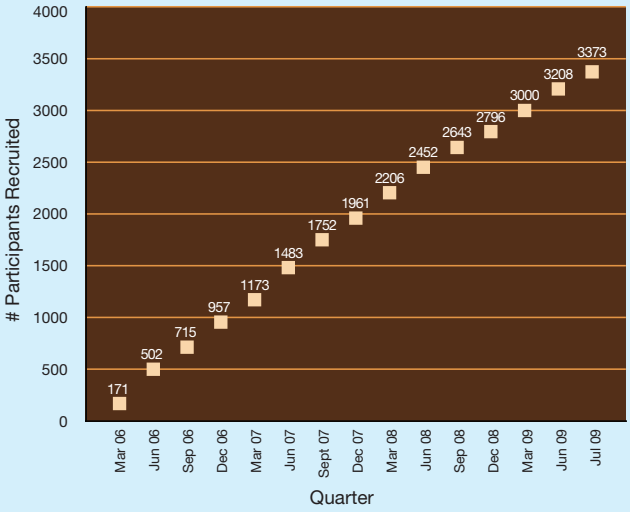


Figure 3.2 SDPI HH Participant Recruitment



Source: Evaluation of the SDPI Healthy Heart Project

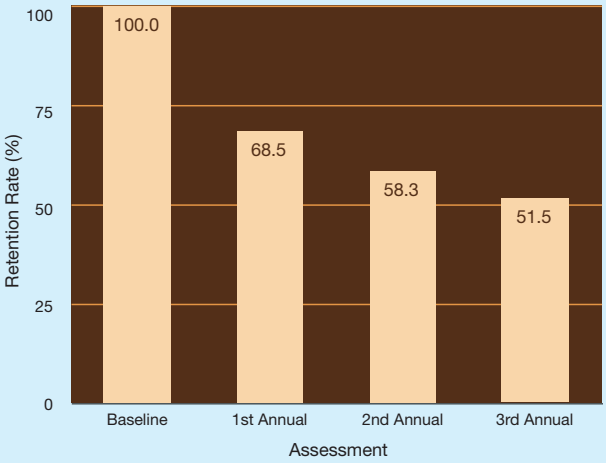
Results: SDPI HH grant programs recruited 3,373 participants by July 2009—about 235 per quarter.

Impact: Successful recruitment strategies helped enroll enough participants to evaluate the demonstration project.

Participant Retention

Of the 3,373 SDPI HH participants who completed their baseline assessment, 3,350 started case management visits and about 69% (2,269) completed their 1st annual assessment (Figure 3.3). This one-year retention rate is comparable to similar translational studies in the United States (Sisk et al., 2006). At the time data were analyzed for this report, not all participants had yet reached the time for their 2nd or 3rd annual assessments. Of those who had reached these anniversaries, the 2nd year assessment rate was about 58% (1,029 participants) and the 3rd year rate was about 51% (369 participants).

Figure 3.3 SDPI HH Participant Retention



Source: Evaluation of the SDPI Healthy Heart Project

Results: About 69% of SDPI HH participants completed the 1st annual assessment.

Impact: Retention of participants is essential for collecting complete data for evaluation of the demonstration project.

Case Management Visits

The SDPI HH participants began attending case management visits after they completed their baseline assessments. Each participant was scheduled for monthly visits at the beginning of the intervention and switched to quarterly visits once their health status met target goals for CVD risk reduction.

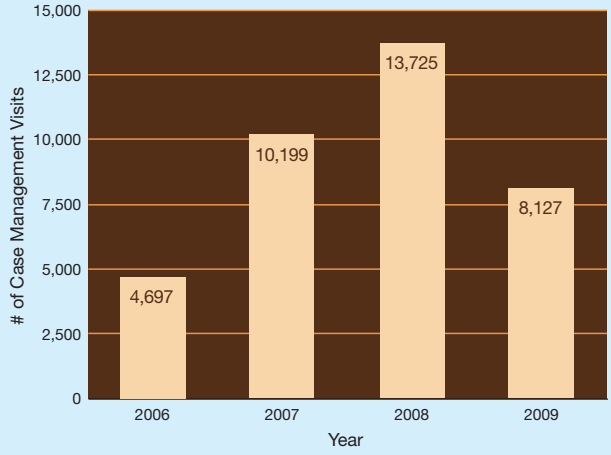
On average, SDPI HH participants attended about 7 case management visits in the first year after their baseline assessment. The SDPI HH case managers provided a total of 36,748 visits—about 28 visits per month per grant program (Figure 3.4).

Yakama Nation is one of four SDPI Healthy Heart Projects using pharmacists as case managers. The pharmacists are clinically trained to adjust medications and have more time to build health partnerships with each patient.

"The more time we can spend one-on-one, the more trust we build with participants and the more we can fine tune their health care."
Robin John, R.Ph., Lead Case Manager

Robin John, R.Ph., Lead Case Manager and
Elgie Wahsise, SDPI Healthy Heart Project Participant
Yakama Indian Health Service Healthy Heart Project
Toppenish, WA

Figure 3.4 SDPI HH Case Management Visits



Source: Evaluation of the SDPI Healthy Heart Project
Source: Evaluation of the SDPI Healthy Heart Project

Results: As more participants were enrolled in the SDPI HH programs, the annual number of case management visits nearly tripled from 4,697 in 2006 to 13,725 in 2008 and declined to 8,127 in 2009 as the study was winding down.

Impact: Case management visits were the major component of the SDPI HH intervention. Participation in the intervention is strongly associated with positive outcomes.

Data Collection

Data collection ended for most participants on July 31, 2009, but continued for some participants through July 31, 2010, so that 1st annual assessments could be completed for as many participants as possible. The 1st annual assessment of participants' lifestyle and clinical characteristics was conducted on the anniversary of their first lifestyle visit and repeated on the 2nd and 3rd anniversaries. The results presented in the following sections show the changes in participants' behavioral and clinical characteristics from baseline through the 3rd annual assessments.

SDPI HH Participants Made Improvements in CVD Risk Reduction Behaviors

Following the SDPI HH intervention, participants made improvements in key CVD risk reduction behaviors from baseline to the 3rd annual assessment (Table 3.2). More participants were nonsmokers after the intervention. More participants consumed healthy foods and more had increased their physical activity to at least 150 minutes per week.

Along with these changes in lifestyle behaviors, SDPI HH participants showed significant improvements in achieving clinical CVD risk factor targets (Figure 3.5).

"I have lost 17.6 pounds, lowered my A1C from 8.2 to 6.2 and dropped my blood pressure from 138/86 to 119/78. I want to teach my relatives that we can beat this disease. We need to stop and think about how long we really want to be here on Mother Earth with our children and grandchildren."

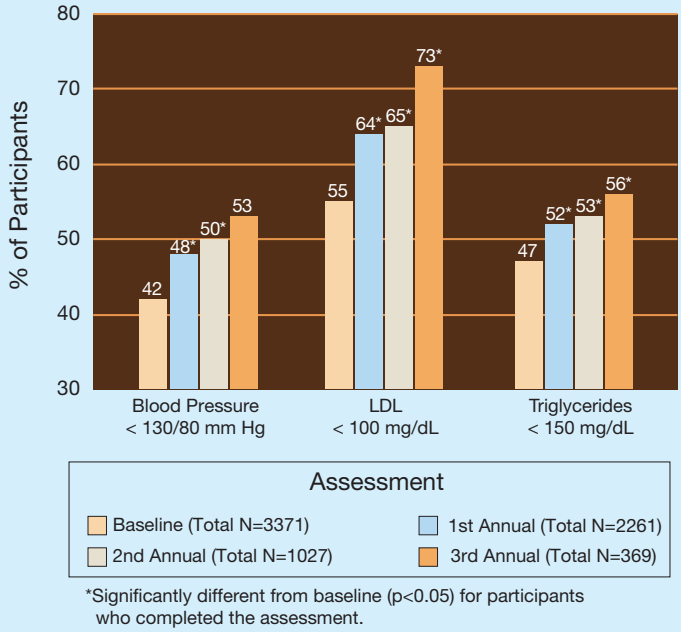
Doris Cooke, Ihanktonwan Dakota (Yankton Sioux)
SDPI Healthy Heart Project Participant
Wagner IHS Healthy Heart Project
Wagner, SD

Table 3.2 SDPI HH Changes in CVD Risk Reduction Behaviors

MEASURE	RESULTS	
Lifestyle Behaviors	**Baseline[1]**	**3rd Annual[2]**
Non-smokers	79%	89%
Ate healthy foods once or more per week	78%	86%
Ate unhealthy foods less than once per week	68%	81%
150 minutes or more of exercise per week	27%	40%

[1] Baseline = Before starting the case management intervention
[2] 3rd Annual = Assessment approximately three years after baseline
Source: Evaluation of the SDPI Healthy Heart Project

Figure 3.5 SDPI HH Achievement of CVD Risk Factor Targets



Source: Evaluation of the SDPI Healthy Heart Project

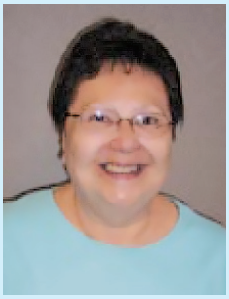
Results:
At the 3rd annual assessments:

- 53% met the target goal for blood pressure compared with 42% at baseline.
- 73% reached the LDL cholesterol target compared with 55% at baseline.
- 56% reached the triglyceride target compared with 47% at baseline (a risk factor target associated with CVD).

Impact: Lowering blood pressure and blood lipid levels to target goals is essential for reducing risk of CVD in people with diabetes (American Diabetes Association, 2012).

SDPI HH Reduced Participants' 10-Year Risk of Coronary Heart Disease

The Framingham Coronary Heart Disease (CHD) Risk Score is a widely used model for predicting a person's risk for developing CHD in the next 10 years (Wilson et al., 1998). The score assigns points to risk factors, including age, diabetes status, smoking status, blood pressure, total cholesterol, and LDL cholesterol. The SDPI HH evaluation used this score to assess the relative changes in future CHD risk among participants.



"I lost 36 pounds. My blood pressure decreased from 145/76 to 126/74. I've made a lot of progress and I know I can continue to keep my blood sugars under control and to lose more weight."

Janice Brown, St. Regis Mohawk
St. Regis Mohawk Tribe Healthy Heart Project Participant
Hogansburg, NY

The average Framingham CHD Risk Score of the SDPI HH participants decreased significantly from baseline to each follow-up assessment. Among those who completed the 1st annual assessment, their Framingham CHD Risk Score decreased from an average of 8.8% at baseline to 8.3% at follow-up, a relative risk reduction of 6%.

Reducing Cardiovascular Disease Risk through Translation of Research

These results demonstrate that SDPI HH succeeded in implementing intensive case management to reduce CVD risk factors and 10-year risk of developing CHD in AI/AN people with diabetes. Reduction in CHD risk and improvements in blood sugar, blood pressure, and blood lipid management mean reductions in diabetes-related complications such as heart attacks and strokes, kidney disease, blindness, and amputations (American Diabetes Association, 2012).

Each improvement in these clinical measures translates into reductions in health care costs (O'Connell et al., 2012). Most importantly, each of these improvements means American Indian and Alaska Native people have the power to manage diabetes, prevent its complications, and have a better quality of life.

"I want everyone to know that you don't have to wait until you have a stroke to take advantage of all the Healthy Heart Program has to offer. Get started early and learn how to manage your diabetes!"

Glendine Blanchard, Absentee Shawnee
Absentee Shawnee Tribe Healthy Heart Program Participant
Shawnee, OK

SDPI Healthy Heart Initiatives

After completion of the demonstration project, SDPI funding was used to continue these activities and to develop strategies to disseminate the findings and lessons learned from the demonstration project to all IHS, Tribal and Urban Indian health programs.

"I lost my parents and a sister from complications of diabetes. I have eight brothers and sisters living with diabetes and I was diagnosed in 1993.

My motivation to join the Cherokee Diabetes Program in 2007 came when I was at the clinic because my blood sugars were out of control, even though I was on the maximum dosage of insulin and oral medications. With the support of the program staff, I have lost 35 pounds and am in control of my diabetes. After 17 years, I no longer require insulin to manage my diabetes.

Honestly, I love the Cherokee Diabetes Program! It has challenged me in new ways and given me the opportunity to take control of my diabetes, my health, and my future."

Ulela Harris, Eastern Band of Cherokee Indians
Cherokee Community-Directed Diabetes Program Participant
Cherokee, NC

CHAPTER 4
SDPI Community-Directed Diabetes Programs: Successful Interventions, Remarkable Results

Since 1998, the IHS has distributed SDPI grants to 338 IHS, Tribal, and Urban Indian health programs in 35 states to deliver diabetes treatment and prevention services in American Indian and Alaska Native (AI/AN) communities. These grant programs are known as the SDPI Community-Directed Diabetes Programs. The Indian Health Service, through the Division of Diabetes Treatment and Prevention (IHS Division of Diabetes), administers these funds with guidance from the Tribal Leaders Diabetes Committee.

Caring for people with diabetes, Puyallup Tribal Health Authority Diabetes Program, WA

SDPI funding has made it possible for AI/AN communities to develop and sustain quality diabetes treatment and prevention programs—often, where few resources existed before. Unlike the SDPI Demonstration Projects where the intervention design was more uniform, the Community-Directed Programs adapt proven strategies at the local level to meet their particular communities' needs. As a result, interventions have been implemented in a multitude of ways and many lessons have been learned over the past 12 years. The use of tailored approaches designed for specific populations is consistent with public health research that shows there is no one "right" formula for reducing health disparities in underserved populations (Wallerstein et al., 2011).

Given the objective of the Community-Directed component of SDPI to identify and meet local needs, no two programs are necessarily alike. Yet, they all base their interventions on Indian Health Diabetes Best Practices, which are evidence- and consensus-based approaches to achieve and measure program improvements.

With reauthorization of SDPI for FY 2010-2011, the IHS Division of Diabetes revised the Funding Opportunity Announcement for the Community-Directed Programs to require adoption and routine use of the Best Practices. To successfully compete for funding, each grant program now must incorporate use of at least one Best Practice relevant to the objective of their local program. Also, they must evaluate their programs and report the results. These new requirements will enhance program performance, provide new lessons learned, and increase the grant programs' accountability.

Compared with 1997, before SDPI funding was available, the Community-Directed Programs have dramatically increased access to medical treatment services for people with diabetes. They also have expanded the availability of programs to reduce diabetes risk in adults and youth, including nutrition, physical activity, weight management, and psychosocial health services that meet the unique needs of their communities.

Providing Quality Medical Care for People with Diabetes

The vast majority of Community-Directed Programs report that their health care facilities have integrated key elements of quality diabetes treatment (Table 4.1). Diabetes clinics enhance care by improving efficiency and convenience for the patient (National Diabetes Education Program, 2011). Diabetes teams, consisting of multidisciplinary health professionals, improve care by using coordinated, comprehensive approaches similar to the intervention used in the SDPI Healthy Heart Project.

Diabetes registries help health care providers care for people with diabetes by guiding treatment plans, anticipating problems, and monitoring progress. In addition to providing these key elements, some programs purchase key diabetes-related medications and self-monitoring supplies, such as glucose test strips.

Table 4.1 Percent of SDPI Community-Directed Programs Reporting Key Elements of Quality Diabetes Medical Care

	1997[1]	2010
Diabetes clinics	31%	71%
Diabetes clinical teams	30%	94%
Diabetes patient registries	34%	94%

[1] Baseline = Before SDPI funding was available
Source: Evaluation of the SDPI Community-Directed Diabetes Programs

Providing Quality Diabetes Education

Diabetes education is a cornerstone of effective diabetes care and is related to improved outcomes (Funnell et al., 2012). The vast majority of Community-Directed Programs report that culturally appropriate group and/or individual diabetes education programs are available in their communities. Evidence-based, patient-centered approaches are used to train people in daily management of diabetes and to support them in making and maintaining healthy lifestyle changes (Table 4.2).

Table 4.2 Percent of SDPI Community-Directed Programs Reporting Diabetes Education Programs

	1997[1]	2010
Organized diabetes education programs	25%	95%
Culturally tailored diabetes education	36%	99%

[1] Baseline = Before SDPI funding was available
Source: Evaluation of the SDPI Community-Directed Diabetes Programs

Integrating Diabetes and Psychosocial Care

Depression, poverty, and other stressors have an enormous impact on people's ability to care for their diabetes (Peyrot and Rubin, 2007; Chaufan et al., 2011). Community-Directed Programs address these factors in a variety of ways. Many grant programs link individuals with local social service programs such as substance abuse treatment programs, vocational rehabilitation, housing programs, childcare and education services, and domestic violence shelters. They also conduct screening for depression and offer group support to help patients cope with stress, such as the use of traditional Talking Circles (Table 4.3).

Sonoma County Indian Health's Talking Circle Program
Santa Rosa, CA

Table 4.3 Percent of SDPI Community-Directed Programs Addressing Psychosocial Health

	1997[1]	2010
Coordination with social service programs	34%	78%
Screening for depression	9%[2]	70%

[1] Baseline = Before SDPI funding was available
[2] Data collection began in 2005
Source: 1) Evaluation of the SDPI Community-Directed Diabetes Programs
2) IHS Diabetes Care and Outcomes Audit

Improving Access to Healthy Foods and Good Nutrition

Ted Burkhart, Tlingit, changed his eating habits to include more fruits and vegetables to lose weight and manage his diabetes.

Good nutrition has far-reaching health benefits by helping to prevent, delay, and manage diabetes, obesity, and other chronic diseases. Since 1997, the majority of Community-Directed Programs report the availability of interventions focused on nutrition education and increasing access to healthy food (Table 4.4).

Nutrition education, a key intervention to help prevent and treat diabetes, is used widely by the Community-Directed Programs. Registered dietitians provide group and individual education sessions on topics such as healthy food choices, low-fat cooking techniques, and grocery shopping. Medical nutrition therapy, which involves intensive nutrition counseling and follow-up, is offered to help people manage their diabetes. In addition, some Community-Directed Programs offer classes and training programs for clinical and community outreach workers and staff of Tribal food programs to improve their knowledge of nutrition information.

Helping people to improve their food choices depends, however, on the ability to obtain healthy foods (White House Task Force on Childhood Obesity, 2010). Many programs help community members improve access to healthy foods by referring them to supplemental food programs, creating community gardens, and collaborating with local businesses to increase the availability of healthy foods.

Table 4.4 Percent of SDPI Community-Directed Programs Reporting Nutrition Interventions

	1997[1]	2010
Nutrition services for adults	39%	89%
Access to registered dietitians	37%	77%

[1] Baseline = Before SDPI funding was available
Source: Evaluation of the SDPI Community-Directed Diabetes Programs

Increasing Regular Physical Activity

Zuni Pueblo SDPI Community-Directed Diabetes Program Walk, NM

Regular physical activity is essential for preventing and managing diabetes. One-hundred fifty (150) minutes per week of moderate physical activity can help prevent and control diabetes as well as cardiovascular disease, high blood pressure, and other chronic conditions (U.S. Department of Health and Human Services, 2008).

The majority of Community-Directed Programs report the availability of physical activity programs and resources (Table 4.5). A major accomplishment has been training local community members to support and deliver physical activity programs, thereby increasing local capacity.

When tailoring physical activity programs for their communities, the Community-Directed programs incorporate traditional AI/AN activities such as powwow dancing, canoeing, and hiking. Tribal wellness policies are now in place in many communities to promote physical activity among Tribal members. Grant programs also have created innovative partnerships with other local organizations, the private sector, and the community to encourage physical activity.

Table 4.5 Percent of SDPI Community-Directed Programs Reporting Physical Activity Interventions

	1997[1]	2010
Community walking and running programs	20%	91%
Community exercise classes	16%	78%
Access to physical activity specialists	8%	74%

[1] Baseline = Before SDPI funding was available
Source: Evaluation of the SDPI Community-Directed Diabetes Programs

Promoting Healthy Weight

Worksite nutrition class

As shown by both the NIH Diabetes Prevention Program study and the SDPI Diabetes Prevention Demonstration Project, modest weight loss in people with prediabetes is an effective strategy for preventing onset of diabetes (Knowler et al., 2002). Weight management also is essential for controlling blood sugar, blood pressure, and lipids in people with diabetes (American Diabetes Association, 2012).

Table 4.6 Percent of SDPI Community-Directed Programs Reporting Healthy Weight Programs

Adult weight management programs	19%	76%

[1] Baseline = Before SDPI funding was available
Source: Evaluation of the SDPI Community-Directed Diabetes Programs

Community-Directed Programs offer a wide array of weight management activities in their communities (Table 4.6). They use innovative weight management activities similar to those used in the SDPI DP Demonstration Project. These include group support, individual weight counseling programs, and family nutrition programs. Many programs have established partnerships in their communities with schools, work sites, and businesses to offer weight management activities.

Reducing Risk of Type 2 Diabetes in Youth

Interventions aimed at reducing risk for diabetes in children and youth have great potential to lower the future burden of the disease (Dabelea et al., 2007). The majority of Community-Directed Programs promote healthy behaviors, physical activity, and weight management among AI/AN youth, families, and communities (Table 4.7). To prevent obesity and reduce diabetes risk in children, many programs implement public awareness campaigns and health promotion programs.

Hattie Conklin (left) and her friends, Shoshone-Paiute of Duck Valley, NV, practice dancing to stay at a healthy weight.

Table 4.7 Percent of SDPI Community-Directed Programs Reporting Interventions for Youth

	1997[1]	2010
Diabetes risk-reduction programs	6%	74%
Nutrition services	65%	85%
Physical activity programs	13%	80%
Safe environments for physical activity	15%	82%

[1] Baseline = Before SDPI funding was available
Source: Evaluation of the SDPI Community-Directed Diabetes Programs

Building Capabilities and Accountability in the Community-Directed Diabetes Programs

The IHS Division of Diabetes is charged with developing and maintaining the supportive structures needed to achieve SDPI's dramatic increases in access to diabetes treatment and prevention services. Administrative funding for SDPI supports national and Area level efforts to strengthen the capabilities of grant program staff and to improve diabetes outcomes.

The IHS Division of Diabetes employs multiple strategies to improve the capabilities and accountability of the SDPI grant programs, including:

- **National Diabetes Consultants** – provide expertise on diabetes treatment and prevention to grant program staff
- **Area Diabetes Consultants** – work with individual grantees to improve programs and grant accountability
- **Comprehensive Diabetes Training and Technical Assistance** – conferences, webinars, online courses, and technical assistance calls to increase knowledge and build skills
- **Clinical Tools** – Standards of Care, Best Practices, treatment algorithms, and quick-reference cards based on the latest diabetes science
- **Indian Health Diabetes Website** (www.diabetes.ihs.gov) – central information source for all SDPI tools, training, and resources

Providing Diabetes Data Infrastructure Support

As directed by Congress, administrative funding from the SDPI has been allocated for staff support and technology innovations to strengthen the diabetes data infrastructure of the Indian health system. Program funds have helped to expand the capacity for diabetes surveillance and ongoing monitoring of diabetes care and diabetes-related health outcomes in three key areas:

- **Information Technology** – electronic health record improvements to enhance diabetes care and data collection
- **Data Infrastructure** – diabetes surveillance, IHS National Data Warehouse, and diabetes care cost analysis
- **IHS Diabetes Care and Outcomes Audit** – required annual patient chart audit of the quality and outcomes of diabetes clinical care

Using Clinical Data to Improve Diabetes Care and Patient Outcomes

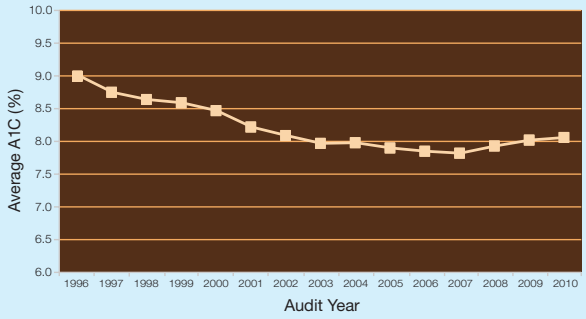
The annual IHS Diabetes Care and Outcomes Audit (the Audit) is the cornerstone of the Indian health diabetes care surveillance system. The Audit tracks annual performance on 59 diabetes care measures based on the IHS Standards of Care for People with Diabetes. Data collection for the Audit follows a standardized protocol to ensure statistical integrity and allows for tracking results over time. In recent years, the Audit process has been modernized through the WebAudit, a set of Internet-based tools that automate data submission and centralize data storage for participating health care facilities.

The Audit collects and analyzes data on diabetes medical care and clinical outcomes, thereby providing essential feedback to help sites improve their treatment services. Patient care measures include laboratory tests to assess diabetes control and the use of diabetes-related medications. Clinical outcome measures include blood sugar, blood pressure, and blood lipid values. Community-Directed Programs are required to address results of their sites' Audit data in their applications for SDPI funding.

Remarkable Clinical Results During SDPI

During the same time period that the Community-Directed Programs have dramatically increased access to diabetes services and made quality diabetes care practices commonplace, key clinical measures for AI/AN people with diabetes show achievement or maintenance at or near national targets. These remarkable results have been sustained throughout the SDPI era. Data from the annual IHS Diabetes Care and Outcomes Audit from across the Indian health system show significant improvements in clinical care during SDPI:

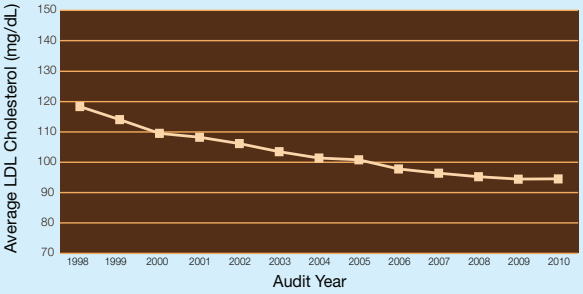
Figure 4.1 Average Blood Sugar



Source: IHS Diabetes Care and Outcomes Audit

Target: A1C <7% for most patients (American Diabetes Association, 2012).
Outcome: The average blood sugar level decreased from 9.0% in 1996 to 8.1% in 2010 as measured by the A1C test.
Impact: Every percentage point drop in A1C results can reduce risk of eye, kidney, and nerve complications by 40% (Centers for Disease Control and Prevention, 2011).

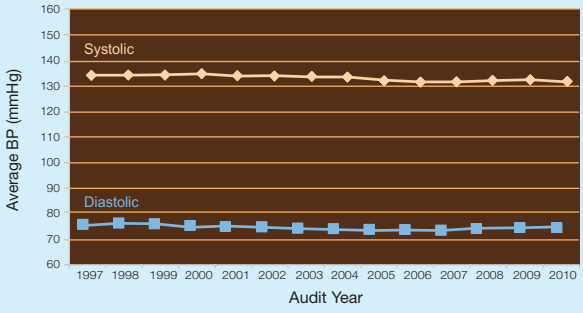
Figure 4.2 Average LDL Cholesterol



Source: IHS Diabetes Care and Outcomes Audit

Target: LDL cholesterol <100 mg/dL (American Diabetes Association, 2012).
Outcome: Average LDL cholesterol declined from 118 mg/dL in 1998 to 95 mg/dL in 2010.
Impact: Improved control of LDL cholesterol can reduce cardiovascular complications by 20-50% (Centers for Disease Control and Prevention, 2011).

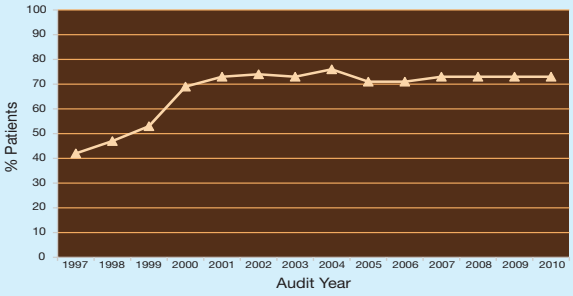
Figure 4.3 Average Blood Pressure



Source: IHS Diabetes Care and Outcomes Audit

Target: Blood pressure <130/80 mmHg (American Diabetes Association, 2012).
Outcome: Blood pressure has been well-controlled throughout the SDPI era. The average blood pressure in 2010 was 132/75 mmHg.
Impact: Blood pressure control reduces the risk of cardiovascular disease among people with diabetes by 33-50% and reduces the risk of eye, kidney, and nerve complications by about 33%. Lowering blood pressure in patients with early diabetic kidney disease can reduce the decline in their kidney function by 30-70% (Centers for Disease Control and Prevention, 2011).

Figure 4.4 Use of ACE Inhibitors and ARBs for Blood Pressure Control



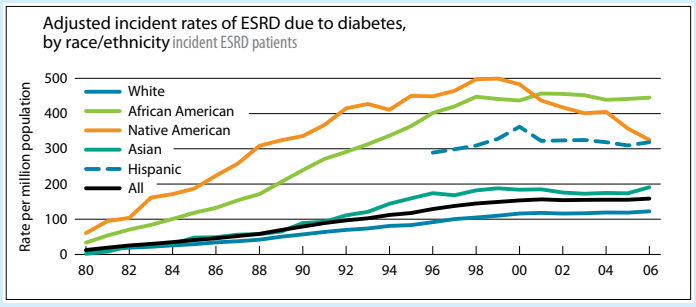
Source: IHS Diabetes Care and Outcomes Audit

Target: Treatment with angiotensin-converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) is recommended for people with diabetes and hypertension, unless contraindicated.
Outcome: Use of these blood pressure-lowering medications increased from 42% in 1997 to 73% in 2010.
Impact: Treatment with ACE inhibitors and ARBs is more effective in reducing the decline in kidney function than is treatment with other blood pressure-lowering medications (American Diabetes Association, 2012).

Achieving Significant Reduction in End Stage Renal Disease Incidence

Sustained improvements in blood sugar, LDL cholesterol, and blood pressure control, combined with the use of ACE inhibitors and ARBs have a tremendous impact on reducing rates of diabetes complications and treatment costs. This impact is most evident in the rates of end stage renal disease (ESRD) in AI/AN people with diabetes when compared with other racial and ethnic groups in the United States (Figure 4.5).

Figure 4.5 Adjusted Incident Rates of ESRD Due to Diabetes, By Race and Ethnicity



Source: United States Renal Data System, 2008

According to the United States Renal Data System (USRDS), between 1999 and 2006, the incidence rate of ESRD due to diabetes in AI/AN people fell by 28%. ESRD incidence due to diabetes in AI/AN people rose rapidly until 1999, followed by a significant decline beginning in 2000. This is a greater decline than for any other racial or ethnic group.

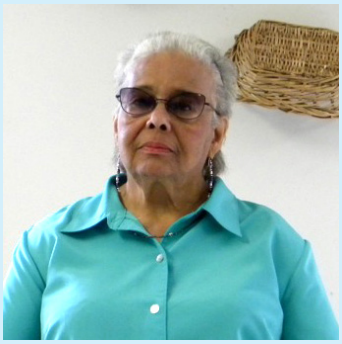
The rate of new cases of ESRD due to diabetes among AI/AN people decreased beginning in 2000 after steadily increasing for the previous two decades. This decrease reduced the burden of dialysis costs that would have been incurred by the health care system.

Medicare costs per year for one patient on hemodialysis were $82,285 in 2009 (U.S. Renal Data System, 2011). **Reducing the rate of progression to kidney failure requiring dialysis translates into millions of dollars in cost savings for Medicare, IHS, and other third party payers.**

SDPI's Successful Interventions Have Led to Remarkable Results

The SDPI Community-Directed Programs, now with more than a decade of experience, have implemented and sustained diabetes interventions that have significantly improved clinical outcomes for AI/AN people. These results could not have been achieved without the use of proven treatment strategies and ongoing data feedback to drive improvements in diabetes care services. In addition, the IHS Division of Diabetes has provided ongoing technical assistance, training, and education to continually enhance the skills and capabilities of the Community-Directed Programs.

While it is not possible to determine the extent to which the remarkable clinical outcomes described in this chapter are due solely to SDPI, nothing else has impacted diabetes resources across the Indian health system as much as SDPI over the past 12 years. As Congress envisioned, SDPI has been instrumental in effecting tremendous changes in the diabetes landscape across the Indian health system.



"I want to continue participating in the Diabetes Program so I can continue to control my diabetes, feel good, and prevent the complications to my eyes, heart, and kidneys."

Mary Lou Stanton, Narragansett
Narragansett Indian Health Clinic Diabetes Program
Charlestown, RI

Left to right: Alannah Blackgoat, Blackfeet/Navajo, and Jalynn Deon, Lakota, in Albuquerque, NM

"Today, after 20 years of insulin injections, I am able to manage my diabetes without insulin. Before I was diagnosed with type 2 diabetes in 1978, I really didn't know much about diabetes.

I had made many healthy changes over the years, but I woke up one day and decided to learn all I could about diabetes and joined the Hualapai Healthy Heart Program. I lost 26 pounds and lowered my blood sugar, blood pressure, and cholesterol. I eat fewer eggs and tortillas instead of fry bread, and I quit drinking soda. I've also switched from beef to buffalo meat, venison, and elk meat.

Diabetes is something that we should attack and pay attention to as a Native nation. We need to fight diabetes using our cultural and traditional methods."

Rudy Clark, Hualapai
Hualapai Healthy Heart Project Participant
Peach Springs, AZ

CHAPTER 5
SDPI: Transforming the Diabetes Landscape

The Special Diabetes Program for Indians (SDPI) has played an indispensable role in achieving substantial health benefits that directly affect people's lives and impact health care costs. Using evidence-based practices adapted for their communities, the 404 SDPI grant programs have made tremendous improvements in diabetes treatment and prevention across the country.

The SDPI Community-Directed Diabetes Programs have helped the Indian health system achieve and maintain control of key diabetes clinical measures at or near national targets. Sustaining these levels for the long term is essential in order to prevent the onset of diabetes complications such as end stage renal disease (ESRD). The decline in rates of ESRD in American Indian and Alaska Native (AI/AN) people with diabetes during the SDPI era is a monumental achievement that no other U.S. racial or ethnic group has experienced to this degree. This ESRD decline has huge cost-saving implications now and in the future.

The SDPI Demonstration Projects have made major advances in translating diabetes research to AI/AN communities. The SDPI Diabetes Prevention Program reduced risk factors for diabetes in people with prediabetes. This translation project achieved rates of diabetes incidence in high risk AI/AN people similar to those achieved in the National Institutes of Health Diabetes Prevention Program lifestyle intervention group. In people with diabetes, the SDPI Healthy Heart Program reduced risk for cardiovascular disease, the most costly and deadly diabetes complication.

The cost savings associated with these clinical outcomes far outweigh the resources that have been invested in SDPI.

"Before SDPI, we had over a 5-month wait to get a patient into the diabetes clinic. SDPI funds have made possible a state-of-the-art diabetes program here in Cherokee where we see success stories every day of people controlling their diabetes. Without SDPI, we would go back to having too little care available for far too many patients."

Sally Sneed Penick, R.N., C.D.E.
Program Manager, Cherokee Diabetes Program
Eastern Band of Cherokee Indians
Cherokee, NC

Why SDPI Works

Many factors have contributed to SDPI's success:

- Meaningful involvement of Tribal Leaders and community members from the inception of SDPI
- Ongoing guidance and direction from the IHS Tribal Leaders Diabetes Committee
- Tailored implementation of science-based interventions that incorporate community needs, values, and priorities
- Sustained infusion of funding resources targeted specifically for diabetes
- Vastly increased access to quality diabetes treatment and prevention services
- Integrated and effective national, regional, and local infrastructure that disseminates diabetes science and exchanges lessons learned
- The IHS Division of Diabetes provides extensive support to grantees, including:
  - Assistance with grants management and accountability
  - Comprehensive training on diabetes science and program management—online and at conferences
  - Clinical practice tools—diabetes standards of care, best practices, and treatment algorithms
  - Patient education resources—curricula, handouts, and publications for adults and youth
  - IHS Diabetes Care and Outcomes Audit— required annual patient chart audit of the quality and outcomes of
  - diabetes care
  - IHS Division of Diabetes website—central information resource that provides access to all of the Division's clinical and patient tools
- SDPI continues to evolve—incorporating new science, strengthening what works, and increasing accountability for grant funds

Clinical practice tools–treatment algorithms

Patient education resources–publications for adults and youth

As with all successful programs in AI/AN communities, SDPI is more than the sum of these parts. By honoring Tribal sovereignty and the values of AI/AN people, SDPI has tapped into their spirit of caring for each other and for future generations. This spirit infuses the people involved with SDPI with the energy to sustain and renew their efforts over the long term.

The Value of SDPI Going Forward

Diabetes clinical measures and ESRD incidence rates show that SDPI's interventions are working, however, the challenges ahead are still daunting. The prevalence of diabetes in AI/AN people is twice the rate of the general U.S. population. However, the prevalence in the U.S. general population is increasing, and the risk factors affecting the entire population also impact AI/ANs. Many factors make it difficult to treat the disease and its complications, especially in low-resource communities. The cost of treating adults with diabetes is two to three times that of treating those who do not have the disease.

Stan Jones, Sr., Tulalip
Tulalip, WA

SDPI is needed to address the challenges ahead.
Building on the successful interventions described in this report, SDPI has the expertise and capability to meet these challenges. The infrastructure is in place to disseminate new diabetes approaches quickly and to support their adoption throughout the Indian health system.

SDPI not only provides the resources that enable the 404 grant programs to employ hundreds of health care professionals but also supplies the tools that help hundreds more receive training in delivering quality diabetes services. This strong network of professionals has dramatically increased access to diabetes medical care and prevention services for tens of thousands of American Indian and Alaska Native people.

SDPI resources put a spotlight on diabetes. These resources enable local communities to concentrate on providing essential services to prevent and treat diabetes—services that are not often reimbursable by third party payers. The spotlight on diabetes would fade quickly without SDPI funding as communities would not have the resources to deal with the diabetes epidemic.

SDPI is a successful model for reducing health disparities. SDPI shows what can be achieved when modest resources are infused on a sustained basis while partnering with low-resource/high-risk communities. SDPI's model can inform development and delivery of diabetes services in other high-risk apopulations in the United States.

Making Progress toward a Healthier Future

Guided by Congress's vision, scientific research, and community-driven priorities, SDPI funding sustains one of the most comprehensive and effective systems to prevent and treat diabetes in the United States. This system has already had a major impact on reducing health disparities in diabetes and reaches far beyond the resources that have been invested.

As the science of diabetes continues to evolve, SDPI will keep working with American Indian and Alaska Native people to do whatever it takes to create a healthier future.

Left to right: Marcelo Quinto, Tlingit, and Florentino Barril, Tlingit, in Juneau, AK

APPENDIX 1
Map and Funding Amounts for SDPI Demonstration Projects

List of Diabetes Prevention Demonstration Projects

State	IHS Area	Grant Program Name	Consortium With Other Tribes or Agencies	Award Amount 2004	Award Amount Per Year 2005-9	Total
AK	Alaska	Kenaitze		$330,000	$324,300	$1,951,500
AK	Alaska	Norton Sound		$330,000	$324,300	$1,951,500
AK	Alaska	SEARHC		$404,000	$397,100	$2,389,500
AK	Alaska	Southcentral Foundation		$404,000	$397,100	$2,389,500
AZ	Phoenix	Colorado River		$404,000	$397,100	$2,389,500
AZ	Phoenix	Gila River		$404,000	$397,100	$2,389,500
AZ	Navajo	Tuba City		$404,000	$397,100	$2,389,500
CA	California	IHC – Santa Clara	X	$330,000	$324,300	$1,951,500
CA	California	Sonoma County		$330,000	$324,300	$1,951,500
CA	California	UAI Involvement		$330,000	$324,300	$1,951,500
CA	California	United Indian Health Services	X	$404,000	$397,100	$2,389,500
ID	Portland	Coeur d'Alene		$330,000	$324,300	$1,951,500
KS	Oklahoma	Haskell Health	X	$404,000	$397,100	$2,389,500
MN	Bemidji	Fond Du Lac		$330,000	$324,300	$1,951,500
MN	Bemidji	IHB of Minneapolis		$330,000	$324,300	$1,951,500
MN	Bemidji	Red Lake		$330,000	$324,300	$1,951,500
MS	Nashville	Mississippi Choctaw		$404,000	$397,100	$2,389,500
MT	Billings	Rocky Boy		$330,000	$324,300	$1,951,500
ND	Aberdeen	Trenton IHS	X	$330,000	$324,300	$1,951,500
NE	Aberdeen	Winnebago Tribe		$330,000	$324,300	$1,951,500
NM	Albuquerque	San Felipe Pueblo	X	$330,000	$324,300	$1,951,500
NM	Albuquerque	Zuni Pueblo		$404,000	$397,100	$2,389,500
NY	Nashville	Seneca Nation		$330,000	$324,300	$1,951,500
OK	Oklahoma	Cherokee Nation		$404,000	$397,100	$2,389,500
OK	Oklahoma	Chickasaw Nation		$404,000	$397,100	$2,389,500
OK	Oklahoma	Lawton IHS	X	$404,000	$397,100	$2,389,500
OR	Portland	Cow Creek Band	X	$404,000	$397,100	$2,389,500
OR	Portland	Warm Springs		$404,000	$397,100	$2,389,500
SD	Aberdeen	Cheyenne River Sioux		$330,000	$324,300	$1,951,500
SD	Aberdeen	Pine Ridge IHS		$404,000	$397,100	$2,389,500
SD	Aberdeen	Rapid City IHS		$330,000	$324,300	$1,951,500
WA	Portland	Colville		$330,000	$324,300	$1,951,500
WA	Portland	Chehalis	X	$330,000	$324,300	$1,951,500
WA	Portland	Quinault		$330,000	$324,300	$1,951,500
WI	Bemidji	Ho-Chunk		$330,000	$324,300	$1,951,500
WI	Bemidji	Menominee		$330,000	$324,300	$1,951,500
Total				**$12,990,000**	**$12,766,800**	**$76,824,000**

List of Healthy Heart Demonstration Projects

State	IHS Area	Grant Program Name	Consortium With Other Tribes or Agencies	Award Amount 2004	Award Amount Per Year 2005-9	Total
AK	Alaska	Yukon-Kuskokwim		$330,000	$324,300	$1,951,500
AZ	Phoenix	Hualapai		$330,000	$324,300	$1,951,500
AZ	Phoenix	Whiteriver IHS		$404,000	$397,100	$2,389,500
AZ	Navajo	Navajo Area IHS		$404,000	$397,100	$2,389,500
AZ	Tucson	Tohono O'Odham Nation	X	$404,000	$397,100	$2,389,500
CA	California	Indian Health Council		$330,000	$324,300	$1,951,500
CA	California	Redding Rancheria	X	$330,000	$324,300	$1,951,500
CA	California	Riverside-San Bernardino		$404,000	$397,100	$2,389,500
CA	California	Toiyabe		$330,000	$324,300	$1,951,500
MI	Bemidji	Sault Ste Marie		$330,000	$324,300	$1,951,500
MN	Bemidji	Leech Lake		$404,000	$397,100	$2,389,500
MN	Bemidji	Mille Lacs Band	X	$330,000	$324,300	$1,951,500
MT	Billings	Blackfeet Tribe		$404,000	$397,100	$2,389,500
MT	Billings	Confederated Salish & Kootenai		$330,000	$324,300	$1,951,500
MT	Billings	Ft Belknap	X	$330,000	$324,300	$1,951,500
NM	Albuquerque	Albuquerque IHS		$404,000	$397,100	$2,389,500
NM	Albuquerque	Ramah Navajo		$330,000	$324,300	$1,951,500
NM	Albuquerque	Santo Domingo		$330,000	$324,300	$1,951,500
NM	Albuquerque	Taos-Picuris		$330,000	$324,300	$1,951,500
NY	Nashville	St. Regis Mohawk		$330,000	$324,300	$1,951,500
OK	Oklahoma	Absentee Shawnee		$330,000	$324,300	$1,951,500
OK	Oklahoma	Choctaw Nation		$404,000	$397,100	$2,389,500
OK	Oklahoma	IHC Resource Center of Tulsa	X	$330,000	$324,300	$1,951,500
OK	Oklahoma	Muscogee Creek		$404,000	$397,100	$2,389,500
SD	Aberdeen	Wagner Health Care IHS		$330,000	$324,300	$1,951,500
UT	Phoenix	Uintah & Ouray IHS		$404,000	$397,100	$2,389,500
WA	Portland	NW Washington IHB		$330,000	$324,300	$1,951,500
WA	Portland	Seattle IHB		$330,000	$324,300	$1,951,500
WA	Portland	Yakama IHC		$404,000	$397,100	$2,389,500
WI	Bemidji	Bad River Band		$330,000	$324,300	$1,951,500
Total				**$10,714,000**	**$10,529,800**	**$63,363,000**

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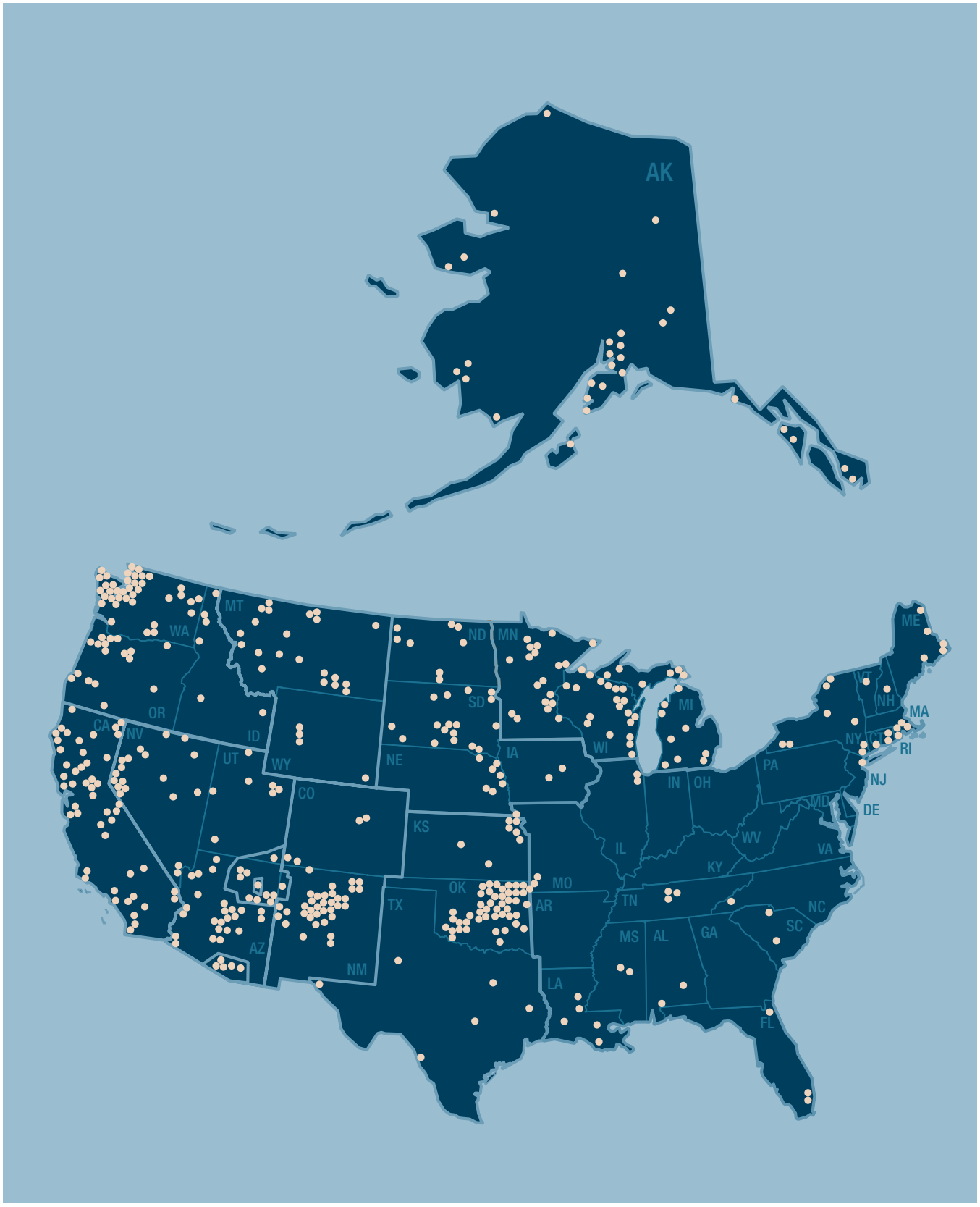
APPENDIX 2
Maps and Funding Amounts for SDPI Community-Directed Diabetes Programs

All Areas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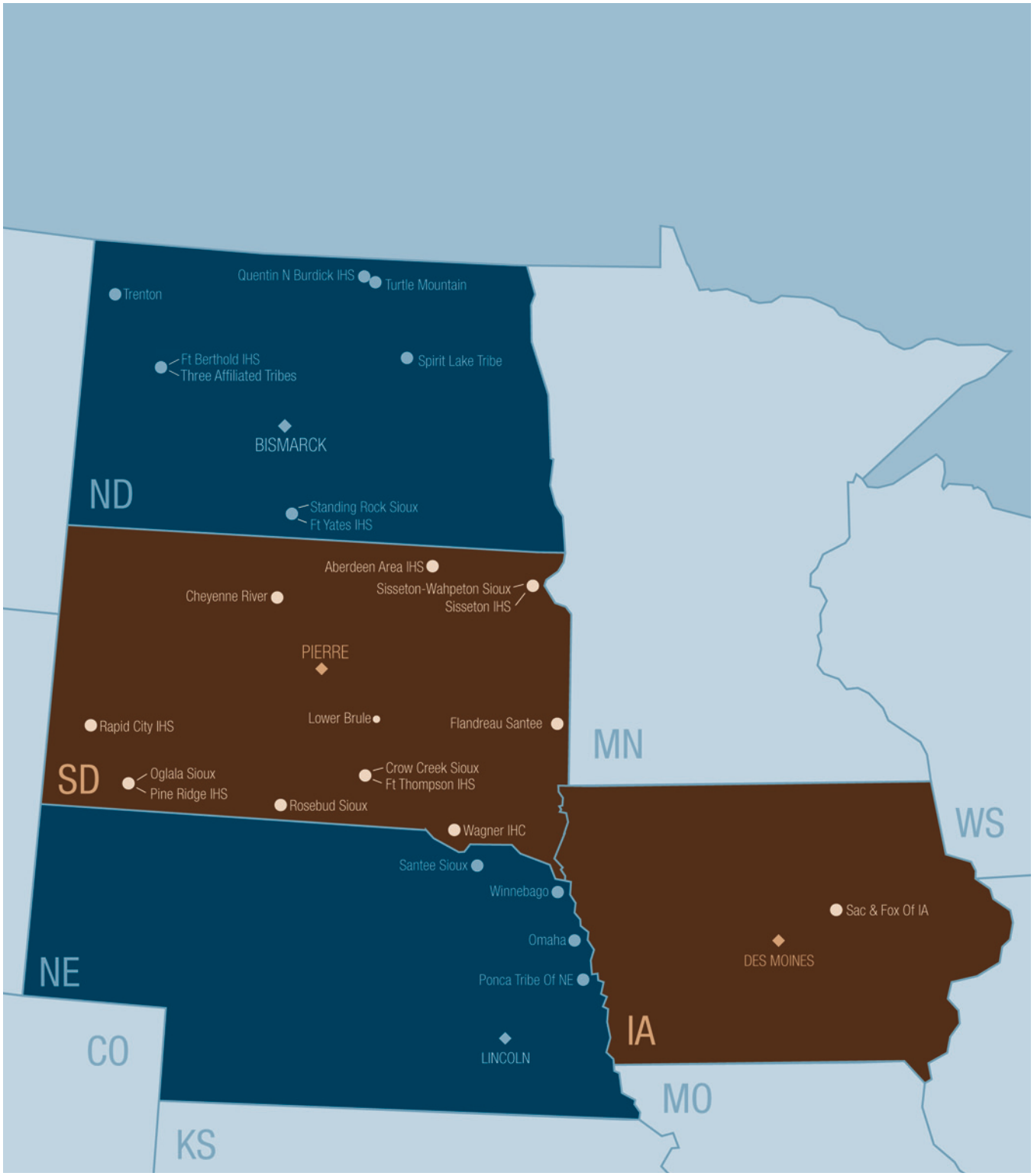
Funding Amounts Overall By Area And Fiscal Year

Area	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Aberdeen	$3,163,974	$3,163,974	$3,130,725	$8,963,221	$8,665,319	$8,665,319	$9,432,052	$9,432,052	$9,432,052	$9,432,052	$9,432,052	$9,432,052	$9,432,052	$101,776,896
Alaska	$2,816,838	$2,816,838	$2,783,589	$8,080,726	$8,234,947	$8,234,947	$8,963,599	$8,963,599	$8,963,599	$8,963,599	$8,963,599	$8,963,599	$8,963,599	$95,713,078
Albuquerque	$2,274,460	$2,274,460	$2,241,204	$6,979,237	$6,724,242	$6,724,242	$7,395,069	$7,319,223	$7,319,223	$7,319,223	$7,319,223	$7,319,223	$7,319,223	$78,528,252
Bemidji	$2,298,507	$2,298,507	$2,298,507	$7,392,572	$7,145,000	$7,145,000	$7,777,210	$7,777,210	$7,777,210	$7,777,210	$7,777,210	$7,777,210	$7,777,210	$83,018,563
Billings	$1,470,397	$1,709,497	$1,671,057	$4,975,512	$4,806,401	$4,806,401	$5,231,685	$5,277,397	$5,301,948	$5,231,685	$5,231,685	$5,231,685	$5,231,685	$56,177,035
California	$1,107,729	$1,570,591	$1,523,245	$4,910,618	$5,238,371	$5,238,371	$6,344,378	$6,338,378	$6,338,378	$6,344,378	$6,344,378	$6,344,378	$6,344,378	$63,987,571
Nashville	$1,443,862	$1,443,862	$1,410,614	$4,263,941	$4,399,740	$4,399,739	$5,462,036	$5,462,036	$5,461,903	$5,461,971	$5,462,107	$5,462,037	$5,461,968	$55,595,816
Navajo	$4,320,747	$4,320,747	$4,287,498	$12,944,988	$12,914,263	$12,914,263	$14,056,955	$14,056,955	$14,056,955	$14,056,955	$14,056,955	$14,056,955	$14,056,955	$150,101,191
Oklahoma	$4,787,735	$4,787,735	$4,754,486	$15,899,979	$16,615,789	$16,117,178	$17,950,277	$18,908,010	$18,908,010	$18,908,010	$18,112,325	$18,112,325	$18,112,325	$191,974,184
Phoenix	$3,798,793	$3,798,793	$3,765,544	$11,583,796	$11,523,886	$11,523,886	$13,674,139	$13,674,139	$13,674,139	$13,674,138	$13,674,138	$13,674,138	$13,674,138	$141,713,667
Portland	$1,592,172	$1,592,172	$1,558,473	$4,917,519	$4,972,408	$4,950,035	$5,734,543	$5,734,543	$5,728,734	$5,734,543	$5,734,543	$5,734,543	$5,734,543	$59,718,771
Tucson	$769,542	$674,156	$736,293	$2,281,660	$2,332,831	$2,332,831	$2,539,246	$2,539,246	$2,539,246	$2,539,246	$2,539,246	$2,539,246	$2,539,246	$26,902,035
Urban	$1,453,125	$1,500,000	$1,438,516	$4,772,637	$4,848,200	$5,086,572	$7,343,512	$7,343,512	$7,355,007	$7,352,507	$7,423,507	$7,443,507	$7,443,507	$70,804,109
Total	**$31,297,881**	**$31,951,332**	**$31,599,751**	**$97,966,406**	**$98,421,397**	**$98,138,784**	**$111,904,701**	**$112,826,300**	**$112,856,404**	**$112,795,517**	**$112,070,968**	**$112,090,898**	**$112,090,829**	**$1,176,011,168**

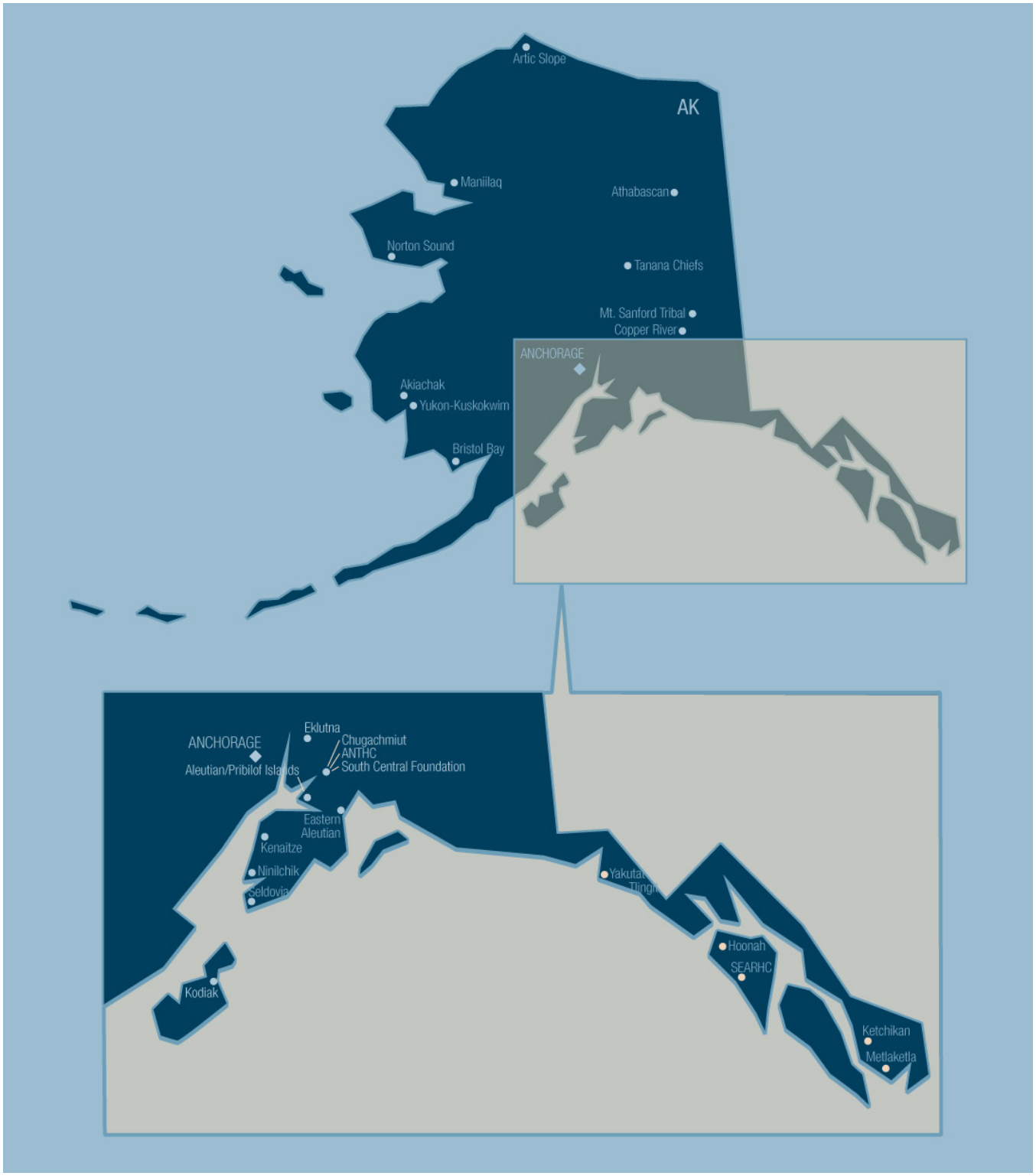
Aberdeen Area



Funding Amounts for Aberdeen Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Aberdeen Area IHS	$116,153	$116,153	$82,904	$282,904	$282,904	$282,904	$200,000	$200,000	$200,000	$200,000	$200,000	$200,000	$200,000	$2,563,922
Cheyenne River	$172,007	$172,007	$172,007	$513,636	$494,158	$494,158	$553,400	$553,400	$553,400	$553,400	$553,400	$553,400	$553,400	$5,891,773
Crow Creek Sioux	$0	$0	$134,012	$363,574	$323,519	$323,519	$349,768	$349,768	$349,768	$359,768	$359,768	$359,768	$359,768	$3,633,000
Flandreau Santee	$116,058	$116,058	$116,058	$270,097	$266,393	$266,393	$279,583	$279,583	$279,583	$279,583	$279,583	$279,583	$279,583	$3,108,138
Ft Berthold IHS	$171,753	$171,753	$171,753	$492,752	$475,008	$475,008	$518,067	$518,067	$518,067	$518,067	$518,067	$0	$0	$4,548,362
Ft Thompson IHS	$134,012	$134,012	$0	$0	$30,000	$30,000	$30,000	$30,000	$30,000	$20,000	$20,000	$20,000	$20,000	$498,024
Ft Yates IHS	$0	$0	$0	$0	$0	$37,000	$48,000	$50,000	$50,000	$50,000	$50,000	$50,000	$50,000	$385,000
Lower Brule	$128,911	$128,911	$128,911	$296,499	$291,656	$291,656	$305,962	$305,962	$305,962	$305,962	$305,962	$305,962	$305,962	$3,408,278
Oglala Sioux	$313,716	$313,716	$313,716	$1,085,121	$849,501	$1,029,501	$1,186,481	$1,066,481	$1,066,481	$1,146,481	$1,101,481	$1,186,481	$1,186,481	$11,845,638
Omaha	$135,478	$135,478	$135,478	$393,411	$380,971	$380,971	$406,148	$406,148	$406,148	$406,148	$406,148	$406,148	$406,148	$4,404,823
Pine Ridge IHS	$0	$0	$0	$0	$180,000	$0	$0	$120,000	$120,000	$40,000	$85,000	$0	$0	$545,000
Ponca Tribe of NE	$102,910	$102,910	$102,910	$254,734	$251,217	$251,217	$264,069	$264,069	$264,069	$264,069	$264,069	$264,069	$264,069	$2,914,381
Quentin N Burdick IHS	$0	$0	$0	$70,000	$100,000	$150,000	$150,000	$0	$0	$0	$0	$0	$0	$470,000
Rapid City IHS	$202,570	$202,570	$202,570	$615,138	$589,694	$589,694	$666,393	$666,393	$666,393	$666,393	$666,393	$666,393	$666,393	$7,066,987
Rosebud Sioux	$205,122	$205,122	$205,122	$712,002	$678,628	$678,628	$767,889	$767,889	$767,889	$767,889	$767,889	$767,889	$767,889	$8,059,847
Sac and Fox of Mississippi in Iowa	$106,141	$106,141	$106,141	$245,852	$243,353	$243,353	$254,197	$254,197	$254,197	$254,197	$254,197	$254,197	$254,197	$2,830,360
Santee Sioux	$109,026	$109,026	$109,026	$263,230	$259,512	$259,512	$267,476	$267,476	$267,476	$267,476	$267,476	$267,476	$267,476	$2,981,664
Sisseton IHS	$0	$0	$0	$0	$21,000	$6,000	$46,000	$32,000	$10,000	$0	$0	$0	$0	$115,000
Sisseton-Wahpeton Sioux	$153,686	$153,686	$153,686	$425,450	$390,847	$405,847	$407,660	$421,660	$443,660	$453,660	$453,660	$453,660	$453,660	$4,770,822
Spirit Lake	$174,170	$174,170	$174,170	$426,964	$414,956	$414,956	$452,673	$452,673	$452,673	$452,673	$452,673	$452,673	$452,673	$4,948,097
Standing Rock Sioux	$259,483	$259,483	$259,483	$631,459	$609,428	$572,428	$626,234	$624,234	$624,234	$624,234	$624,234	$624,234	$624,234	$6,963,402
Three Affiliated Tribes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$518,067	$518,067	$1,036,134
Trenton	$110,006	$110,006	$110,006	$261,263	$257,794	$257,794	$269,797	$269,797	$269,797	$269,797	$269,797	$269,797	$269,797	$2,995,448
Turtle Mountain	$184,562	$184,562	$184,562	$592,395	$531,463	$481,463	$579,226	$729,226	$729,226	$729,226	$729,226	$729,226	$729,226	$7,113,589
Wagner IHC	$128,180	$128,180	$128,180	$366,110	$355,352	$355,352	$384,668	$384,668	$384,668	$384,668	$384,668	$384,668	$384,668	$4,154,030
Winnebago	$140,030	$140,030	$140,030	$400,630	$387,965	$387,965	$418,361	$418,361	$418,361	$418,361	$418,361	$418,361	$418,361	$4,525,177
Total for Area	**$3,163,974**	**$3,163,974**	**$3,130,725**	**$8,963,221**	**$8,665,319**	**$8,665,319**	**$9,432,052**	**$9,432,052**	**$9,432,052**	**$9,432,052**	**$9,432,052**	**$9,432,052**	**$9,432,052**	**$101,776,896**

Alaska Area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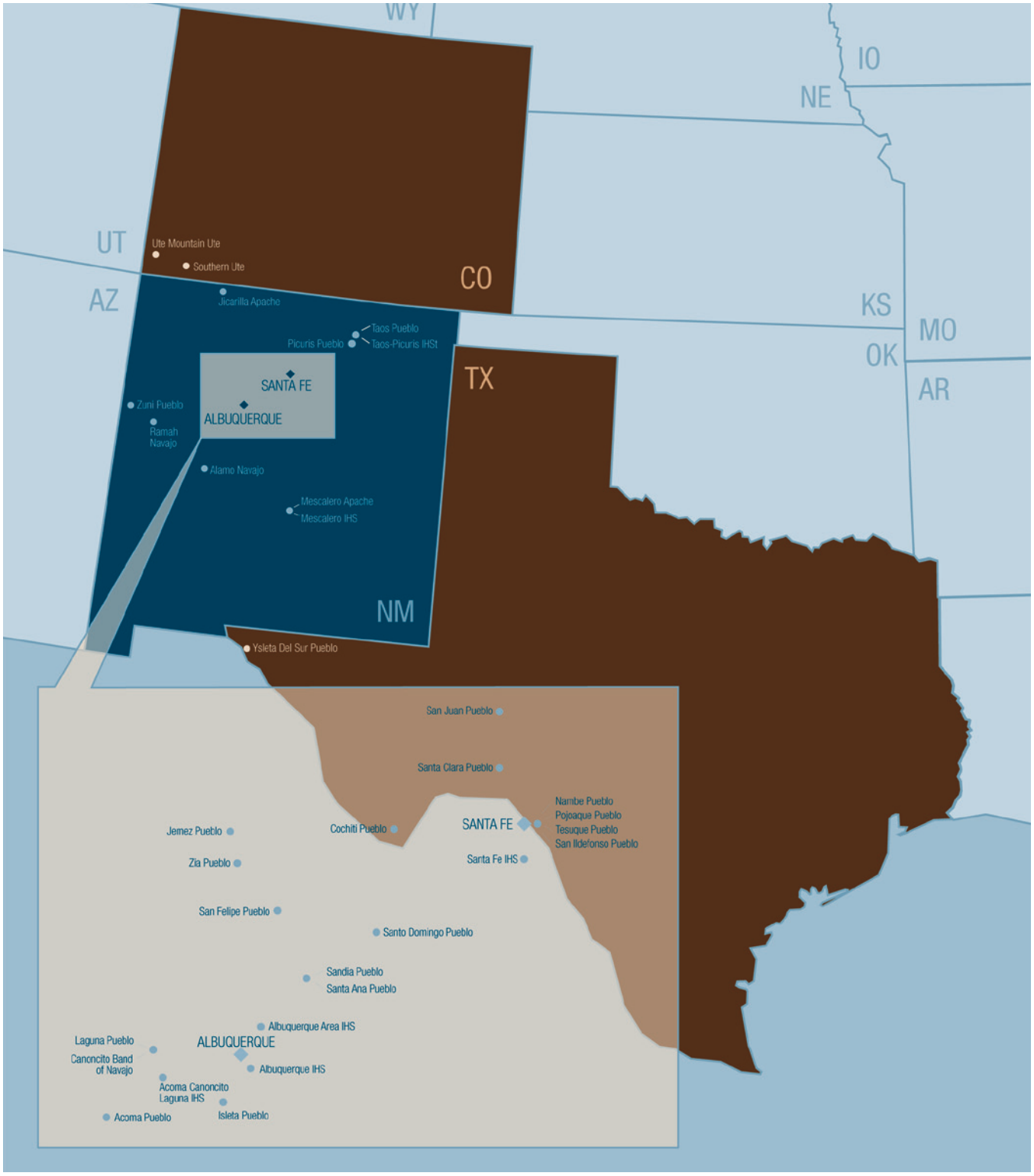
Nanilchik
Seldovia
Yakutat
Tlingit
Hoonah
SEARHC
Kodiak
Ketchikan
Metlaketla

Funding Amounts for Alaska Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Akiachak	$9,383	$9,383	$9,272	$9,272	$0	$0	$0	$0	$0	$0	$0	$0	$0	$37,310
Aleutian/Pribilof Islands	$82,015	$82,015	$45,264	$119,868	$114,256	$114,256	$124,366	$124,366	$124,366	$124,366	$124,366	$124,366	$124,366	$1,428,236
ANTHC	$299,601	$299,601	$296,061	$596,061	$596,061	$596,061	$648,802	$648,802	$648,802	$648,802	$648,802	$648,802	$648,802	$7,225,060
Arctic Slope	$91,707	$91,707	$90,625	$272,400	$278,387	$278,387	$303,019	$303,019	$303,019	$303,019	$303,019	$303,019	$303,019	$3,224,346
Athabascan	$37,143	$37,143	$36,705	$105,010	$104,609	$104,609	$113,865	$113,865	$113,865	$113,865	$113,865	$113,865	$113,865	$1,222,274
Bristol Bay	$252,265	$252,265	$249,288	$698,289	$687,642	$687,642	$748,487	$748,487	$748,487	$748,487	$748,487	$748,487	$748,487	$8,066,800
Chugachmiut	$50,245	$50,245	$49,652	$148,047	$150,691	$150,691	$164,025	$164,025	$164,025	$164,025	$164,025	$164,025	$164,025	$1,747,746
Copper River	$34,971	$34,971	$34,558	$90,355	$85,453	$85,453	$93,014	$93,014	$93,014	$93,014	$93,014	$93,014	$93,014	$1,016,859
Eastern Aleutian	$0	$0	$35,783	$99,282	$97,248	$97,248	$105,853	$105,853	$105,853	$105,853	$105,853	$105,853	$105,853	$1,070,532
Eklutna	$4,416	$4,416	$4,364	$12,621	$12,646	$12,646	$13,765	$13,765	$13,765	$13,765	$13,765	$13,765	$0	$133,699
Hoonah	$10,120	$10,120	$10,001	$27,940	$27,473	$27,473	$29,904	$29,904	$29,904	$29,904	$29,904	$29,904	$0	$292,551
Kenaitze	$26,586	$26,586	$26,272	$80,876	$83,626	$83,626	$91,025	$91,025	$91,025	$91,025	$91,025	$91,025	$91,025	$964,747
Ketchikan	$34,559	$43,732	$43,216	$127,410	$128,943	$128,943	$140,352	$140,352	$140,352	$140,352	$140,352	$140,352	$140,352	$1,489,267
Kodiak	$73,452	$73,452	$72,585	$215,242	$218,478	$218,478	$237,810	$237,810	$237,810	$237,810	$237,810	$237,810	$237,810	$2,536,357
Maniilaq	$192,152	$192,152	$189,884	$558,036	$563,823	$563,823	$613,712	$613,712	$613,712	$613,712	$613,712	$613,712	$613,712	$6,555,854
Metlaketla	$27,431	$27,431	$27,107	$70,280	$66,119	$66,119	$71,969	$71,969	$71,969	$71,969	$71,969	$71,969	$71,969	$788,270
Mt Sanford Tribal	$11,101	$11,101	$10,970	$32,159	$32,451	$32,451	$35,322	$35,322	$35,322	$35,322	$35,322	$35,322	$35,322	$377,487
Ninilchik	$8,121	$8,121	$8,025	$24,392	$25,066	$25,066	$27,284	$27,284	$27,284	$27,284	$27,284	$27,284	$27,284	$289,779
Norton Sound	$211,718	$211,718	$209,219	$578,621	$565,737	$565,737	$615,795	$615,795	$615,795	$615,795	$615,795	$615,795	$615,795	$6,653,315
SEARHC	$294,970	$285,797	$282,425	$789,018	$775,844	$775,844	$844,493	$844,493	$844,493	$844,493	$844,493	$844,493	$874,397	$9,145,253
Seldovia	$11,405	$11,405	$11,270	$31,480	$30,951	$30,951	$33,690	$33,690	$33,690	$33,690	$33,690	$33,690	$33,690	$363,292
Southcentral Foundation	$206,706	$206,706	$204,266	$1,038,964	$1,278,335	$1,278,335	$1,450,606	$1,450,606	$1,450,606	$1,450,606	$1,450,606	$1,450,606	$1,450,606	$14,367,554
Tanana Chiefs	$299,613	$299,613	$296,077	$847,053	$843,817	$843,817	$859,320	$859,320	$859,320	$859,320	$859,320	$859,320	$859,320	$9,445,230
Yakutat Tlingit	$7,642	$7,642	$7,552	$21,098	$20,746	$20,746	$22,582	$22,582	$22,582	$22,582	$22,582	$22,582	$0	$220,918
Yukon-Kuskokwim	$539,516	$539,516	$533,148	$1,486,952	$1,446,545	$1,446,545	$1,574,539	$1,574,539	$1,574,539	$1,574,539	$1,574,539	$1,574,539	$1,574,539	$17,013,995
Funds Pending Distribution	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$36,347	$36,347
Total for Area	**$2,816,838**	**$2,816,838**	**$2,783,589**	**$8,080,726**	**$8,234,947**	**$8,234,947**	**$8,963,599**	**$8,963,599**	**$8,963,599**	**$8,963,599**	**$8,963,599**	**$8,963,599**	**$8,963,599**	**$95,713,078**

Albuquerque Area



Funding Amounts for Albuquerque Area Grantees by Fiscal Year

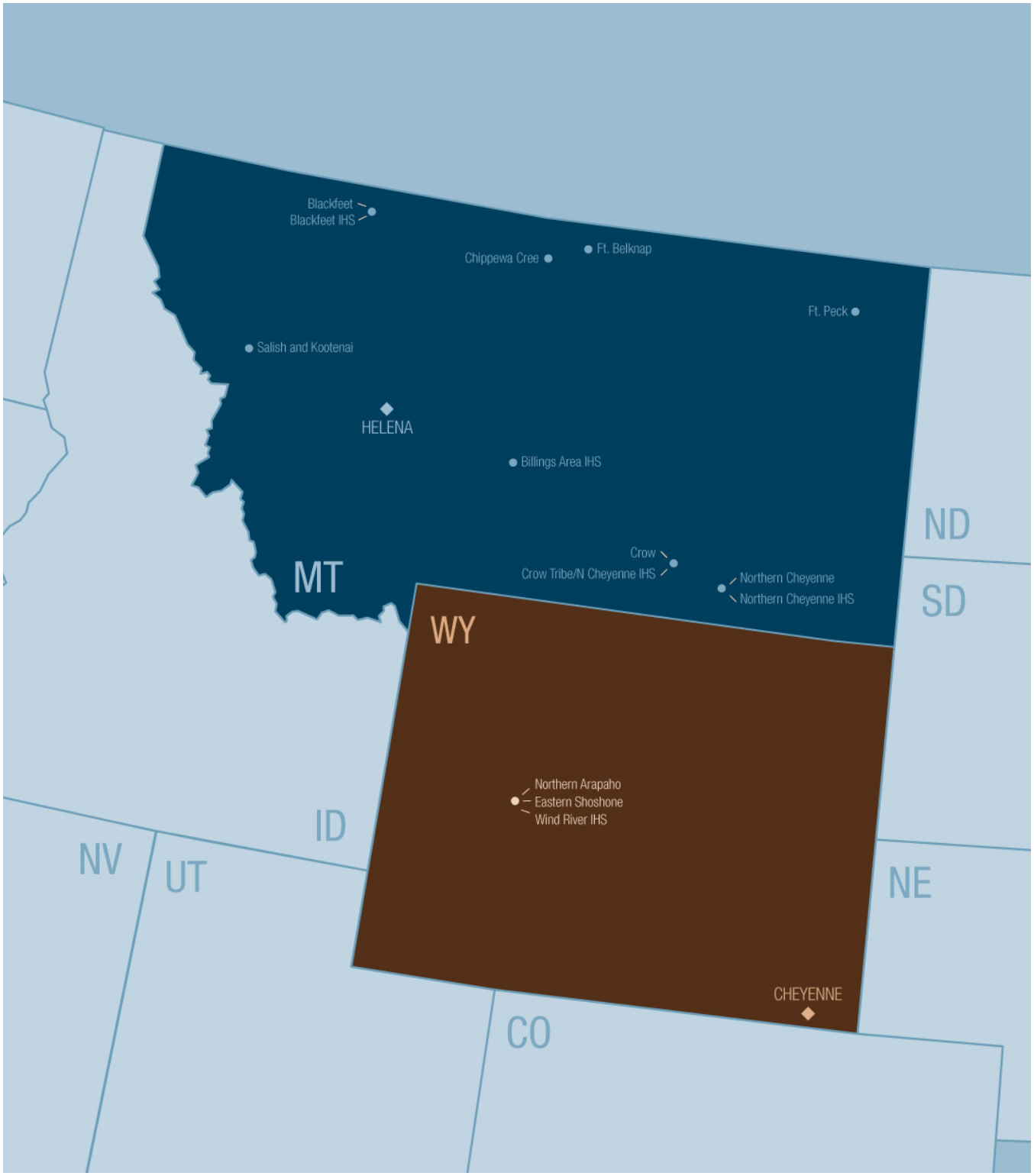
Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Acoma Canoncito Laguna IHS	$37,537	$37,537	$37,537	$65,093	$90,512	$90,512	$90,512	$90,512	$90,512	$90,512	$90,512	$90,512	$90,512	$992,312
Acoma Pueblo	$78,077	$78,077	$78,077	$251,088	$240,888	$240,888	$262,924	$262,924	$262,924	$262,924	$262,924	$262,924	$262,924	$2,807,563
Alamo Navajo	$109,033	$109,033	$109,033	$410,775	$394,634	$394,634	$416,670	$416,670	$416,670	$416,670	$416,670	$416,670	$416,670	$4,443,832
Albuquerque Area IHS	$116,154	$116,154	$82,898	$82,898	$82,898	$82,898	$82,907	$82,907	$82,907	$82,907	$82,907	$82,907	$82,907	$1,144,249
Albuquerque IHS	$255,976	$255,976	$255,976	$548,310	$532,345	$532,345	$150,000	$150,000	$150,000	$150,000	$150,000	$150,000	$150,000	$3,430,928
Canoncito Band of Navajo	$51,081	$51,081	$51,081	$180,043	$181,998	$181,998	$204,034	$204,034	$204,034	$204,034	$204,034	$204,034	$204,034	$2,125,520
Cochiti Pueblo	$0	$0	$0	$90,956	$127,037	$127,037	$149,073	$149,073	$149,073	$149,073	$149,073	$149,073	$149,073	$1,388,541
Isleta Pueblo	$186,706	$186,706	$186,706	$703,485	$674,825	$674,825	$696,861	$696,861	$696,861	$696,861	$696,861	$696,861	$696,861	$7,491,280
Jemez Pueblo	$138,415	$138,415	$138,415	$519,609	$500,025	$500,025	$522,061	$522,061	$522,061	$522,061	$522,061	$522,061	$522,061	$5,589,331
Jicarilla Apache	$78,956	$78,956	$78,956	$253,725	$243,525	$243,525	$265,561	$265,561	$265,561	$265,561	$265,561	$265,561	$265,561	$2,836,570
Laguna Pueblo	$105,290	$105,290	$105,290	$374,517	$324,192	$324,192	$346,228	$346,228	$346,228	$346,228	$346,228	$346,228	$346,228	$3,762,367
Mescalero Apache	$78,419	$78,419	$78,419	$252,114	$241,914	$241,914	$263,950	$263,950	$263,950	$263,950	$263,950	$263,950	$263,950	$2,818,849
Mescalero IHS	$18,451	$18,451	$18,451	$57,459	$56,186	$56,186	$56,186	$56,186	$56,186	$56,186	$56,186	$56,186	$56,186	$618,486
Nambe Pueblo	$27,263	$27,263	$27,263	$86,003	$83,454	$89,580	$111,616	$111,616	$111,616	$111,616	$111,616	$111,616	$111,616	$1,122,138
Picuris Pueblo	$19,626	$19,626	$19,626	$78,395	$75,846	$75,846	$97,882	$97,882	$97,882	$97,882	$97,882	$97,882	$97,882	$974,139
Pojoaque Pueblo	$21,457	$21,457	$21,457	$81,780	$80,507	$80,507	$102,543	$102,543	$102,543	$102,543	$102,543	$102,543	$102,543	$1,024,966
Ramah Navajo	$69,973	$69,973	$69,973	$222,562	$214,911	$214,911	$236,947	$236,947	$236,947	$236,947	$236,947	$236,947	$236,947	$2,520,932
San Felipe Pueblo	$62,750	$62,750	$62,750	$247,956	$237,756	$237,756	$259,792	$259,792	$259,792	$259,792	$259,792	$259,792	$259,792	$2,730,262
San Ildefonso Pueblo	$0	$0	$0	$0	$0	$103,531	$125,567	$125,567	$125,567	$125,567	$125,567	$125,567	$125,567	$982,500
San Juan Pueblo	$0	$0	$0	$190,849	$183,198	$183,198	$205,234	$205,234	$205,234	$205,234	$205,234	$205,234	$205,234	$1,993,883
Sandia Pueblo	$39,889	$39,889	$39,889	$151,161	$144,811	$144,811	$166,847	$166,847	$166,847	$166,847	$166,847	$166,847	$166,847	$1,728,379
Santa Ana Pueblo	$0	$0	$0	$0	$0	$0	$193,300	$193,300	$193,300	$193,300	$193,300	$193,300	$193,300	$1,353,100
Santa Clara Pueblo	$0	$0	$0	$0	$148,336	$148,336	$170,372	$170,372	$170,372	$170,372	$170,372	$170,372	$170,372	$1,489,276
Santa Fe IHS	$274,658	$274,658	$274,658	$419,038	$216,772	$13,279	$13,279	$13,279	$13,279	$13,279	$13,279	$13,279	$13,279	$1,566,016
Santo Domingo Pueblo	$83,935	$83,935	$83,935	$331,028	$318,279	$318,279	$340,315	$340,315	$340,315	$340,315	$340,315	$340,315	$340,315	$3,601,596
Southern Ute	$61,907	$61,907	$61,907	$198,364	$190,713	$190,713	$212,749	$212,749	$212,749	$212,749	$212,749	$212,749	$212,749	$2,254,754
Taos Pueblo	$49,040	$49,040	$49,040	$193,429	$185,778	$185,778	$207,814	$207,814	$207,814	$207,814	$207,814	$207,814	$207,814	$2,166,803
Taos-Picuris IHS	$0	$0	$0	$0	$0	$0	$75,846	$0	$0	$0	$0	$0	$0	$75,846
Tesuque Pueblo	$0	$0	$0	$0	$0	$93,836	$115,872	$115,872	$115,872	$115,872	$115,872	$115,872	$115,872	$904,940
Ute Mountain Ute	$84,231	$84,231	$84,231	$269,550	$259,350	$259,350	$281,386	$281,386	$281,386	$281,386	$281,386	$281,386	$281,386	$3,010,645
Ysleta Del Sur Pueblo	$31,090	$31,090	$31,090	$97,484	$94,935	$94,935	$116,971	$116,971	$116,971	$116,971	$116,971	$116,971	$116,971	$1,199,421
Zia Pueblo	$0	$0	$0	$0	$0	$0	$233,117	$233,117	$233,117	$233,117	$233,117	$233,117	$233,117	$1,631,819
Zuni Pueblo	$194,546	$194,546	$194,546	$621,566	$598,617	$598,617	$620,653	$620,653	$620,653	$620,653	$620,653	$620,653	$620,653	$6,747,009
Total for Area	$2,274,460	$2,274,460	$2,241,204	$6,979,237	$6,724,242	$6,724,242	$7,395,069	$7,319,223	$7,319,223	$7,319,223	$7,319,223	$7,319,223	$7,319,223	$78,528,252

Bemidji Area

Funding Amounts for Bemidji Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Bad River Band	$42,580	$42,930	$42,930	$138,590	$129,380	$128,210	$136,380	$131,590	$130,100	$127,410	$121,360	$115,130	$110,790	$1,397,380
Bay Mills	$38,150	$38,410	$38,410	$115,660	$96,030	$98,740	$105,880	$105,580	$106,600	$103,890	$108,260	$107,250	$109,810	$1,172,670
Bemidji Area IHS	$133,742	$115,987	$115,987	$158,255	$82,900	$82,898	$90,166	$90,166	$90,166	$157,856	$162,026	$162,146	$159,506	$1,601,801
Boise Forte	$37,190	$37,440	$37,440	$107,410	$98,650	$94,680	$104,760	$104,520	$106,310	$105,870	$106,580	$100,880	$104,370	$1,146,100
Fond Du Lac	$137,690	$138,940	$138,940	$499,680	$491,730	$444,370	$473,560	$463,320	$452,430	$462,810	$402,910	$506,350	$429,900	$5,042,630
Forest County Potawatomi	$34,300	$34,500	$34,500	$105,150	$98,550	$103,780	$116,910	$129,910	$119,830	$110,060	$117,870	$117,860	$119,070	$1,242,290
Grand Portage	$31,000	$31,140	$31,140	$74,010	$52,890	$52,900	$54,800	$53,980	$52,850	$51,210	$50,250	$48,310	$48,480	$632,960
Grand Traverse Band	$42,290	$42,620	$42,620	$122,160	$132,250	$136,760	$144,490	$136,660	$113,810	$106,640	$104,290	$96,740	$102,250	$1,323,580
Gun Lake Band Potawatomi	$0	$0	$0	$60,342	$39,940	$39,652	$40,744	$40,020	$39,620	$39,300	$39,234	$33,060	$34,124	$406,036
Hannahville/MI Potawatomi	$35,700	$35,920	$35,920	$102,200	$86,390	$84,350	$89,860	$118,230	$88,440	$77,720	$78,030	$77,670	$79,500	$989,930
Ho-Chunk	$61,000	$61,560	$61,560	$230,230	$252,750	$262,520	$284,000	$286,250	$286,940	$291,410	$301,780	$381,150	$377,300	$3,138,450
Huron Potawatomi	$31,800	$31,950	$31,950	$78,780	$56,880	$56,260	$58,460	$57,080	$56,210	$55,500	$55,270	$33,470	$43,620	$647,230
Keweenaw Bay/L'Anse	$46,070	$46,460	$46,460	$145,430	$137,000	$139,290	$152,770	$154,900	$156,470	$153,010	$155,540	$153,740	$148,670	$1,635,810
Lac Courte Oreilles	$70,740	$71,380	$71,380	$237,320	$238,130	$236,130	$255,940	$247,590	$244,320	$248,980	$223,020	$247,400	$227,700	$2,620,030
Lac du Flambeau	$54,930	$55,420	$55,420	$198,940	$193,390	$195,410	$213,640	$214,030	$213,270	$215,930	$221,000	$217,640	$220,990	$2,270,010
Lac Vieux Desert	$30,040	$30,160	$30,160	$74,270	$50,570	$51,420	$55,230	$55,910	$56,850	$57,380	$59,000	$57,320	$59,180	$667,490
Leech Lake	$185,365	$187,050	$187,050	$650,090	$669,760	$684,530	$748,220	$753,330	$758,540	$718,720	$737,470	$681,910	$691,730	$7,653,765
Little River Ottawa	$30,840	$30,970	$30,970	$0	$60,560	$59,870	$69,330	$67,850	$67,860	$75,020	$79,560	$81,810	$82,600	$737,240
Little Traverse Odawa	$35,140	$35,350	$35,350	$95,760	$77,460	$81,430	$92,620	$97,710	$101,420	$102,450	$106,010	$106,250	$109,810	$1,076,760
Lower Sioux	$0	$0	$0	$44,330	$55,360	$55,970	$60,480	$61,450	$63,410	$64,220	$66,030	$66,100	$67,450	$604,800
Menominee	$140,360	$141,630	$141,630	$497,360	$508,590	$513,630	$560,300	$556,990	$558,970	$564,080	$577,130	$571,980	$580,980	$5,913,630
Mille Lacs	$47,090	$47,510	$47,510	$201,320	$221,500	$216,810	$245,350	$247,770	$255,360	$249,680	$252,800	$243,290	$244,460	$2,520,450
Oneida	$159,640	$161,090	$161,090	$582,720	$597,100	$597,990	$656,180	$658,690	$667,180	$681,180	$706,940	$711,390	$732,510	$7,073,700
Pokagon Potawatomi	$39,450	$39,730	$39,730	$117,650	$101,680	$100,170	$105,560	$102,180	$100,040	$98,300	$86,930	$86,220	$87,060	$1,104,700
Prairie Island	$29,230	$29,350	$29,350	$74,190	$51,630	$47,260	$51,510	$53,320	$54,130	$54,970	$54,790	$55,360	$0	$585,090
Red Cliff	$40,040	$40,340	$40,340	$121,970	$109,800	$110,360	$115,270	$113,960	$116,130	$118,740	$124,470	$123,960	$128,510	$1,303,890
Red Lake	$150,040	$151,400	$151,400	$529,990	$534,650	$528,730	$568,120	$543,800	$543,660	$533,590	$542,380	$529,670	$540,810	$5,848,240
Saginaw Chippewa	$47,580	$48,000	$48,000	$152,670	$151,380	$157,830	$179,470	$187,530	$210,190	$223,080	$203,130	$196,490	$206,650	$2,012,000
Sault Ste Marie Chippewa	$258,540	$260,880	$260,880	$802,030	$776,580	$768,410	$831,370	$832,994	$846,424	$865,484	$871,160	$825,404	$836,490	$9,036,646
Shakopee Sioux	$0	$0	$0	$79,380	$53,040	$54,380	$55,860	$60,330	$64,550	$0	$0	$0	$0	$367,540
Sokaogon	$30,940	$31,070	$31,070	$73,280	$47,690	$45,530	$47,270	$46,920	$48,260	$50,630	$51,490	$51,860	$52,210	$608,220
St Croix	$41,540	$41,860	$41,860	$136,610	$123,430	$124,990	$140,350	$138,900	$141,600	$142,940	$130,680	$130,110	$121,940	$1,456,810
Stockbridge-Munsee	$47,150	$47,570	$47,570	$143,700	$129,530	$138,100	$156,690	$145,300	$146,430	$149,730	$154,450	$155,180	$159,110	$1,620,510
Upper Sioux	$29,450	$29,570	$29,570	$66,985	$44,060	$44,390	$45,620	$45,600	$44,710	$43,880	$42,360	$41,800	$43,080	$551,075
White Earth	$158,890	$160,320	$160,320	$574,110	$593,770	$607,250	$670,050	$672,850	$674,130	$675,540	$683,010	$662,310	$658,810	$6,951,360
Funds Pending Distribution	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$57,740	$57,740
Total for Area	**$2,298,507**	**$2,298,507**	**$2,298,507**	**$7,392,572**	**$7,145,000**	**$7,145,000**	**$7,777,210**	**$7,777,210**	**$7,777,210**	**$7,777,210**	**$7,777,210**	**$7,777,210**	**$7,777,210**	**$83,018,563**

Billings Area



Funding Amounts for Billings Area Grantees by Fiscal Year

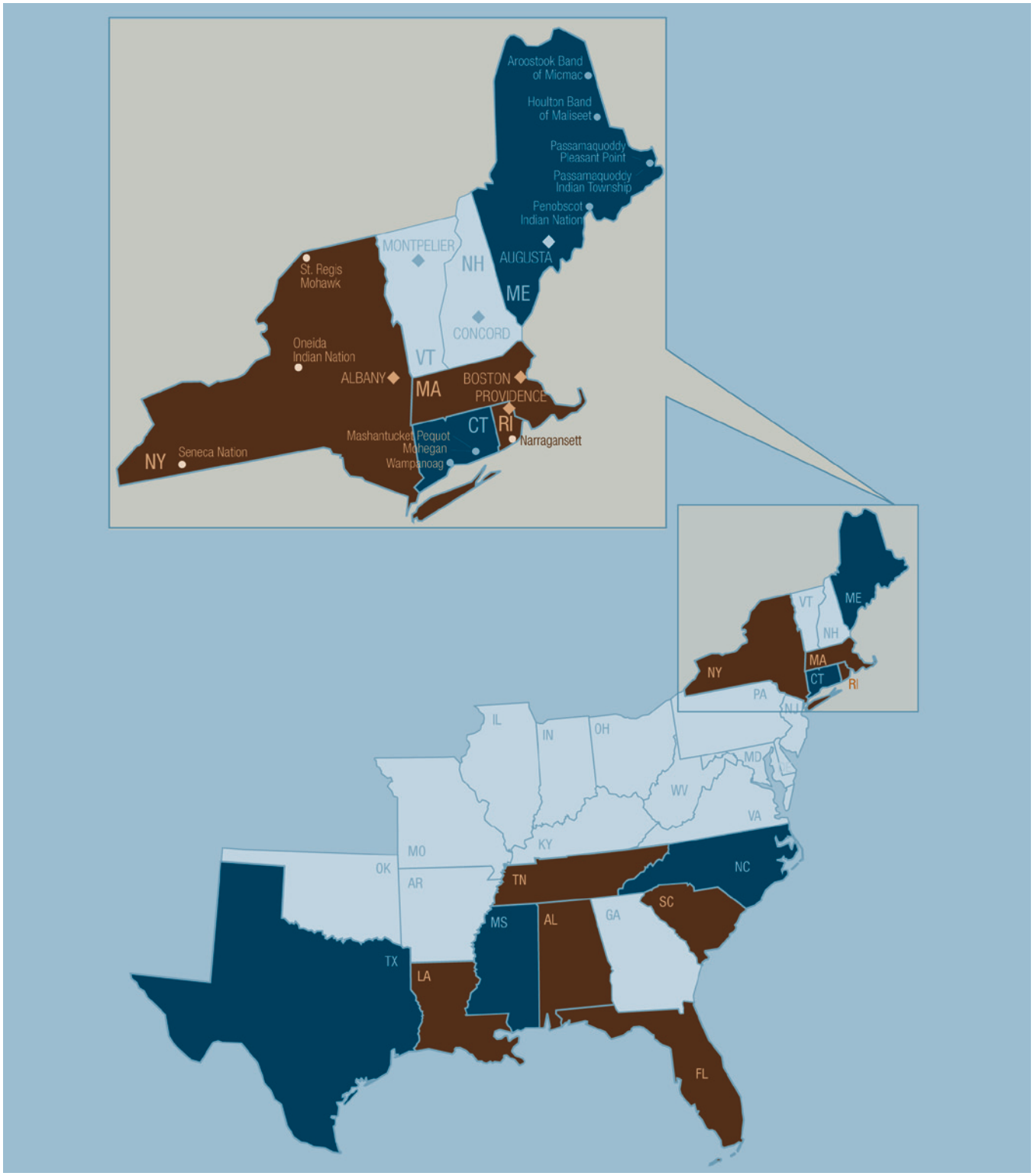
Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Billings Area IHS	$116,197	$116,197	$71,531	$76,724	$0	$0	$0	$0	$0	$0	$0	$0	$0	$380,649
Blackfeet	$271,300	$271,300	$271,300	$589,148	$653,784	$576,696	$626,015	$626,015	$626,015	$620,048	$620,048	$620,048	$867,948	$7,239,665
Blackfeet IHS	$0	$0	$0	$229,507	$143,608	$220,696	$241,933	$241,933	$241,933	$247,900	$247,900	$247,900	$0	$2,063,310
Chippewa Cree	$100,100	$100,100	$100,100	$327,259	$330,928	$330,928	$360,209	$360,209	$360,209	$360,209	$360,209	$360,209	$360,209	$3,810,878
Crow	$264,500	$264,500	$264,500	$618,488	$561,086	$489,286	$822,486	$895,262	$849,550	$895,262	$895,262	$895,262	$895,262	$8,610,706
Crow/N Cheyenne IHS	$0	$0	$0	$210,592	$261,400	$333,200	$72,776	$45,712	$115,975	$0	$0	$0	$0	$1,039,655
Eastern Shoshone	$0	$85,001	$85,001	$249,554	$239,754	$239,754	$232,141	$260,424	$260,424	$260,424	$260,424	$260,424	$260,424	$2,693,749
Ft Belknap	$119,400	$119,400	$125,626	$378,872	$368,934	$368,934	$401,578	$401,578	$401,578	$401,578	$401,578	$401,578	$401,578	$4,292,212
Ft Peck	$210,700	$210,700	$210,700	$637,749	$622,129	$622,129	$677,177	$677,177	$677,177	$677,177	$677,177	$677,177	$677,177	$7,254,346
Northern Arapaho	$0	$154,099	$154,099	$461,180	$447,329	$447,329	$487,454	$487,454	$487,454	$487,454	$487,454	$487,454	$487,454	$5,076,214
Northern Cheyenne	$162,100	$162,100	$162,100	$328,249	$306,749	$297,976	$341,242	$532,242	$502,242	$502,242	$502,242	$502,242	$532,242	$4,833,968
Northern Cheyenne IHS	$0	$0	$0	$169,500	$182,227	$191,000	$191,000	$0	$30,000	$30,000	$30,000	$30,000	$0	$853,727
Salish and Kootenai	$226,100	$226,100	$226,100	$698,690	$688,473	$688,473	$749,391	$749,391	$749,391	$749,391	$749,391	$749,391	$749,391	$7,999,673
Wind River IHS	$0	$0	$0	$0	$0	$0	$28,283	$0	$0	$0	$0	$0	$0	$28,283
Total for Area	**$1,470,397**	**$1,709,497**	**$1,671,057**	**$4,975,512**	**$4,806,401**	**$4,806,401**	**$5,231,685**	**$5,277,397**	**$5,301,948**	**$5,231,685**	**$5,231,685**	**$5,231,685**	**$5,231,685**	**$56,177,035**

California Area

Funding Amounts for California Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Cabazon	$1,500	$1,586	$1,500	$5,000	$6,000	$6,000	$0	$0	$0	$0	$0	$0	$0	$21,586
California Area IHS	$135,829	$118,028	$82,905	$182,905	$182,903	$182,903	$200,000	$200,000	$200,000	$200,000	$200,000	$200,000	$200,000	$2,285,473
Central Valley	$76,275	$111,965	$111,031	$374,790	$401,128	$401,128	$439,199	$439,199	$439,199	$439,199	$439,199	$439,199	$439,199	$4,550,710
Chapa-De	$56,817	$83,403	$82,708	$241,426	$257,277	$257,277	$274,673	$274,673	$274,673	$274,673	$274,673	$274,673	$274,673	$2,901,619
Colusa	$1,524	$2,237	$2,218	$16,566	$16,900	$16,900	$18,126	$18,126	$18,126	$18,126	$18,126	$18,126	$18,126	$183,227
Consolidated Tribal Health	$39,585	$58,107	$57,623	$172,707	$184,201	$184,201	$217,508	$217,508	$217,508	$217,508	$217,508	$217,508	$217,508	$2,218,980
CRIHB, Inc.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
* Ft Bidwell - Warner Mtn.	$1,500	$2,135	$1,974	$16,536	$17,592	$17,592	$32,068	$32,068	$32,068	$32,068	$32,068	$32,068	$32,068	$281,805
* MACT Tuolumne	$25,719	$37,753	$37,439	$114,937	$122,677	$122,677	$154,765	$154,765	$154,765	$154,765	$154,765	$154,765	$154,765	$1,544,557
* Shingle Springs	$10,119	$14,803	$14,572	$44,973	$48,009	$48,009	$48,009	$48,009	$48,009	$48,009	$48,009	$48,009	$48,009	$516,548
* Sonoma County	$60,200	$88,368	$87,632	$333,060	$357,567	$357,567	$411,313	$411,313	$411,313	$411,313	$411,313	$411,313	$411,313	$4,163,585
* United Indian Health Services	$90,000	$132,163	$131,171	$425,132	$454,487	$454,487	$454,487	$454,487	$454,487	$454,487	$454,487	$454,487	$454,487	$4,868,849
Feather River	$46,243	$67,881	$67,315	$217,502	$232,500	$232,500	$383,427	$383,427	$383,427	$383,427	$383,427	$383,427	$383,427	$3,547,930
Greenville Rancheria	$0	$24,334	$24,131	$82,233	$88,036	$88,036	$88,036	$88,036	$88,036	$94,036	$88,036	$88,036	$88,036	$929,022
Hoopa Valley	$42,617	$62,558	$62,037	$202,426	$220,846	$220,846	$235,634	$235,634	$235,634	$235,634	$235,634	$235,634	$235,634	$2,460,768
Indian Health Council	$64,588	$94,810	$94,020	$301,971	$322,737	$322,737	$365,302	$365,302	$365,302	$365,302	$365,302	$365,302	$365,302	$3,757,977
Karuk	$30,031	$44,083	$43,716	$122,867	$130,771	$130,771	$157,554	$157,554	$157,554	$157,554	$157,554	$157,554	$157,554	$1,605,117
Lake County	$17,461	$25,631	$25,418	$97,765	$104,990	$104,990	$209,142	$209,142	$209,142	$209,142	$209,142	$209,142	$209,142	$1,840,249
Modoc	$3,200	$4,697	$4,658	$22,002	$22,336	$22,336	$25,097	$25,097	$25,097	$25,097	$25,097	$25,097	$25,097	$254,908
Northern Valley	$18,863	$27,689	$27,458	$119,273	$128,441	$128,441	$174,285	$174,285	$174,285	$174,285	$174,285	$180,285	$174,285	$1,676,160
Pit River	$12,738	$18,698	$18,542	$62,134	$66,489	$66,489	$103,177	$103,177	$103,177	$103,177	$103,177	$103,177	$103,177	$967,329
Redding	$66,066	$96,979	$96,171	$286,046	$305,010	$305,010	$373,667	$373,667	$373,667	$373,667	$373,667	$373,667	$373,667	$3,770,951
Riverside San Bernardino	$139,128	$204,227	$202,523	$701,187	$744,982	$744,982	$938,351	$938,351	$938,351	$938,351	$938,351	$938,351	$938,351	$9,305,486
Round Valley	$15,633	$22,948	$22,756	$90,316	$97,062	$97,062	$112,937	$112,937	$112,937	$112,937	$112,937	$112,937	$112,937	$1,136,336
Santa Ynez	$7,771	$11,407	$11,312	$33,256	$35,449	$35,449	$49,223	$43,223	$43,223	$43,223	$43,223	$49,223	$43,223	$449,205
Southern Indian Health Council	$47,386	$69,558	$68,979	$186,873	$198,647	$198,647	$216,114	$216,114	$216,114	$216,114	$216,114	$216,114	$216,114	$2,282,888
Susanville	$11,367	$16,686	$16,546	$59,285	$63,553	$63,553	$104,571	$104,571	$104,571	$104,571	$104,571	$104,571	$104,571	$962,987
Sycuan Band	$0	$2,249	$2,329	$16,068	$16,400	$16,400	$27,886	$27,886	$27,886	$27,886	$27,886	$27,886	$27,886	$248,648
Table Mtn. Rancheria	$0	$0	$0	$1,500	$6,000	$6,000	$12,549	$12,549	$12,549	$12,549	$12,549	$12,549	$12,549	$101,343
Toiyabe	$43,516	$63,878	$63,345	$204,321	$218,400	$218,400	$306,742	$306,742	$306,742	$306,742	$306,742	$306,742	$306,742	$2,959,054
Tule River	$42,053	$61,730	$61,216	$175,561	$186,981	$186,981	$210,536	$210,536	$210,536	$210,536	$210,536	$210,536	$210,536	$2,188,274
Funds Pending Distribution	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,000	$6,000
Total for Area	$1,107,729	$1,570,591	$1,523,245	$4,910,618	$5,238,371	$5,238,371	$6,344,378	$6,338,378	$6,338,378	$6,344,378	$6,344,378	$6,344,378	$6,344,378	$63,987,571

Nashville Area (North)



Nashville Area (North)

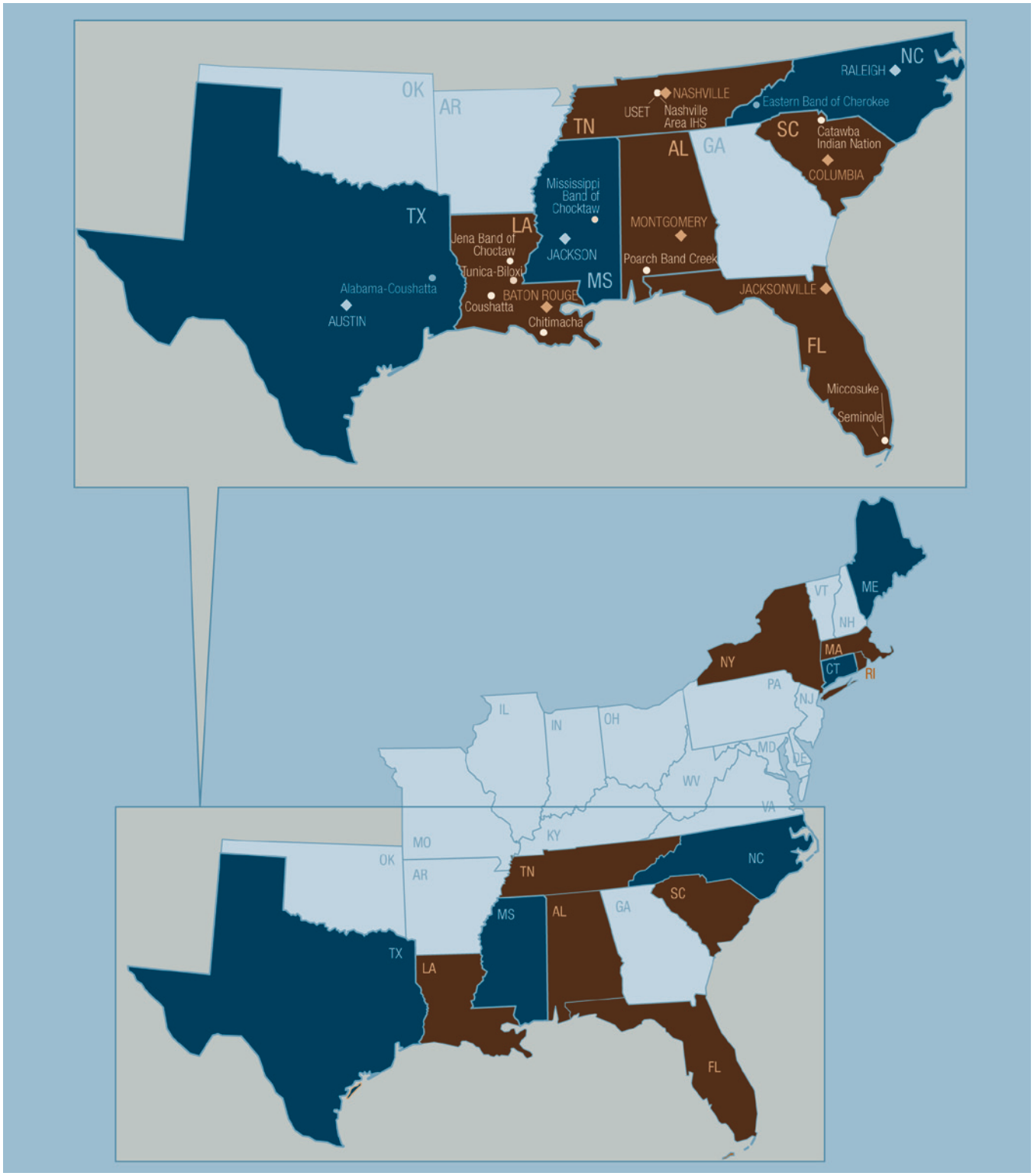
Funding Amounts for Nashville Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
*Aroostook Band of Micmac	$23,977	$26,335	$23,080	$68,359	$50,923	$50,923	$60,503	$60,503	$78,017	$77,967	$81,792	$97,092	$81,153	$780,624
*Houlton Band of Maliseet	$22,830	$23,937	$22,300	$67,360	$55,018	$55,018	$68,817	$68,817	$68,324	$69,337	$74,711	$70,042	$72,998	$739,509
*Mashantucket Pequot	$27,434	$31,041	$29,716	$98,177	$76,680	$76,680	$94,792	$94,792	$104,961	$97,000	$107,534	$110,671	$154,503	$1,103,981
*Mohegan	$36,903	$40,101	$32,120	$100,167	$104,010	$104,010	$133,809	$133,809	$117,274	$82,116	$82,334	$66,806	$86,568	$1,120,027
*Narragansett	$26,513	$28,888	$27,986	$81,482	$86,691	$86,691	$103,452	$103,452	$114,858	$117,756	$103,984	$103,646	$96,912	$1,082,311
*Oneida Indian Nation	$38,310	$43,254	$45,107	$138,173	$134,866	$134,866	$160,854	$160,854	$184,203	$182,786	$185,539	$168,198	$161,843	$1,738,853
*Passamaquoddy Indian Township	$29,397	$33,740	$30,640	$98,922	$72,612	$72,612	$85,564	$85,564	$88,740	$97,746	$96,182	$89,500	$86,492	$967,711
*Passamaquoddy Pleasant Point	$32,629	$37,123	$30,744	$93,612	$76,065	$76,065	$88,947	$88,947	$100,089	$95,424	$99,868	$90,812	$95,473	$1,005,798
*Penobscot Indian Nation	$39,491	$42,368	$32,373	$98,790	$71,788	$71,788	$90,244	$90,244	$94,527	$102,521	$99,004	$97,115	$101,389	$1,031,642
*Seneca Nation	$118,797	$128,485	$119,423	$358,008	$492,718	$492,718	$758,383	$758,383	$546,540	$491,412	$524,789	$538,206	$566,619	$5,894,481
*St. Regis Mohawk	$94,765	$96,192	$85,261	$306,163	$247,451	$247,451	$274,269	$274,269	$285,825	$337,025	$335,306	$329,558	$328,423	$3,241,958
*Wampanoag	$21,958	$24,893	$19,757	$60,098	$49,852	$49,852	$60,820	$60,820	$61,700	$60,535	$59,584	$64,495	$67,244	$661,608

*Program receives funds indirectly through USET.

Nashville Area continues on next page

Nashville Area (South)



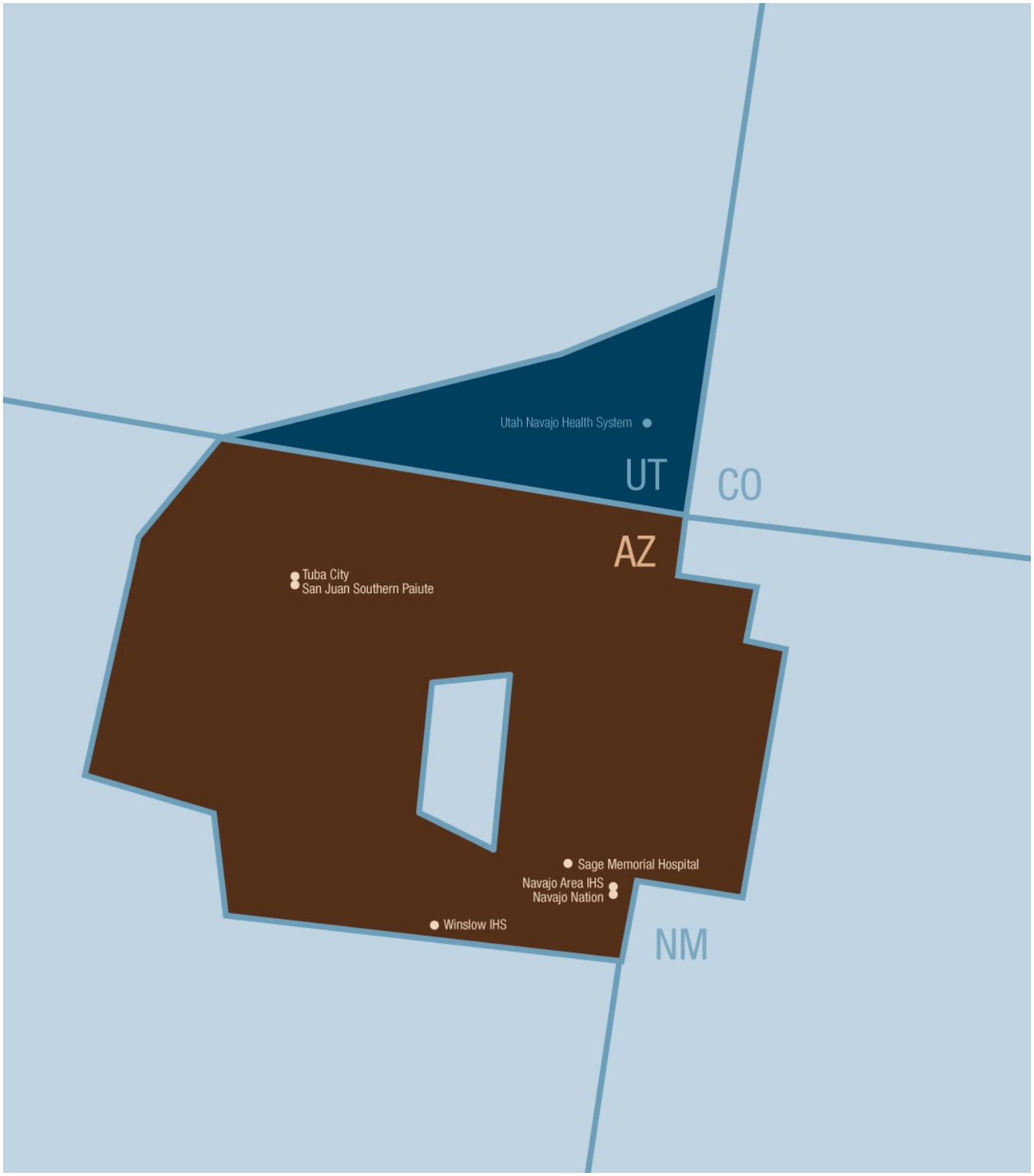
Nashville Area (South)

Funding Amounts for Nashville Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
USET	$85,268	$85,230	$83,691	$84,607	$84,609	$84,609	$84,609	$84,609	$84,609	$81,922	$79,915	$79,915	$79,915	$1,083,508
* Alabama-Coushatta	$30,301	$33,582	$32,577	$99,244	$99,803	$99,803	$126,180	$126,180	$152,442	$152,312	$143,877	$149,606	$147,178	$1,393,085
* Chitimacha	$23,994	$26,670	$24,045	$73,857	$64,254	$64,254	$80,971	$80,971	$83,164	$80,164	$84,203	$77,230	$77,434	$841,211
* Coushatta	$21,053	$22,403	$24,679	$71,842	$71,737	$71,737	$94,040	$94,040	$96,250	$91,744	$106,050	$93,552	$96,615	$955,742
* Jena Band of Choctaw	$15,461	$16,878	$13,914	$57,375	$52,635	$52,635	$64,130	$64,130	$63,728	$65,687	$68,440	$64,134	$64,708	$663,855
* Miccosukee	$27,104	$29,525	$28,711	$89,187	$90,151	$90,150	$116,654	$116,654	$98,866	$104,908	$107,829	$116,407	$119,555	$1,135,701
* Mississippi Band of Choctaw	$171,700	$190,091	$203,720	$705,672	$792,502	$792,502	$1,057,598	$1,057,598	$1,209,079	$1,071,926	$1,053,236	$1,061,761	$1,014,657	$10,382,042
* Poarch Band Creek	$49,655	$57,977	$44,442	$145,675	$139,048	$139,048	$158,046	$158,046	$186,868	$191,253	$197,072	$186,840	$199,088	$1,853,058
* Seminole	$58,081	$63,434	$66,535	$268,239	$274,885	$274,885	$343,366	$343,366	$312,784	$326,802	$324,993	$348,879	$363,267	$3,369,516
* Tunica-Biloxi	$14,803	$15,949	$14,844	$60,214	$54,064	$54,064	$67,550	$67,550	$64,761	$66,125	$68,705	$73,987	$72,486	$695,102
Catawba Indian Nation	$72,971	$79,084	$27,260	$101,119	$92,999	$92,999	$112,544	$112,544	$120,669	$132,377	$137,774	$142,872	$134,905	$1,360,117
Eastern Band of Cherokee	$244,313	$266,682	$264,784	$854,694	$1,064,379	$1,064,379	$1,175,894	$1,175,894	$1,143,625	$1,285,126	$1,239,386	$1,240,713	$1,192,543	$12,212,412
Nashville Area IHS	$116,154	$0	$82,905	$82,905	$0	$0	$0	$0	$0	$0	$0	$0	$0	$281,964
Total for Area	**$1,443,862**	**$1,443,862**	**$1,410,614**	**$4,263,941**	**$4,399,740**	**$4,399,739**	**$5,462,036**	**$5,462,036**	**$5,461,903**	**$5,461,971**	**$5,462,107**	**$5,462,037**	**$5,461,968**	**$55,595,816**

*Program receives funds indirectly through USET.

Navajo Area

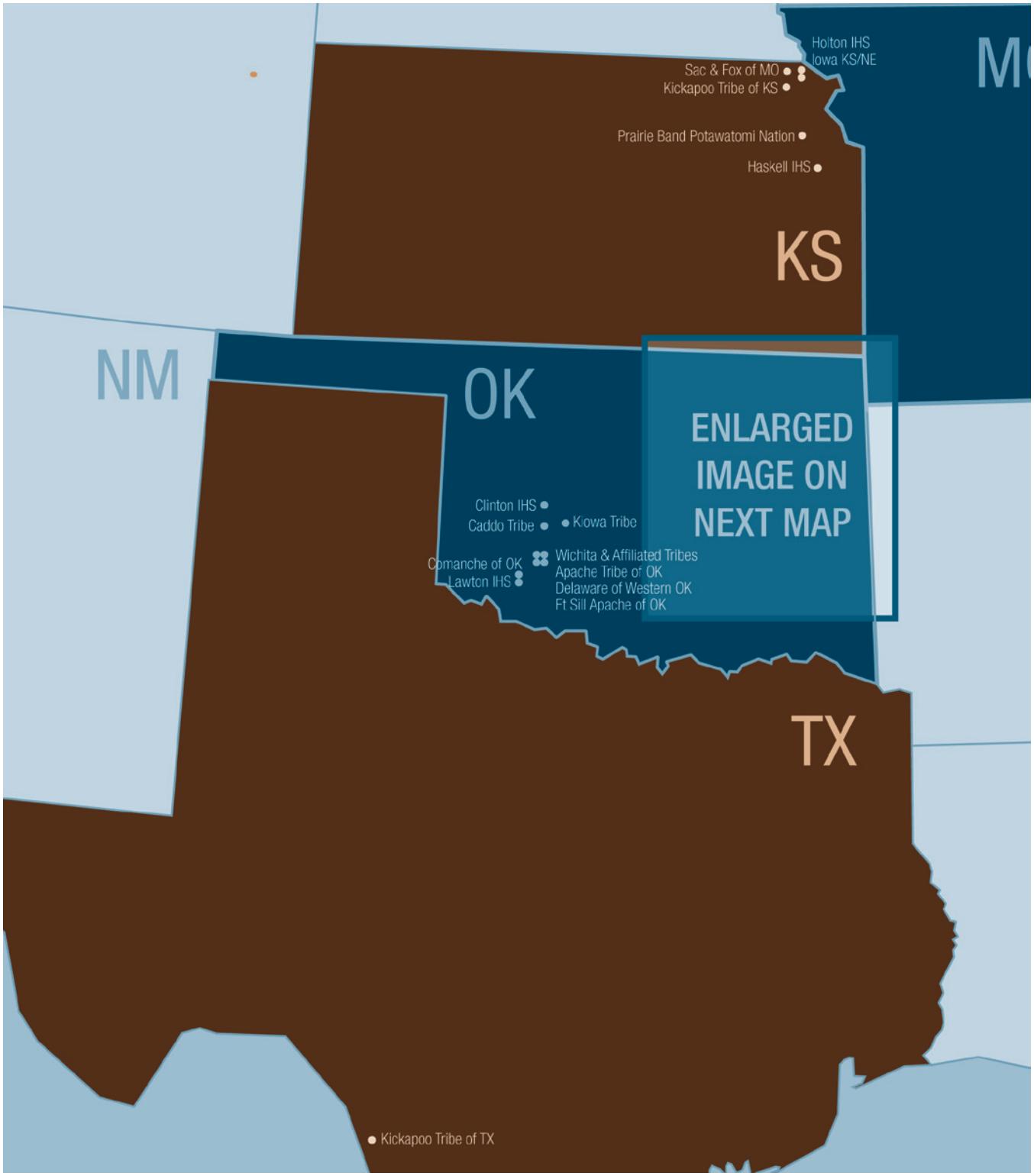

Utah Navajo Health System
UT
CO
AZ
Tuba City
San Juan Southern Paiute
Sage Memorial Hospital
Navajo Area IHS
Navajo Nation
Winslow IHS
NM

Navajo Area

Funding Amounts for Navajo Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Navajo Area IHS	$2,920,874	$2,820,874	$2,937,797	$5,531,850	$7,373,275	$5,601,275	$5,961,374	$5,961,374	$5,961,374	$5,961,374	$5,961,374	$5,961,374	$6,056,144	$69,010,333
Navajo Nation	$1,344,873	$1,444,873	$1,264,701	$7,283,138	$5,410,988	$6,443,988	$6,806,788	$6,806,788	$6,483,988	$6,483,988	$6,283,988	$6,483,988	$6,483,988	$69,026,077
Sage Memorial Hospital	$0	$0	$0	$0	$0	$0	$0	$0	$250,000	$250,000	$450,000	$250,000	$256,890	$1,456,890
San Juan Southern Paiute	$55,000	$55,000	$85,000	$130,000	$130,000	$130,000	$130,000	$130,000	$130,000	$130,000	$130,000	$130,000	$0	$1,365,000
Tuba City	$0	$0	$0	$0	$0	$454,500	$542,212	$542,212	$542,212	$542,212	$542,212	$542,212	$557,422	$4,265,194
Utah Navajo Health Systems	$0	$0	$0	$0	$0	$0	$258,000	$258,000	$330,800	$330,800	$330,800	$330,800	$335,350	$2,174,550
Winslow IHS	$0	$0	$0	$0	$0	$284,500	$358,581	$358,581	$358,581	$358,581	$358,581	$358,581	$367,161	$2,803,147
Total for Area	**$4,320,747**	**$4,320,747**	**$4,287,498**	**$12,944,988**	**$12,914,263**	**$12,914,263**	**$14,056,955**	**$14,056,955**	**$14,056,955**	**$14,056,955**	**$14,056,955**	**$14,056,955**	**$14,056,955**	**$150,101,191**

Oklahoma City Area



Oklahoma City Area

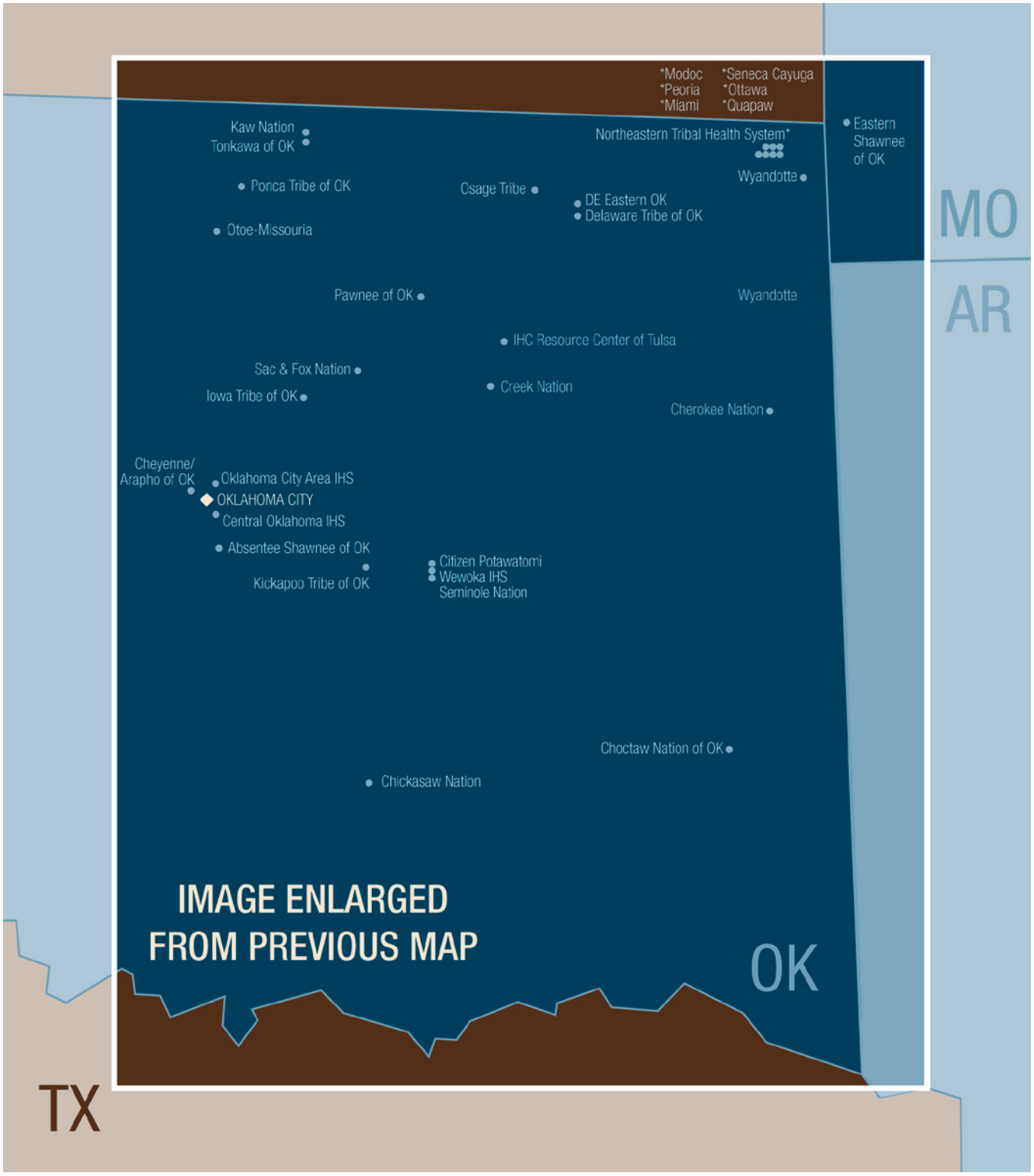
Funding Amounts for Oklahoma City Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Apache Tribe of OK	$49,205	$49,205	$48,197	$105,951	$107,504	$10,750	$0	$121,498	$121,498	$121,498	$0	$0	$0	$735,306
Caddo Tribe	$47,482	$47,482	$46,475	$97,320	$98,747	$9,875	$0	$111,601	$111,601	$111,601	$0	$111,601	$111,601	$905,386
Clinton IHS	$0	$0	$0	$0	$0	$150,000	$150,000	$100,000	$100,000	$0	$0	$0	$0	$500,000
Comanche of OK	$124,823	$124,823	$123,815	$376,629	$382,150	$382,150	$431,894	$431,894	$431,894	$431,894	$431,894	$431,894	$431,894	$4,537,648
Delaware of Western OK	$34,717	$34,717	$33,709	$50,478	$51,218	$5,122	$0	$57,885	$57,885	$57,885	$0	$0	$0	$383,616
Ft Sill Apache of OK	$31,053	$31,053	$30,045	$36,286	$36,815	$36,815	$41,607	$41,607	$41,607	$41,607	$41,607	$41,607	$41,607	$493,316
Haskell IHS	$53,388	$53,388	$52,380	$183,952	$186,649	$186,649	$210,945	$210,945	$210,945	$210,945	$210,945	$210,945	$210,945	$2,193,021
Holton IHS	$3,520	$3,520	$2,512	$0	$0	$133,939	$57,695	$57,695	$57,695	$57,695	$57,695	$57,695	$57,695	$547,356
* Iowa KS/NE	$30,695	$30,695	$30,695	$51,050	$51,050	$0	$0	$0	$0	$0	$0	$0	$0	$194,185
Kickapoo Tribe of KS	$35,681	$35,681	$34,673	$54,360	$55,157	$55,157	$62,337	$62,337	$62,337	$62,337	$62,337	$62,337	$62,337	$707,068
Kickapoo Tribe of TX	$35,539	$35,539	$34,532	$52,207	$52,972	$52,972	$59,867	$59,867	$59,867	$59,867	$59,867	$59,867	$59,867	$682,830
Kiowa Tribe	$140,353	$140,353	$139,345	$440,120	$446,572	$44,657	$0	$504,701	$504,701	$504,701	$0	$0	$0	$2,865,503
Lawton IHS	$0	$0	$0	$270,659	$561,040	$724,595	$633,637	$795,685	$795,685	$795,685	$795,685	$684,084	$684,084	$6,740,839
Prairie Band Potawatomi Nation	$39,167	$39,167	$39,167	$82,889	$82,889	$0	$93,679	$93,679	$93,679	$93,679	$93,679	$93,679	$93,679	$939,032
Sac and Fox of MO	$25,938	$25,938	$25,938	$31,521	$31,521	$31,521	$35,624	$35,624	$35,624	$35,624	$35,624	$35,624	$35,624	$421,745
Wichita and Affiliated Tribes	$44,706	$44,706	$43,698	$89,679	$90,994	$90,994	$102,839	$102,839	$102,839	$102,839	$102,839	$102,839	$102,839	$1,124,650

* Program receives funds indirectly through Holton IHS.

Oklahoma City Area continues on next page

Oklahoma City Area

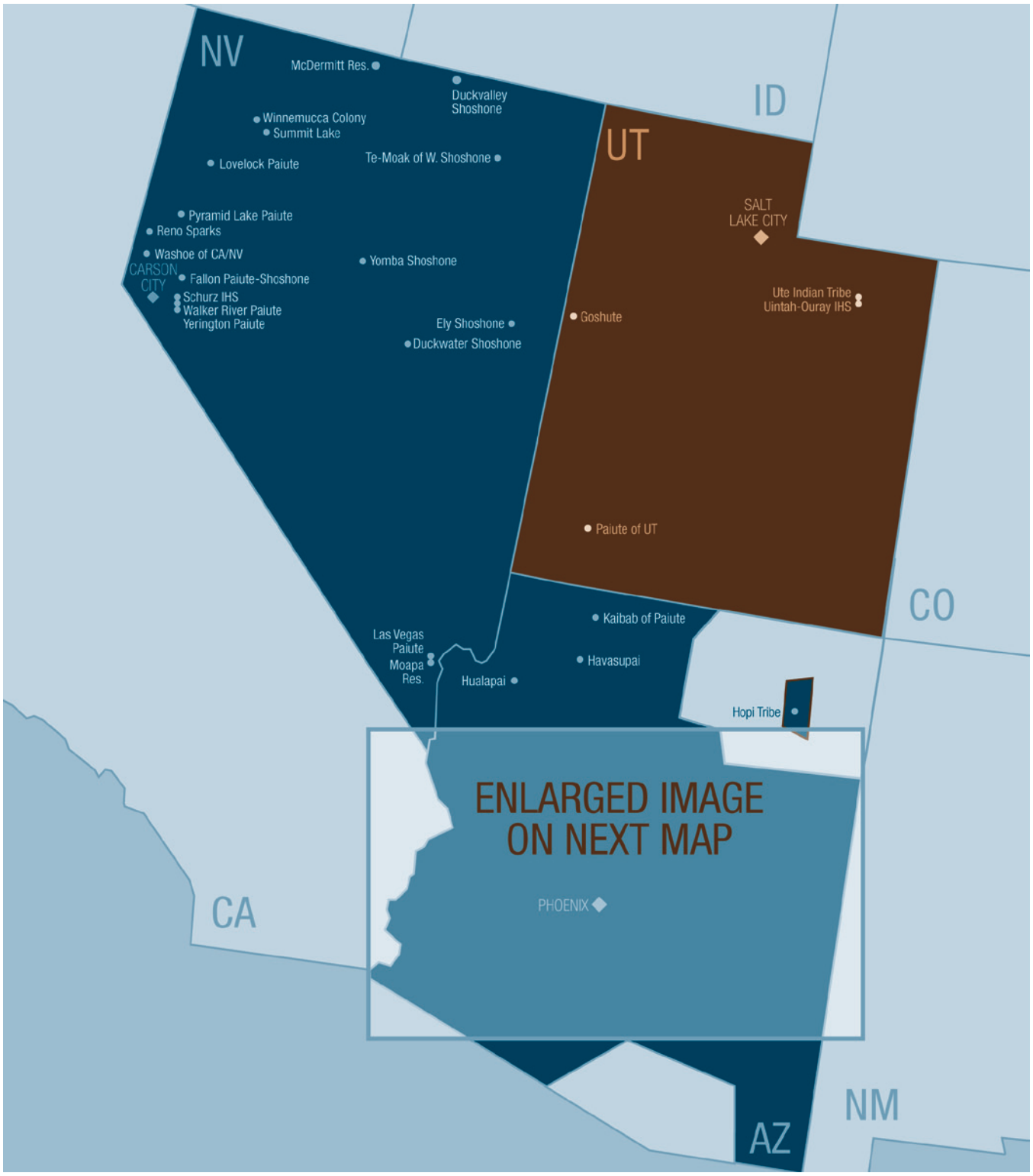


Funding Amounts for Oklahoma City Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Absentee Shawnee of OK	$109,268	$109,268	$108,260	$258,111	$261,895	$261,895	$295,985	$295,985	$295,985	$295,985	$295,985	$295,985	$295,985	$3,180,592
Central Oklahoma IHS	$105,711	$105,711	$104,703	$345,920	$350,991	$350,991	$396,679	$396,679	$396,679	$396,679	$396,679	$396,679	$396,679	$4,140,780
Cherokee Nation	$1,381,059	$1,381,059	$1,380,051	$5,322,116	$5,400,134	$5,400,131	$6,103,057	$6,103,057	$6,103,057	$6,136,145	$6,136,145	$6,136,145	$6,136,145	$63,118,301
Cheyenne/Arapaho of OK	$159,830	$159,830	$158,822	$542,471	$550,423	$400,423	$472,071	$522,071	$522,071	$622,071	$622,071	$622,071	$622,071	$5,976,296
Chickasaw Nation	$203,090	$203,090	$202,082	$734,776	$745,547	$745,547	$842,594	$842,594	$842,594	$842,594	$842,594	$842,594	$842,594	$8,732,290
Choctaw Nation of OK	$547,434	$547,434	$546,426	$2,150,479	$2,182,003	$2,182,003	$2,466,031	$2,466,031	$2,466,031	$2,466,031	$2,466,031	$2,466,031	$2,466,031	$25,417,996
Citizen Potawatomi	$146,524	$146,524	$145,516	$546,538	$554,550	$554,550	$626,735	$626,735	$626,735	$626,735	$626,735	$626,735	$626,735	$6,481,347
Creek Nation	$382,262	$382,262	$381,254	$1,426,486	$1,447,398	$1,447,398	$1,635,803	$1,635,803	$1,635,803	$1,635,803	$1,635,803	$1,635,803	$1,635,803	$16,917,681
Delaware Tribe of OK	$0	$0	$0	$0	$0	$0	$33,088	$33,088	$33,088	$0	$0	$0	$0	$99,264
Eastern Shawnee of OK	$35,539	$35,539	$34,532	$51,234	$51,234	$0	$0	$0	$0	$0	$0	$0	$0	$208,078
IHC Resource of Tulsa	$105,711	$105,711	$104,703	$345,920	$350,991	$350,991	$396,679	$396,679	$396,679	$396,679	$396,679	$396,679	$396,679	$4,140,780
Iowa Tribe of OK	$36,902	$36,902	$35,894	$79,259	$80,421	$80,421	$90,889	$90,889	$90,889	$90,889	$90,889	$90,889	$90,889	$986,022
Kaw Nation	$37,545	$37,545	$36,537	$70,981	$72,022	$72,022	$81,397	$81,397	$81,397	$81,397	$81,397	$81,397	$81,397	$896,431
Kickapoo Tribe of OK	$91,115	$91,115	$90,107	$283,994	$288,157	$288,157	$325,666	$325,666	$325,666	$325,666	$325,666	$325,666	$325,666	$3,412,307
Northeastern Tribal Health System	$187,965	$187,965	$186,965	$438,503	$302,671	$302,671	$342,070	$342,070	$342,070	$342,070	$342,070	$342,070	$342,070	$4,001,230
*Miami														
*Modoc														
*Ottawa														
*Peoria														
*Quapaw														
*Seneca Cayuga														
Oklahoma City Area IHS	$0	$0	$0	$0	$88,010	$88,010	$99,462	$99,462	$99,462	$99,462	$99,462	$99,462	$99,462	$872,254
Osage Tribe	$93,622	$93,622	$92,614	$308,311	$342,109	$312,832	$320,465	$320,465	$320,465	$320,465	$320,465	$320,465	$320,465	$3,486,365
*DE Eastern OK														
Otoe-Missouria	$51,995	$51,995	$50,987	$117,628	$119,352	$119,352	$134,888	$134,888	$134,888	$134,888	$134,888	$134,888	$134,888	$1,455,525
Pawnee of OK	$58,937	$58,937	$57,929	$140,971	$143,038	$143,038	$161,657	$161,657	$161,657	$161,657	$161,657	$161,657	$161,657	$1,734,449
Ponca Tribe of OK	$78,786	$78,786	$77,779	$217,669	$220,860	$220,860	$249,609	$249,609	$249,609	$249,609	$249,609	$249,609	$249,609	$2,642,003
Sac and Fox Nation	$111,505	$111,505	$110,497	$408,354	$414,340	$414,340	$468,274	$468,274	$468,274	$468,274	$468,274	$468,274	$468,274	$4,848,459
Seminole Nation	$0	$0	$0	$98,222	$0	$0	$0	$0	$0	$0	$366,317	$366,317	$366,317	$1,197,173
Tonkawa of OK	$33,097	$33,097	$32,089	$44,867	$45,525	$45,525	$51,451	$51,451	$51,451	$51,451	$51,451	$51,451	$51,451	$594,357
Wewoka IHS	$99,227	$99,227	$98,222	$0	$324,126	$324,126	$366,317	$366,317	$366,317	$366,317	$0	$0	$0	$2,410,196
Wyandotte	$34,344	$34,344	$33,336	$44,068	$44,714	$96,699	$109,286	$109,286	$109,286	$109,286	$109,286	$109,286	$109,286	$1,052,507
Total for Area	**$4,787,735**	**$4,787,735**	**$4,754,486**	**$15,899,979**	**$16,615,789**	**$16,117,178**	**$17,950,277**	**$18,908,010**	**$18,908,010**	**$18,908,010**	**$18,112,325**	**$18,112,325**	**$18,112,325**	**$191,974,184**

*Program receives funds indirectly through Northeastern Tribal Health System or Osage Tribe.

Phoenix Area



Phoenix Area

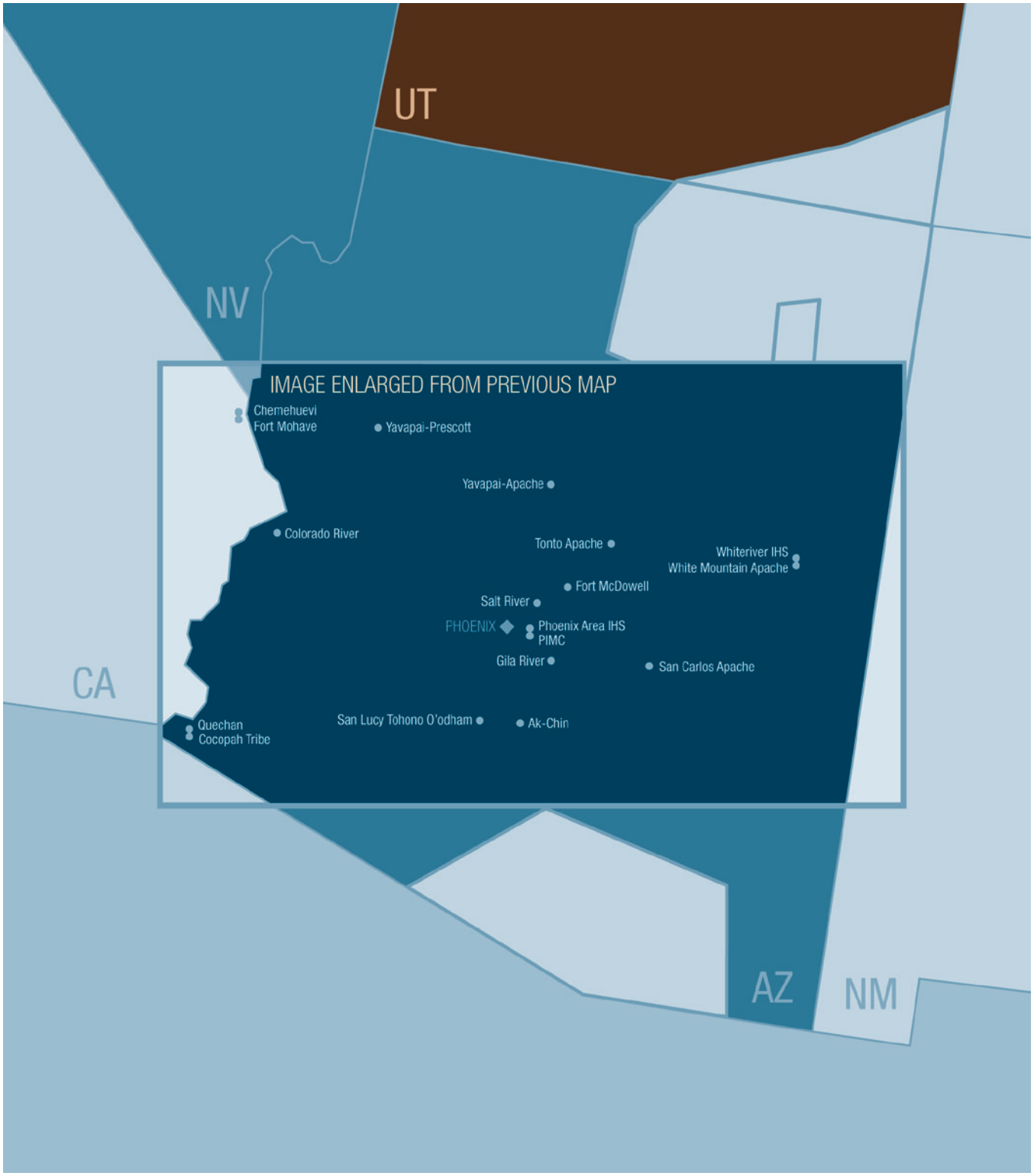
Funding Amounts for Phoenix Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Duckvalley Shoshone	$59,217	$59,217	$59,217	$197,343	$196,322	$196,322	$234,193	$234,193	$234,193	$234,193	$234,193	$234,193	$234,193	$2,406,989
Duckwater Shoshone	$19,422	$19,422	$19,422	$87,058	$86,608	$86,608	$97,921	$97,921	$97,921	$97,921	$97,921	$97,921	$97,921	$1,003,987
Ely Shoshone	$23,051	$23,051	$23,051	$100,300	$99,781	$99,781	$114,677	$114,677	$114,677	$114,677	$114,677	$114,677	$114,677	$1,171,754
Fallon Paiute-Shoshone	$53,728	$53,728	$53,728	$186,944	$185,977	$185,977	$225,108	$225,108	$225,108	$225,108	$225,108	$225,108	$225,108	$2,295,838
Goshute	$18,263	$18,263	$18,263	$89,569	$89,106	$89,106	$108,620	$108,620	$108,620	$108,620	$108,620	$108,620	$108,620	$1,082,910
Havasupai	$28,966	$28,966	$28,966	$114,535	$113,943	$113,943	$130,222	$130,222	$130,222	$130,222	$130,222	$130,222	$130,222	$1,340,873
Hopi Tribe	$204,127	$204,127	$204,127	$608,292	$605,146	$605,146	$674,906	$674,906	$674,906	$674,906	$674,906	$674,906	$674,906	$7,155,307
Hualapai	$68,152	$68,152	$68,152	$224,985	$223,821	$223,821	$273,055	$273,055	$273,055	$273,055	$273,055	$273,055	$273,055	$2,788,468
Kaibab of Paiute	$16,860	$16,860	$16,860	$83,101	$82,671	$82,671	$99,132	$99,132	$99,132	$99,132	$99,132	$99,132	$99,132	$992,947
Las Vegas Paiute	$58,451	$58,451	$58,451	$234,187	$232,976	$232,976	$301,831	$301,831	$301,831	$301,830	$301,830	$301,830	$301,830	$2,988,305
*Moapa Res.														
Lovelock Paiute	$21,526	$21,526	$21,526	$92,315	$91,838	$91,838	$105,289	$105,289	$105,289	$105,289	$105,289	$105,289	$105,289	$1,077,592
Paiute of UT	$30,339	$30,339	$30,339	$110,482	$109,911	$109,911	$167,672	$167,672	$167,672	$167,672	$167,672	$167,672	$167,672	$1,595,025
Pyramid Lake Paiute	$57,723	$57,723	$57,723	$204,582	$203,524	$203,524	$254,482	$254,482	$254,482	$254,482	$254,482	$254,482	$254,482	$2,566,173
Reno Sparks	$109,289	$109,289	$109,289	$340,280	$338,520	$338,520	$418,715	$418,715	$418,715	$418,715	$418,715	$418,715	$418,715	$4,276,192
Schurz IHS	$67,535	$67,535	$67,535	$285,846	$284,365	$284,365	$319,502	$319,502	$319,502	$319,502	$319,502	$319,502	$319,502	$3,293,695
*McDermitt Res.														
*Summit Lake														
*Winnemucca Colony														
Te-Moak of W. Shoshone	$71,628	$71,628	$71,628	$229,598	$228,411	$228,411	$266,191	$266,191	$266,191	$266,191	$266,191	$266,191	$266,191	$2,764,641
Uintah-Ouray IHS	$152,740	$152,740	$152,740	$479,481	$477,002	$75,090	$89,341	$89,341	$89,341	$89,341	$89,341	$89,341	$89,341	$2,115,180
Ute Indian Tribe	$0	$0	$0	$0	$0	$401,912	$482,712	$482,712	$482,712	$482,712	$482,712	$482,712	$482,712	$3,780,896
Walker River Paiute	$44,915	$44,915	$44,915	$156,788	$155,977	$155,977	$176,656	$176,656	$176,656	$176,656	$176,656	$176,656	$176,656	$1,840,079
Washoe of CA/NV	$79,587	$79,587	$79,587	$253,939	$252,626	$252,626	$305,962	$305,962	$305,962	$305,962	$305,962	$305,962	$305,962	$3,139,686
Yerington Paiute	$31,254	$31,254	$31,254	$123,179	$122,542	$122,542	$145,262	$145,262	$145,262	$145,262	$145,262	$145,262	$145,262	$1,478,859
Yomba Shoshone	$18,019	$18,019	$18,019	$82,090	$81,665	$81,665	$93,580	$93,580	$93,580	$93,580	$93,580	$93,580	$93,580	$954,537

*Program receives funds indirectly through Las Vegas Paiute or Schurz IHS.

Phoenix Area continues on next page

Phoenix Area

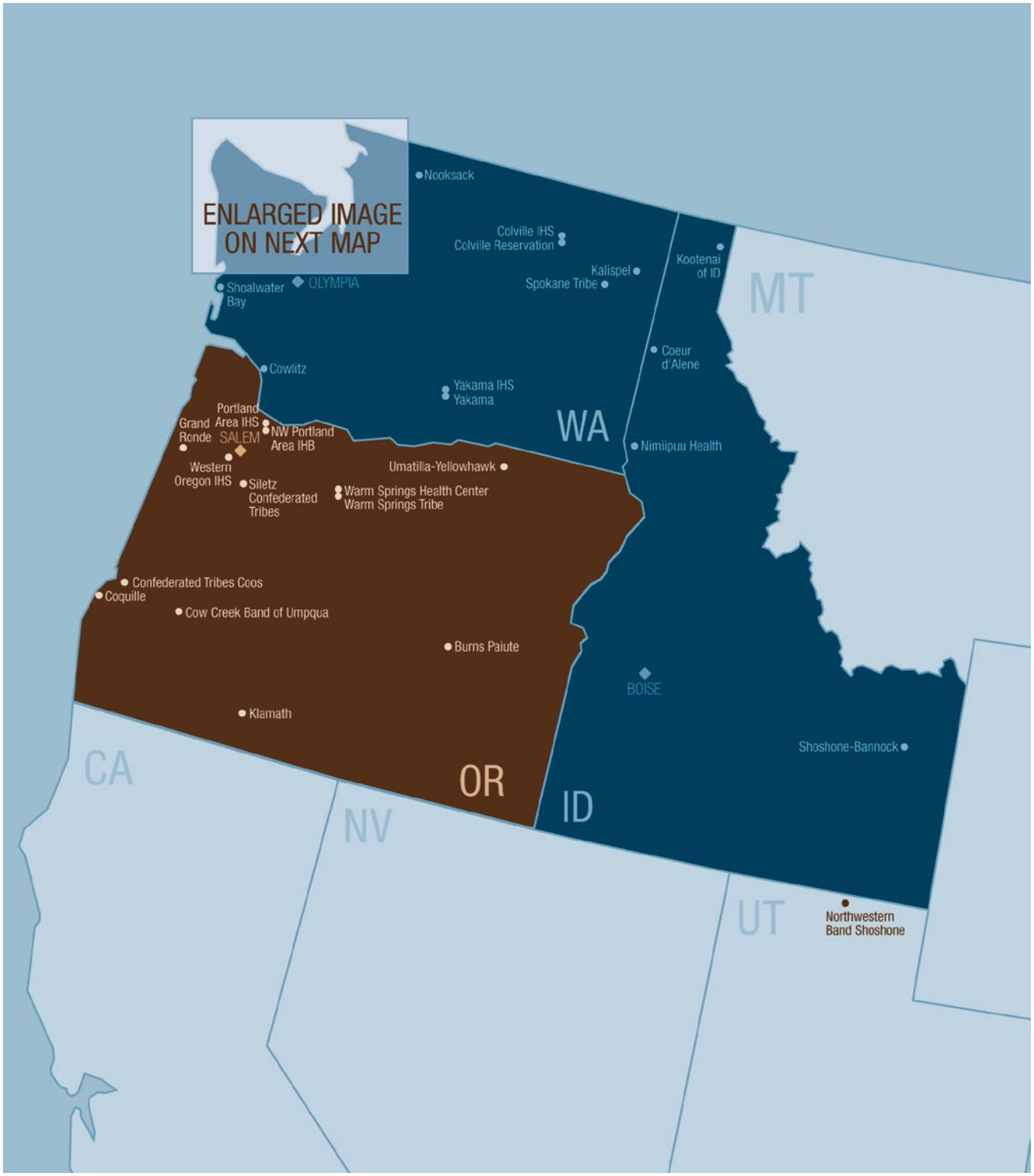


Phoenix Area

Funding Amounts for Phoenix Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Ak-Chin	$0	$0	$0	$0	$119,165	$119,165	$148,089	$148,089	$148,089	$148,089	$148,089	$148,089	$148,089	$1,274,953
Chemehuevi	$21,312	$21,312	$21,312	$91,171	$90,699	$90,699	$107,106	$107,106	$107,106	$107,106	$107,106	$107,106	$107,106	$1,086,247
Cocopah Tribe	$33,785	$33,785	$33,785	$125,503	$124,854	$124,854	$145,363	$145,363	$145,363	$145,363	$145,363	$145,363	$145,363	$1,494,107
Colorado River	$123,774	$123,774	$123,774	$388,356	$386,348	$386,348	$461,615	$461,615	$461,615	$461,615	$461,615	$461,615	$461,615	$4,763,679
Fort McDowell	$35,126	$35,126	$35,126	$142,193	$141,458	$141,458	$183,116	$183,116	$183,116	$183,116	$183,116	$183,116	$183,116	$1,812,299
Fort Mohave	$37,993	$37,993	$37,993	$148,109	$147,343	$147,343	$192,201	$192,201	$192,201	$192,201	$192,201	$192,201	$192,201	$1,902,181
Gila River	$585,365	$585,365	$585,365	$1,718,700	$1,590,647	$1,590,647	$1,959,194	$1,959,194	$1,959,194	$1,959,194	$1,959,194	$1,959,194	$1,959,194	$20,370,447
Phoenix Area IHS	$116,152	$116,152	$82,903	$254,905	$180,734	$217,160	$0	$0	$0	$0	$0	$0	$0	$968,006
PIMC	$492,524	$492,524	$492,524	$1,000,710	$995,535	$959,109	$1,185,000	$1,185,000	$1,185,000	$1,185,000	$1,185,000	$1,185,000	$1,185,000	$12,727,926
Quechan	$99,836	$99,836	$99,836	$319,355	$317,703	$317,703	$390,653	$390,653	$390,653	$390,653	$390,653	$390,653	$390,653	$3,988,840
Salt River	$150,705	$150,705	$150,705	$485,927	$483,414	$483,414	$537,726	$537,726	$537,726	$537,726	$537,726	$537,726	$537,726	$5,668,952
San Carlos Apache	$337,601	$337,601	$337,601	$1,004,292	$999,098	$999,098	$1,211,414	$1,211,414	$1,211,414	$1,211,414	$1,211,414	$1,211,414	$1,211,414	$12,495,189
San Lucy Tohono O'odham	$16,863	$16,863	$16,863	$44,873	$117,493	$117,493	$143,244	$143,244	$143,244	$143,244	$143,244	$143,244	$143,244	$1,333,156
Tonto Apache	$18,812	$18,812	$18,812	$81,642	$81,220	$81,220	$95,902	$95,902	$95,902	$95,902	$95,902	$95,902	$95,902	$971,832
White Mountain Apache	$436,647	$436,647	$436,647	$1,267,210	$714,732	$1,260,656	$1,558,857	$1,558,857	$1,558,857	$1,558,857	$1,558,857	$1,558,857	$1,558,857	$15,464,538
Whiteriver IHS	$0	$0	$0	$0	$545,924	$0	$0	$0	$0	$0	$0	$0	$0	$545,924
Yavapai-Apache	$31,589	$31,589	$31,589	$122,739	$122,104	$122,104	$149,098	$149,098	$149,098	$149,098	$149,098	$149,098	$149,098	$1,505,400
Yavapai-Prescott	$25,917	$25,917	$25,917	$103,217	$102,683	$102,683	$120,532	$120,532	$120,532	$120,532	$120,532	$120,532	$120,532	$1,230,058
Total for Area	**$3,798,793**	**$3,798,793**	**$3,765,544**	**$11,583,796**	**$11,523,886**	**$11,523,886**	**$13,674,139**	**$13,674,139**	**$13,674,139**	**$13,674,138**	**$13,674,138**	**$13,674,138**	**$13,674,138**	**$141,713,667**

Portland Area



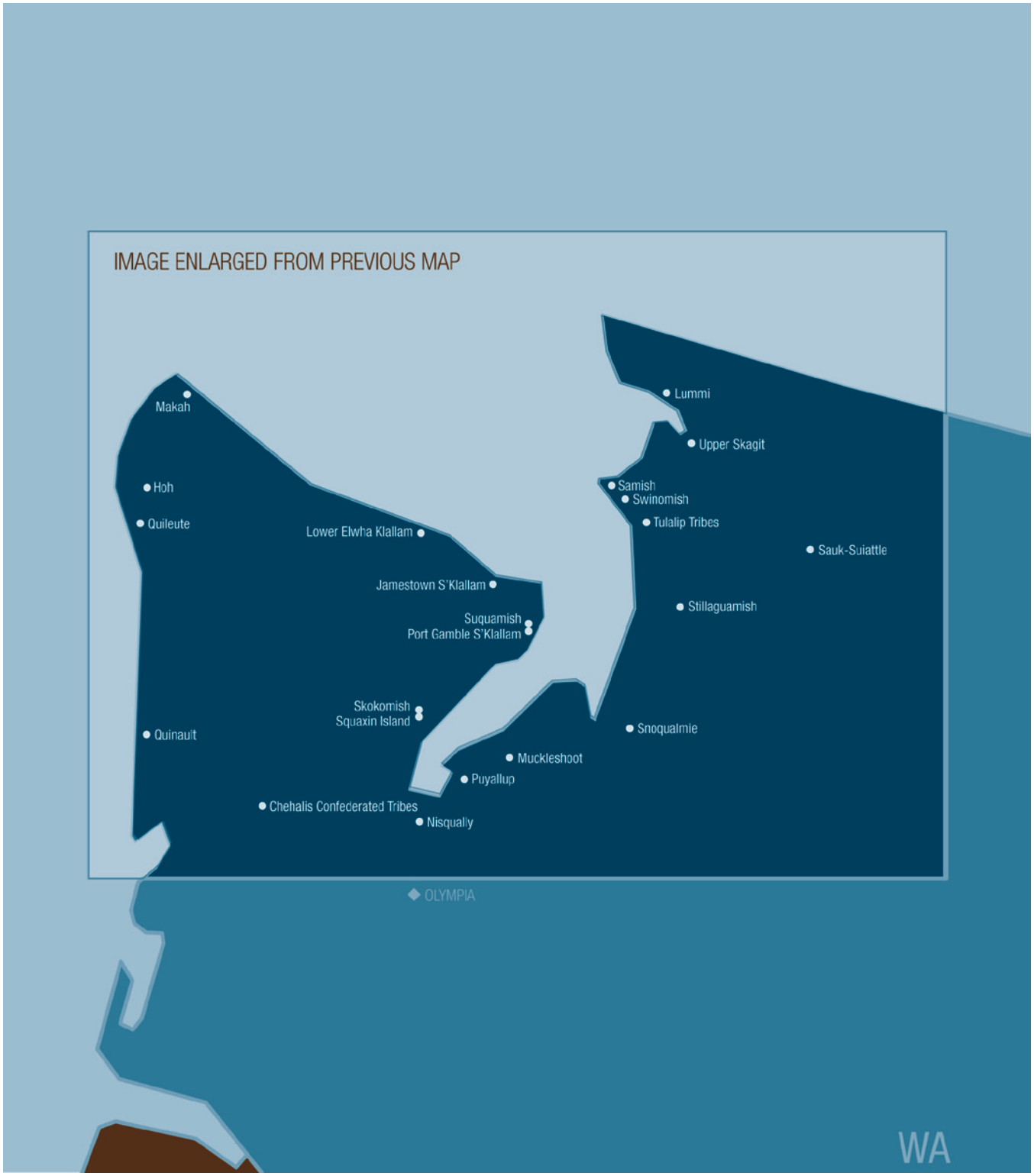
Portland Area

Funding Amounts for Portland Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Burns Paiute	$13,295	$13,295	$13,295	$26,590	$26,746	$26,746	$28,774	$28,774	$28,445	$28,456	$28,456	$28,456	$28,456	$319,784
Coeur d'Alene	$48,986	$48,986	$48,986	$165,879	$168,194	$168,194	$194,915	$194,915	$196,563	$196,761	$196,761	$196,761	$196,761	$2,022,662
Colville IHS	$95,140	$95,140	$95,140	$370,601	$376,056	$376,056	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000	$2,108,133
Colville Reservation	$0	$0	$0	$0	$0	$0	$336,646	$336,646	$335,895	$336,344	$336,344	$336,344	$336,344	$2,354,563
Confederated Tribes Coos	$17,377	$17,377	$17,377	$34,754	$35,040	$35,040	$41,389	$41,389	$39,974	$40,008	$40,008	$40,008	$40,008	$439,749
Coquille	$17,716	$17,716	$17,716	$49,394	$50,021	$50,021	$56,651	$56,651	$56,068	$56,111	$56,111	$56,111	$56,111	$596,398
Cow Creek Band of Umpqua	$20,296	$20,296	$20,296	$55,529	$56,227	$56,227	$67,963	$67,963	$69,717	$69,812	$69,812	$69,812	$69,812	$713,762
Cowlitz	$0	$0	$0	$0	$0	$0	$20,000	$20,000	$50,000	$50,000	$50,000	$50,000	$50,000	$290,000
Grand Ronde	$61,026	$61,026	$61,026	$159,898	$161,856	$161,856	$182,687	$182,687	$180,590	$180,721	$180,721	$180,721	$180,721	$1,935,536
Kalispel	$12,942	$12,942	$12,942	$25,884	$26,041	$26,041	$27,906	$27,906	$28,289	$28,305	$28,305	$28,305	$28,305	$314,113
Klamath	$36,069	$36,069	$36,069	$113,294	$114,823	$114,823	$132,413	$132,413	$134,276	$134,412	$134,412	$134,412	$134,412	$1,387,897
Kootenai of ID	$12,116	$12,116	$12,116	$24,232	$24,344	$24,344	$25,595	$25,595	$25,782	$25,792	$25,792	$25,792	$25,792	$289,408
Nimiipuu Health	$50,715	$50,715	$50,715	$176,971	$179,471	$179,471	$204,875	$204,875	$205,662	$205,845	$205,845	$205,845	$205,845	$2,126,850
Nooksack	$21,812	$21,812	$21,812	$48,703	$49,236	$49,236	$55,852	$55,852	$55,981	$56,028	$56,028	$56,028	$56,028	$604,408
Northwestern Band Shoshone	$13,231	$13,231	$13,231	$26,462	$26,496	$26,496	$27,325	$27,325	$26,848	$26,851	$26,851	$26,851	$26,851	$308,049
NW Portland Area IHB	$0	$0	$0	$195,888	$231,798	$231,798	$286,727	$286,727	$256,727	$256,727	$256,727	$256,727	$256,727	$2,516,573
Portland Area IHS	$116,154	$127,768	$82,905	$114,966	$0	$0	$0	$0	$0	$0	$0	$0	$0	$441,793
Shoalwater Bay	$14,045	$14,045	$14,045	$28,090	$28,333	$28,333	$31,315	$31,315	$31,343	$31,364	$31,364	$31,364	$31,364	$346,320
Shoshone-Bannock	$79,655	$79,655	$79,655	$286,233	$290,324	$290,324	$333,421	$333,421	$331,464	$331,752	$331,752	$331,752	$331,752	$3,431,160
Siletz Confederated Tribes	$78,490	$78,490	$78,490	$250,293	$253,695	$253,695	$287,091	$287,091	$289,761	$290,013	$290,013	$290,013	$290,013	$3,017,148
Spokane Tribe	$42,484	$42,484	$42,484	$116,295	$117,757	$117,757	$132,579	$132,579	$130,197	$130,284	$130,284	$130,284	$130,284	$1,395,752
Umatilla-Yellowhawk	$44,639	$44,639	$44,639	$143,370	$145,325	$145,325	$165,593	$165,593	$164,658	$164,793	$164,793	$164,793	$164,793	$1,722,953
Warm Springs Health Center	$64,684	$64,684	$64,684	$239,128	$242,583	$242,583	$88,145	$88,145	$88,145	$88,145	$88,145	$88,145	$88,145	$1,535,361
Warm Springs Tribe	$0	$0	$0	$0	$0	$0	$194,212	$194,212	$192,999	$193,268	$193,268	$193,268	$193,268	$1,354,495
Western Oregon IHS	$0	$0	$0	$40,000	$41,927	$41,927	$60,508	$60,508	$61,443	$61,580	$61,580	$61,580	$61,580	$552,633
Yakama	$151,717	$151,717	$151,717	$563,536	$551,692	$571,692	$659,292	$659,292	$656,432	$657,025	$657,025	$657,025	$657,025	$6,745,187
Yakama IHS	$0	$0	$0	$0	$20,000	$0	$0	$0	$0	$0	$0	$0	$0	$20,000

Portland Area continues on next page

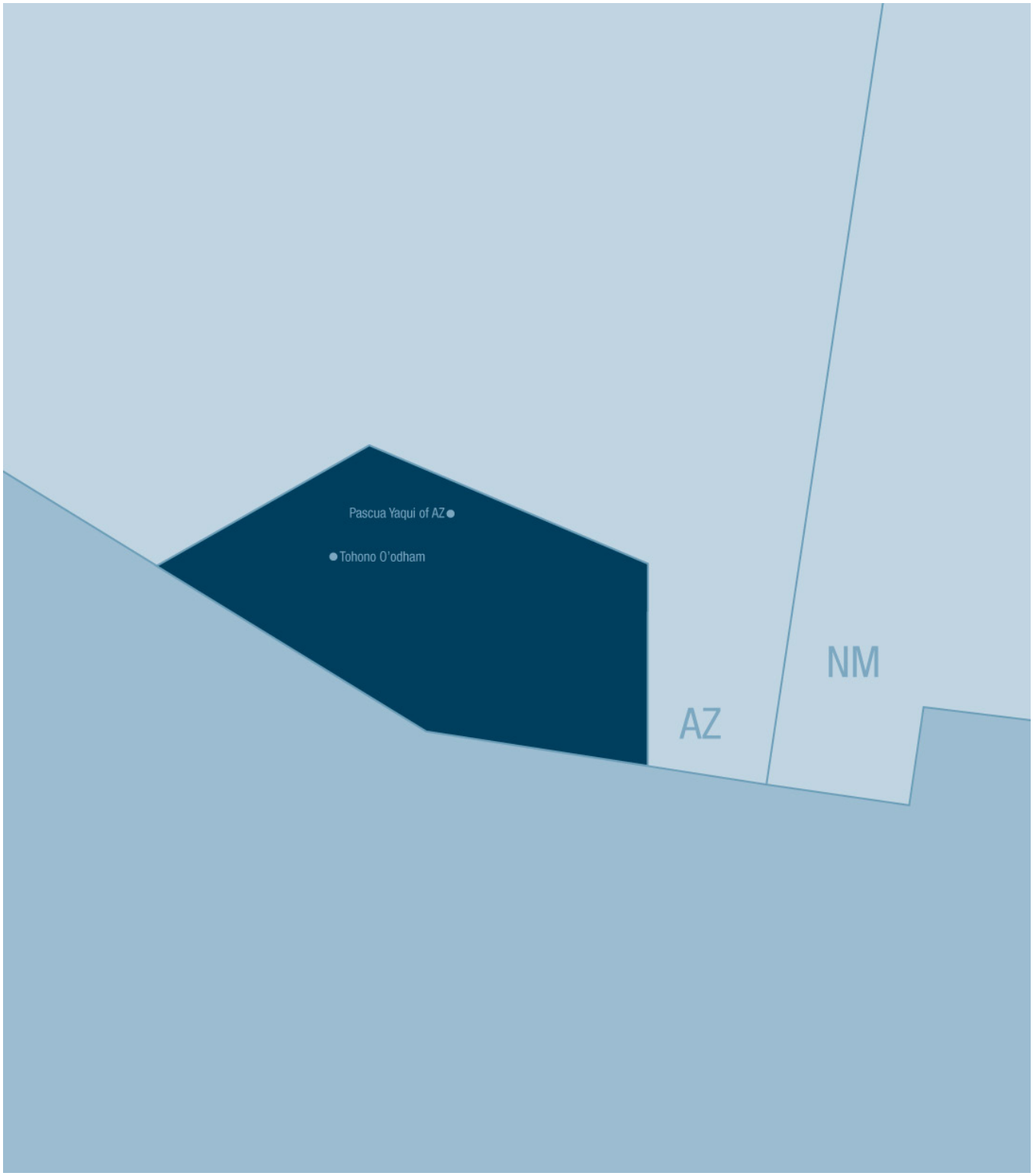
Portland Area



Funding Amounts for Portland Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Chehalis Confederated Tribes	$20,046	$20,046	$20,046	$56,687	$57,413	$57,413	$65,449	$65,449	$64,363	$64,411	$64,411	$64,411	$64,411	$684,556
Hoh	$11,614	$0	$11,164	$11,164	$0	$0	$0	$0	$0	$0	$22,806	$22,806	$0	$79,554
Jamestown S'Klallam	$14,809	$14,809	$14,809	$29,618	$29,778	$29,778	$33,071	$33,071	$32,950	$32,972	$32,972	$32,972	$32,972	$364,581
Lower Elwha Klallam	$22,589	$22,589	$22,589	$52,050	$52,633	$52,633	$58,427	$58,427	$58,321	$58,361	$58,361	$58,361	$58,361	$633,702
Lummi	$59,998	$59,998	$59,998	$222,860	$226,085	$226,085	$255,403	$255,403	$257,309	$257,527	$257,527	$257,527	$257,527	$2,653,247
Makah	$29,542	$29,542	$29,542	$95,363	$96,667	$96,667	$110,505	$110,505	$110,235	$110,330	$110,330	$110,330	$110,330	$1,149,888
Muckleshoot	$42,384	$42,384	$42,384	$146,184	$148,240	$148,240	$171,513	$171,513	$170,858	$171,016	$171,016	$171,016	$171,016	$1,767,764
Nisqually	$24,193	$24,193	$24,193	$52,809	$53,376	$53,376	$60,724	$60,724	$61,467	$61,524	$61,524	$61,524	$61,524	$661,151
Port Gamble S'Klallam	$20,960	$20,960	$20,960	$57,777	$58,506	$58,506	$67,371	$67,371	$68,007	$68,073	$68,073	$68,073	$68,073	$712,710
Puyallup	$92,509	$92,509	$92,509	$348,083	$353,145	$353,145	$411,086	$411,086	$409,812	$410,209	$410,209	$410,209	$410,209	$4,204,720
Quileute	$17,515	$17,515	$17,515	$35,572	$58,303	$35,930	$62,935	$62,935	$62,948	$62,980	$40,174	$40,174	$40,174	$554,670
Quinault	$42,108	$42,108	$42,108	$128,308	$130,015	$130,015	$147,671	$147,671	$147,917	$148,043	$148,043	$148,043	$148,043	$1,550,093
Samish	$12,304	$12,304	$12,304	$24,608	$24,706	$24,706	$27,118	$27,118	$27,398	$27,417	$27,417	$27,417	$27,417	$302,234
Sauk-Suiattle	$12,992	$12,992	$12,992	$25,984	$26,089	$26,089	$27,303	$27,303	$27,245	$27,257	$27,257	$27,257	$27,257	$308,017
Skokomish	$21,800	$21,800	$21,800	$56,928	$57,624	$57,624	$63,477	$63,477	$63,805	$63,849	$63,849	$63,849	$63,849	$683,731
Snoqualmie	$0	$0	$0	$0	$22,398	$22,398	$23,316	$23,316	$23,589	$23,597	$23,597	$23,597	$23,597	$209,405
Squaxin Island	$20,447	$20,447	$20,447	$24,639	$45,574	$45,574	$50,547	$50,547	$49,824	$49,854	$49,854	$49,854	$49,854	$527,462
Stillaguamish	$12,667	$12,667	$12,667	$25,334	$25,447	$25,447	$26,483	$26,483	$26,229	$26,235	$26,235	$26,235	$0	$272,129
Suquamish	$16,300	$16,300	$16,300	$32,600	$32,793	$32,793	$39,039	$39,039	$35,056	$36,079	$36,079	$36,079	$36,079	$404,536
Swinomish	$20,535	$20,535	$20,535	$53,269	$53,917	$53,917	$61,709	$61,709	$60,923	$60,972	$60,972	$60,972	$60,972	$650,937
Tulalip Tribes	$48,685	$48,685	$48,685	$166,106	$168,431	$168,431	$193,198	$193,198	$196,271	$196,466	$196,466	$196,466	$196,466	$2,017,554
Upper Skagit	$15,586	$15,586	$15,586	$15,586	$33,283	$33,283	$36,324	$36,324	$36,948	$36,974	$36,974	$36,974	$36,974	$386,402
Funds Pending Distribution	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$49,041	$49,041
Total for Area	**$1,592,172**	**$1,592,172**	**$1,558,473**	**$4,917,519**	**$4,972,408**	**$4,950,035**	**$5,734,543**	**$5,734,543**	**$5,728,734**	**$5,734,543**	**$5,734,543**	**$5,734,543**	**$5,734,543**	**$59,718,771**

Tucson Area



Tucson Area

Funding Amounts for Tucson Area Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Pascua Yaqui of AZ	$116,822	$137,590	$152,413	$472,305	$482,896	$480,563	$609,419	$609,419	$609,419	$609,419	$609,419	$609,419	$609,419	$6,108,522
Tohono O'odham	$652,720	$536,566	$583,880	$1,809,355	$1,849,935	$1,852,268	$1,929,827	$1,929,827	$1,929,827	$1,929,827	$1,929,827	$1,929,827	$1,929,827	$20,793,513
Total for Area	**$769,542**	**$674,156**	**$736,293**	**$2,281,660**	**$2,332,831**	**$2,332,831**	**$2,539,246**	**$2,539,246**	**$2,539,246**	**$2,539,246**	**$2,539,246**	**$2,539,246**	**$2,539,246**	**$26,902,035**

Urban Programs

Funding Amounts for Urban Grantees by Fiscal Year

Grantee Name	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
AICH - NY	$46,875	$45,454	$44,953	$93,812	$104,723	$103,103	$156,323	$143,012	$143,012	$143,012	$143,012	$143,012	$143,012	$1,453,315
AIHFS - Detroit	$46,875	$45,455	$44,953	$167,201	$135,269	$132,837	$201,393	$228,943	$228,943	$228,943	$286,179	$275,400	$228,943	$2,251,334
AIHP - Bakersfield	$46,875	$45,454	$0	$93,812	$104,723	$103,103	$156,323	$144,711	$144,711	$144,711	$144,711	$144,711	$144,711	$1,418,556
AIHSC - Santa Barbara	$46,875	$45,455	$44,953	$167,201	$165,815	$162,570	$246,482	$224,188	$224,187	$224,187	$224,187	$224,187	$224,187	$2,224,474
American IHS Chicago	$46,875	$45,455	$44,953	$167,201	$135,269	$132,837	$201,393	$226,282	$226,282	$226,282	$282,852	$272,739	$226,282	$2,234,702
Billings IHB	$46,875	$45,455	$44,953	$167,201	$165,815	$162,570	$246,482	$237,292	$237,292	$237,292	$237,292	$237,292	$237,292	$2,303,103
Billings Indian Health Board	$0	$0	$0	$31,080	$14,940	$14,957	$0	$0	$0	$0	$0	$0	$0	$60,977
Dallas Inter-Tribal	$46,875	$45,454	$44,953	$167,201	$165,815	$162,570	$246,482	$259,927	$259,927	$259,927	$259,927	$259,927	$264,635	$2,443,620
Denver Indian Health	$46,875	$45,455	$44,953	$167,201	$165,815	$162,570	$246,482	$234,077	$234,077	$234,077	$234,077	$234,077	$234,077	$2,283,813
First Nations CHS	$46,875	$45,455	$44,953	$167,201	$165,815	$162,570	$246,482	$230,375	$230,374	$230,374	$230,374	$230,374	$230,374	$2,261,596
Fresno Indian Health	$46,875	$45,454	$44,953	$0	$0	$103,103	$156,323	$185,303	$185,303	$185,303	$185,303	$185,303	$185,303	$1,508,526
Gerald L Ignace	$0	$45,454	$44,973	$167,201	$165,815	$162,570	$246,482	$231,775	$231,775	$231,775	$289,719	$278,232	$231,775	$2,327,546
Helena Great Falls IFHC	$46,875	$45,455	$0	$0	$0	$162,570	$246,482	$232,832	$232,832	$232,832	$232,832	$232,832	$232,832	$1,898,374
Helena Indian Alliance	$46,875	$45,455	$44,953	$167,201	$135,269	$162,570	$246,482	$228,671	$228,671	$228,671	$228,671	$228,671	$228,671	$2,220,831
Hunter Health Clinic	$46,875	$45,454	$44,953	$167,201	$165,815	$162,570	$246,482	$235,530	$235,530	$235,530	$235,530	$235,530	$235,530	$2,292,530
IHC/Santa Clara Valley	$46,875	$45,454	$44,953	$167,201	$165,815	$162,570	$246,482	$233,671	$233,671	$233,671	$233,671	$233,671	$233,671	$2,281,376
ITHCC - Tucson	$46,875	$45,454	$44,953	$93,812	$0	$0	$0	$0	$0	$0	$0	$0	$0	$231,094
IWC - Salt Lake City	$0	$45,454	$44,953	$93,812	$104,723	$132,837	$201,393	$238,747	$238,747	$238,747	$238,747	$238,747	$238,747	$2,055,654
Minneapolis IHB	$46,875	$45,455	$44,953	$167,201	$165,815	$162,570	$246,482	$241,307	$241,306	$241,306	$255,383	$287,762	$241,306	$2,387,721
Missoula Indian Center	$46,875	$45,455	$44,953	$93,812	$104,723	$103,103	$156,323	$140,635	$140,635	$140,635	$140,635	$140,635	$140,635	$1,439,054
N.A.T.I.V.E of Spokane	$0	$0	$44,953	$167,216	$165,830	$162,570	$246,482	$237,103	$237,103	$237,103	$237,103	$237,103	$237,103	$2,209,669
NA Center - Boston	$46,875	$45,454	$44,953	$93,812	$104,723	$103,103	$156,323	$142,066	$142,066	$142,066	$142,066	$142,066	$0	$1,305,573
NACA - Flagstaff	$46,875	$45,454	$44,953	$167,201	$165,815	$162,570	$246,482	$237,123	$237,123	$237,123	$237,123	$237,123	$237,123	$2,302,088
NACHC - Phoenix	$46,875	$45,454	$44,953	$167,201	$165,815	$162,570	$246,482	$249,389	$249,389	$249,389	$249,389	$249,389	$249,389	$2,375,684
NAHC - Sacramento	$46,875	$45,455	$44,953	$167,201	$165,815	$162,570	$246,482	$227,519	$227,519	$227,519	$227,519	$227,519	$227,519	$2,244,465
NAIA	$46,875	$45,455	$44,953	$93,812	$104,723	$103,103	$156,323	$189,111	$189,111	$189,111	$189,111	$189,111	$189,111	$1,729,910
NARA - Portland	$46,875	$45,454	$44,953	$167,201	$165,815	$162,570	$246,482	$235,815	$235,815	$235,815	$235,815	$235,815	$235,815	$2,294,240
Nebraska Urban IHC	$46,875	$45,455	$44,953	$167,201	$165,815	$162,570	$246,482	$234,519	$234,519	$234,519	$234,519	$234,519	$234,519	$2,286,465
Nevada Urban	$46,875	$45,454	$44,953	$93,812	$135,269	$132,837	$201,393	$201,351	$201,351	$201,351	$201,351	$201,351	$201,351	$1,908,699
San Diego AIHC	$46,875	$45,455	$44,953	$167,201	$165,815	$162,570	$246,482	$229,281	$229,280	$229,280	$229,280	$229,280	$229,280	$2,255,032
SD Urban Indian Health	$46,875	$45,455	$44,953	$167,201	$135,269	$132,837	$201,393	$261,313	$261,313	$261,313	$261,313	$261,313	$261,313	$2,341,861
Seattle IHB	$46,875	$45,454	$44,953	$167,201	$165,815	$162,570	$246,482	$249,583	$249,583	$249,583	$249,583	$249,583	$249,583	$2,376,848
Seattle IHB	$0	$0	$0	$125,000	$125,000	$125,000	$0	$0	$11,500	$9,000	$80,000	$100,000	$100,000	$675,500
Tucson Indian Center	$0	$0	$0	$0	$104,723	$103,103	$156,323	$140,763	$140,763	$140,763	$140,763	$140,763	$140,763	$1,208,727
UAI Involvement	$46,875	$45,455	$44,953	$93,812	$104,723	$103,103	$156,323	$195,404	$195,403	$195,403	$195,403	$195,403	$195,403	$1,767,663
UIHB Oakland	$46,875	$45,455	$44,953	$167,201	$270,538	$265,673	$246,482	$230,067	$230,067	$230,067	$230,067	$230,067	$230,067	$2,467,579
United AmerIndian Center	$46,875	$45,455	$44,953	$93,812	$104,723	$103,103	$156,323	$185,827	$185,827	$185,827	$0	$0	$0	$1,152,725
Funds Pending Distribution	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$323,185	$323,185
Total for Urban	**$1,453,125**	**$1,500,000**	**$1,438,516**	**$4,772,637**	**$4,848,200**	**$5,086,572**	**$7,343,512**	**$7,343,512**	**$7,355,007**	**$7,352,507**	**$7,423,507**	**$7,443,507**	**$7,443,507**	**$70,804,109**

Funding Amounts for Grantees by State and Fiscal Year

Funding Amounts Overall by State and Fiscal Year

State	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Alabama	$49,655	$57,977	$44,442	$145,675	$139,048	$139,048	$158,046	$158,046	$186,868	$191,253	$197,072	$186,840	$199,088	$1,853,058
Alaska	$2,816,838	$2,816,838	$2,783,589	$8,080,726	$8,234,947	$8,234,947	$8,963,599	$8,963,599	$8,963,599	$8,963,599	$8,963,599	$8,963,599	$8,927,252	$95,676,731
Arizona	$8,053,715	$7,954,066	$7,948,202	$23,745,397	$23,732,140	$23,724,030	$26,454,606	$26,432,594	$26,359,794	$26,359,794	$26,359,794	$26,359,794	$26,355,244	$279,839,170
California	$1,542,034	$1,993,533	$1,897,221	$6,173,527	$6,619,657	$6,701,675	$8,345,064	$8,307,829	$8,307,826	$8,313,826	$8,313,826	$8,313,826	$8,307,826	$83,137,670
Colorado	$193,013	$191,593	$191,091	$635,115	$615,878	$612,633	$740,617	$728,212	$728,212	$728,212	$728,212	$728,212	$728,212	$7,549,212
Connecticut	$86,295	$96,035	$81,593	$258,442	$230,542	$230,542	$289,421	$289,421	$283,935	$239,651	$249,452	$241,972	$308,315	$2,885,616
Florida	$85,185	$92,959	$95,246	$357,426	$365,036	$365,035	$460,020	$460,020	$411,650	$431,710	$432,822	$465,286	$482,822	$4,505,217
Idaho	$191,472	$191,472	$191,472	$653,315	$662,333	$662,333	$758,806	$758,806	$759,471	$760,150	$760,150	$760,150	$760,150	$7,870,080
Illinois	$46,875	$45,455	$44,953	$167,201	$135,269	$132,837	$201,393	$226,282	$226,282	$226,282	$282,852	$272,739	$226,282	$2,234,702
Iowa	$106,141	$106,141	$106,141	$245,852	$243,353	$243,353	$254,197	$254,197	$254,197	$254,197	$254,197	$254,197	$254,197	$2,830,360
Kansas	$235,264	$233,843	$230,318	$570,973	$573,081	$569,836	$706,762	$695,810	$695,810	$695,810	$695,810	$695,810	$695,810	$7,294,937
Louisiana	$75,311	$81,900	$77,482	$263,288	$242,690	$242,690	$306,691	$306,691	$307,903	$303,720	$327,398	$308,903	$311,243	$3,155,910
Maine	$148,324	$163,503	$139,137	$427,043	$326,406	$326,406	$394,075	$394,075	$429,697	$442,995	$451,557	$444,561	$437,505	$4,525,284
Massachusetts	$46,875	$45,454	$44,953	$93,812	$104,723	$103,103	$156,323	$142,066	$142,066	$142,066	$142,066	$142,066	$0	$1,305,573
Michigan	$682,475	$685,905	$685,403	$2,034,153	$1,901,989	$1,907,019	$2,127,177	$2,185,587	$2,172,877	$2,186,717	$2,232,593	$2,130,824	$2,128,707	$23,061,426
Minnesota	$986,562	$974,162	$973,660	$3,226,951	$3,115,755	$3,076,738	$3,414,978	$3,391,743	$3,401,552	$3,359,652	$3,355,989	$3,385,888	$3,229,902	$35,893,532
Mississippi	$171,700	$190,091	$203,720	$705,672	$792,502	$792,502	$1,057,598	$1,057,598	$1,209,079	$1,071,926	$1,053,236	$1,061,761	$1,014,657	$10,382,042
Missouri	$35,539	$35,539	$34,532	$51,234	$51,234	$0	$0	$0	$0	$0	$0	$0	$0	$208,078
Montana	$1,704,772	$1,697,672	$1,611,769	$4,817,884	$4,644,788	$4,828,191	$5,535,899	$5,558,060	$5,582,611	$5,512,348	$5,512,348	$5,512,348	$5,512,348	$58,031,038
Nebraska	$534,319	$532,899	$532,397	$1,479,206	$1,445,480	$1,442,235	$1,602,536	$1,590,573	$1,590,573	$1,590,573	$1,590,573	$1,590,573	$1,590,573	$17,112,510
Nevada	$762,220	$760,799	$760,298	$2,668,261	$2,696,401	$2,693,969	$3,260,762	$3,260,720	$3,260,720	$3,260,719	$3,260,719	$3,260,719	$3,260,719	$33,167,026
New Mexico	$2,144,107	$2,142,687	$2,108,929	$6,581,040	$6,345,059	$6,341,814	$7,030,445	$6,938,492	$6,938,491	$6,938,491	$6,938,491	$6,938,491	$6,938,491	$74,325,028
New York	$298,747	$313,385	$294,744	$896,156	$979,758	$978,138	$1,349,829	$1,336,518	$1,159,580	$1,154,235	$1,188,646	$1,178,974	$1,199,897	$12,328,607
North Carolina	$244,313	$266,682	$264,784	$854,694	$1,064,379	$1,064,379	$1,175,894	$1,175,894	$1,143,625	$1,285,126	$1,239,386	$1,240,713	$1,192,543	$12,212,412
North Dakota	$899,974	$899,974	$899,974	$2,474,833	$2,388,649	$2,388,649	$2,643,997	$2,643,997	$2,643,997	$2,643,997	$2,643,997	$2,643,997	$2,643,997	$28,460,032
Oklahoma	$4,528,268	$4,528,268	$4,500,057	$15,392,766	$16,104,317	$15,656,940	$17,430,130	$18,387,863	$18,387,863	$18,387,863	$18,387,863	$17,592,178	$17,592,178	$186,080,869
Oregon	$516,621	$526,814	$481,450	$1,590,305	$1,525,856	$1,522,611	$1,838,635	$1,827,968	$1,798,618	$1,799,861	$1,799,861	$1,799,861	$1,799,861	$18,828,322
Rhode Island	$26,513	$28,888	$27,986	$81,482	$86,691	$86,691	$103,452	$103,452	$114,858	$117,756	$103,984	$103,646	$96,912	$1,082,311
South Carolina	$72,971	$79,084	$27,260	$101,119	$92,999	$92,999	$112,544	$112,544	$120,669	$132,377	$137,774	$142,872	$134,905	$1,360,117
South Dakota	$1,717,290	$1,715,870	$1,682,119	$5,097,732	$4,888,921	$4,886,489	$5,379,197	$5,439,117	$5,439,117	$5,439,117	$5,439,117	$5,439,117	$5,439,117	$58,002,320
Tennessee	$201,422	$85,230	$166,596	$167,512	$84,609	$84,609	$84,609	$84,609	$84,609	$81,922	$79,915	$79,915	$79,915	$1,365,472
Texas	$143,805	$145,665	$143,152	$416,136	$413,525	$410,280	$549,500	$562,945	$589,207	$589,077	$580,642	$586,371	$588,651	$5,718,956
Utah	$214,573	$260,027	$259,526	$799,806	$807,238	$835,352	$1,335,063	$1,372,417	$1,444,740	$1,444,743	$1,444,743	$1,444,743	$1,449,293	$13,112,264
Washington	$964,598	$951,563	$1,007,179	$3,274,055	$3,380,183	$3,351,305	$3,849,223	$3,842,945	$3,877,798	$3,879,182	$3,950,182	$3,970,182	$3,921,141	$40,219,536
Wisconsin	$770,095	$820,259	$819,276	$2,726,883	$2,698,878	$2,722,323	$3,085,735	$3,087,732	$3,090,632	$3,118,692	$3,019,909	$3,101,892	$3,062,885	$32,125,191
Wyoming	$0	$239,100	$239,100	$710,734	$687,083	$687,083	$747,878	$747,878	$747,878	$747,878	$747,878	$747,878	$747,878	$7,798,246
Funds Pending Distribution	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$472,313	$472,313
Total	**$31,297,881**	**$31,951,332**	**$31,599,751**	**$97,966,406**	**$98,421,397**	**$98,138,784**	**$111,904,701**	**$112,826,300**	**$112,856,404**	**$112,795,517**	**$112,070,968**	**$112,090,898**	**$112,090,829**	**$1,176,011,168**

APPENDIX 3
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