National Indian Health Board

Special Diabetes Program for Indians (SDPI Institute)

Webinar Protocols

- Please keep your phones on mute to minimize background noise.
- Use the chat box anytime or the phone line for questions during the Q&A
- Feel free to ask questions of other people on the line as well

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Housekeeping:

- We are recording the NIHB Staff presentation portion of this session.
- NIHB will be taking notes for our internal records. Please let us know if you would prefer we do not capture your comments.
- We respectfully request that IHS employees working at the federal level) sign off at this time.

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Learning Objectives

By the end of the session, attendees will…

- … be able to explain the history of SDPI
- … understand the functions and challenges of the SDPI program
- … be able to identify potential programmatic and legislative changes to SDPI that have been proposed
- … have shared their needs and priorities related to SDPI over next 5-year cycle

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Introductions

Nina Martin
Public Health Project Manager

Sarah Price,
Public Health Project Coordinator

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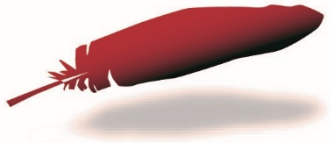

Nina Martin and Sarah Price, NIHB

SDPI OVERVIEW

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Diabetes in Indian Country

Approx. 2x higher	Likelihood of American Indian and Alaska Native adults to have diagnosed diabetes compared with non-Hispanic whites (15% vs. 7.4%; 2013-2015).

Source: Centers for Disease Control and Prevention. *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2017*. Atlanta, GA: U.S. Department of Health and Human Services; 2017. https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

Approx. 2x higher	Incidence **rate of kidney failure** due to diabetes in American Indians and Alaska Natives compared with the overall U.S. population (322 vs. 162 per million; 2015). Source: *Table A.3.1. U.S. Renal Data System, USRDS 2017 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2015.* http://www.usrds.org/adr.aspx
54%	**Decline in incidence of kidney failure from diabetes** for AI and AN, 1996-2013; faster than any other racial groups. Source: *Bullock A, Burrows NR, Narva AS, et al. Vital Signs: Decrease in Incidence of Diabetes-Related End-Stage Renal Disease among American Indians/Alaska Natives — United States, 1996–2013. MMWR Morb Mortal Wkly Rep 2017;66:26-32. DOI: http://dx.doi.org/10.15585/mmwr.mm6601e1*

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1.5+ times higher

Adults with diabetes have heart disease death rates about 1.7 times higher than adults without diabetes.

Source: Centers for Disease Control and Prevention. *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014*. Atlanta, GA: U.S. Department of Health and Human Services; 2014. http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf

The hospitalization rates for stroke are 1.5 times higher among adults with diabetes.

Source: Centers for Disease Control and Prevention. *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014*. Atlanta, GA: U.S. Department of Health and Human Services; 2014. http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf

Approx. 2x higher	People with diagnosed diabetes, on average, have medical expenditures that are approximately 2 times higher than what expenditures would be in the absence of diabetes. **Source:** Centers for Disease Control and Prevention. *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014*. Atlanta, GA: U.S. Department of Health and Human Services; 2014. http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf
41% increase	The estimated total economic cost of diagnosed diabetes in 2012 is $245 billion, a 41% increase from the previous estimate of $174 billion (in 2007 dollars). Source: *American Diabetes Association, *Economic Costs of Diabetes in the US in 2012*. Diabetes Care March 6, 2013. http://care.diabetesjournals.org/content/early/2013/03/05/dc12-2625.full.pdf+html

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SDPI Overview

- Began in 1998
- Since 2004 and through FY2015, SDPI funded 3 major components:
  - Community-Directed grant program
  - Diabetes Prevention (DP)/Healthy Heart (HH) Initiative programs
  - Set-asides
    - Urban Indian Health Programs
    - Data Infrastructure
    - CDC Native Diabetes Wellness Program (discontinued in FY2015)
- FY 2016 + Community-Directed programs only
  - Set-asides
    - Urban Indian Health Programs
    - Data Infrastructure

SDPI Interventions (FY 2016 Grants)

Component	Funding Amt	# Tribal, IHS programs	What does it fund?
Community-Directed Diabetes Grant Program	$130.2 million/yr	243	Interventions that address local community priorities using diabetes best practices
			Examples: Medical care Access to meds Self-monitoring supplies Education and medical nutrition therapy Nutrition, physical activity and weight mgmnt programs Risk-reduction programs for youth

SDPI Set Asides (FY2016)

Component	Funding Amt		#	What does it fund?
• Urban Indian Health Programs	$8.5 million		29 Urban Programs	Community –Directed Programs
• Data Infrastructure Improvement	$5.2 million	$2.6m	National	OIT: RPMS EHR, Diabetes Management System, iCare, Diabetes Audit, web conferencing platform
		$2m	12 Areas	Area identified priorities that support data programs
		$600k	DDTP	Org and analyzing diabetes audit, calculating AI/AN stats

SDPI Program Support

Component	Funding Amt		What does it fund?
Program Support	$6.1 million	IHS Division of Diabetes Treatment and Prevention	All aspects of administration of SDPI, including TLDC support, program support for ADCs, coordination of the annual Diabetes Care and Outcomes Audit, GrantSolutions, Multiple Source Contracts, Division of Grants Management.

Diabetes Best Practices

- Aspirin or Other Antiplatelet Therapy in Cardiovascular Disease
- Blood Pressure Control
- Chronic Kidney Disease Screening and Monitoring
- Dental Exam
- Depression Screening
- Diabetes-related Education
- Eye Exam – Retinopathy Screening
- Foot Exam
- Glycemic Control
- Hepatitis C Screening
- Immunizations: Hepatitis B
- Immunizations: Influenza
- Immunizations: Pneumococcal
- Immunizations: Tetanus/Diphtheria
- Lipid Management in Cardiovascular Disease
- Nutrition Education
- Physical Activity Education
- Tobacco Use Screening
- Tuberculosis Screening

SDPI WORKS!

- The prevalence of diabetes in AI/AN adults decreased from 15.4% in 2013 to 14.6% in 2017.
- The rate of end-stage renal disease (ESRD) due to diabetes in AI/AN people fell by 54% between 1999 and 2013- a greater decline than for any other racial or ethnic group. The reduction in cost for Medicare for each patient SDPI kept of hemodialysis is over $88,000.
- Since SDPI began, there has been a 50% reduction in diabetic eye disease rates among AI/AN.
- The average blood sugar level in AI/AN patients has decreased by 0.9%. Each percentage point drop in A1c levels translates to a 40% reduction in the risk of developing diabetes related complications, including blindness, kidney failure, nerve disease, and amputations.
- Obesity and diabetes rates in youth has not increased in over 10 years! Diabetes rates in adults have also not increased since 2011.

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History of SDPI

- Prior to 1997:
  - National Institutes of Health (NIH) recognizes diabetes as an epidemic in Indian Country, and with support from Congress, IHS creates the National Diabetes Program and Develops Standards of Care

History of SDPI

- 1997: SDPI is created!
  - Congress as part of the Balanced Budget Act of 1997, Public Law 105-33 SDPI funded at $30 million a year for 5 years
- 2001: SDPI extended for 3 years at $100 million per year
- 2002: Congress extends SDPI 5 years at $150 million per year, starting 2004
- 2004: SDPI funded at $150 million per year

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History of SDPI

- 2007-2020
  - SDPI is reauthorized from 1-3 years at a time. SDPI is often funded through short-term continuing resolutions to avoid funding gaps.
  - Funding is stagnant
- 2020- Most recently, SDPI was renewed for 3 years (until 2023), again at $150 million annually

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SDPI FUNDING AMOUNT AND DURATION OF FUNDING IS DECIDED BY CONGRESS, NOT IHS.

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Current and Future SDPI Grant Cycle

- FY 2016-FY 2020
  - 301 programs included in SDPI
  - IHS extended to FY 2021 as a continuation of this grant cycle
  - Only current awardees could apply for FY 2021
  - Funding distribution and formula have remained in place since FY 2016 based on consultation and TLDC recommendations.

Challenges

- Funding uncertainty
- Short term reauthorization
- Stagnant Funding
  - No new programs can apply
- 638 and data collection
- COVID-19

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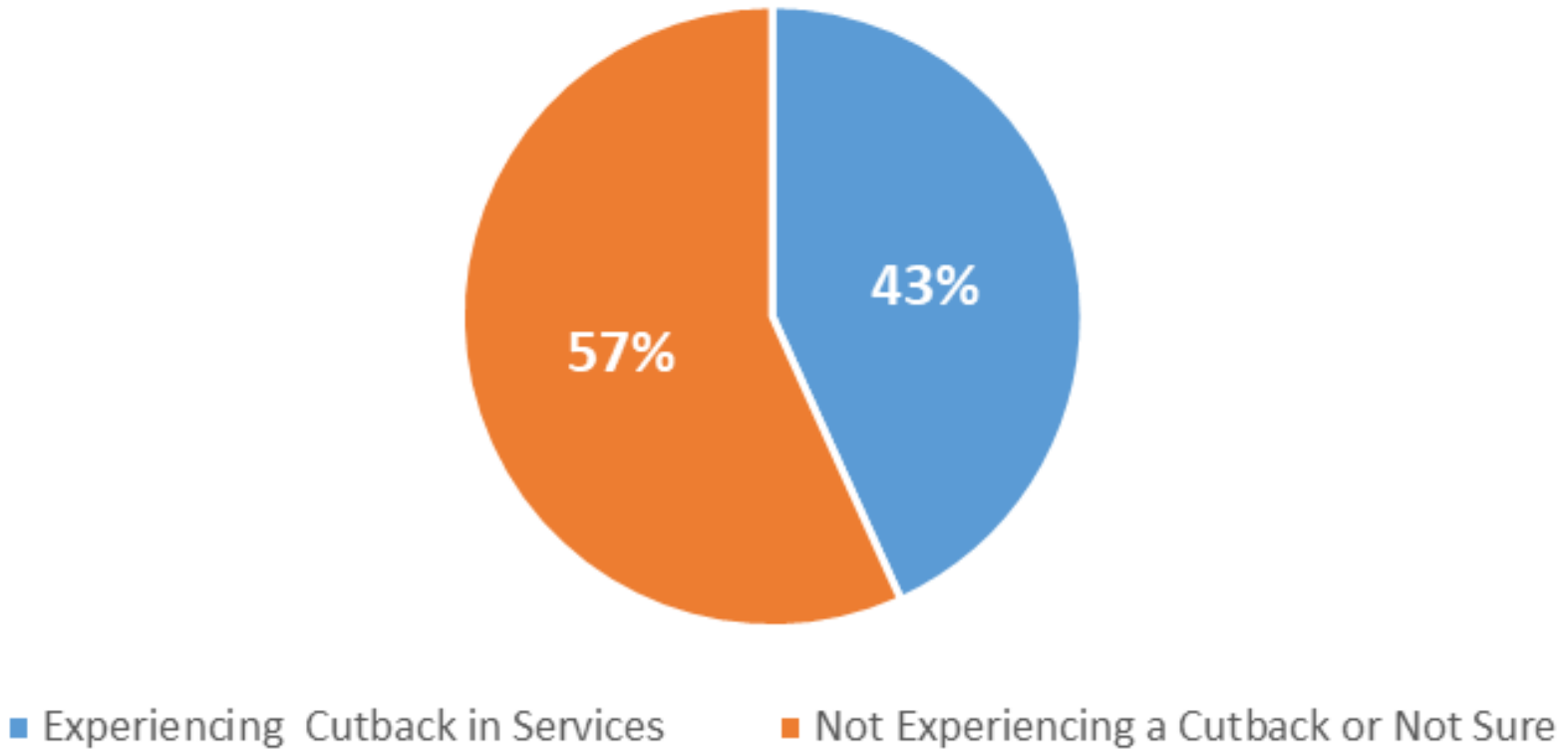
SDPI Programs Experiencing or Expecting to Experience Cutbacks in Services due to Funding Uncertainty (n=162)



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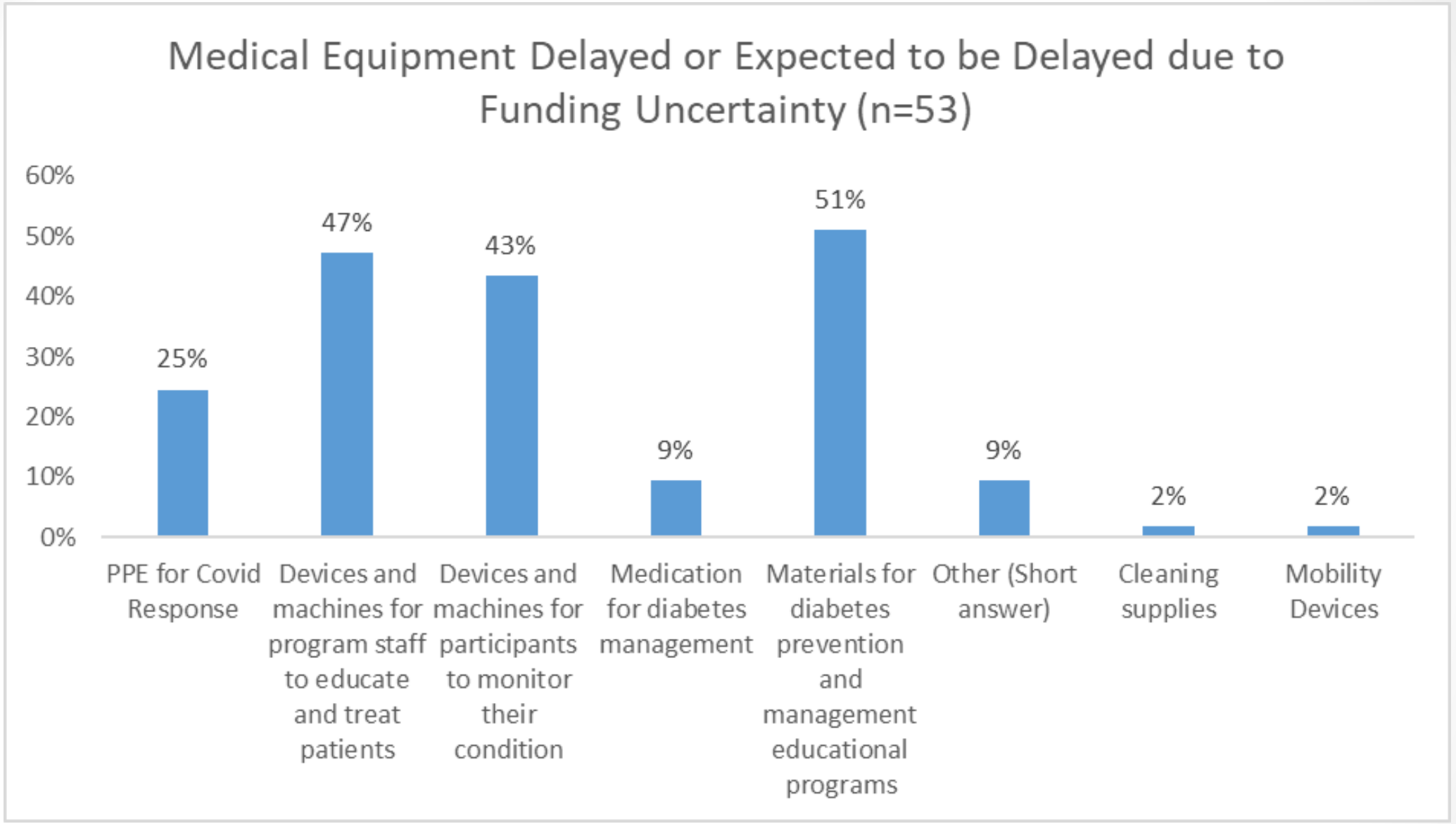

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Tribal Leaders Diabetes Committee

IHS Tribal Advisory Committees

- Direct Service Tribes Advisory Committee (DSTAC)
- **Tribal Leaders Diabetes Committee (TLDC)**
- National Tribal Advisory Committee on Behavioral Health (NTACBH)
- Tribal Self-Governance Advisory Committee (TSGAC)
- IHS Information Systems Advisory Committee (ISAC)

http://www.ihs.gov/tribalconsultation/committees/

TLDC: Background

- The TLDC was created by the Director of IHS in 1998
  - TLDC recommends to the IHS Director a process for distributing SDPI funds
  - TLDC provides IHS and Tribal leadership with an ongoing forum to discuss all matters related to diabetes and the impact of other chronic diseases on AI/AN communities

Charter: Membership

13 Voting Members

12 Tribal Representatives from the 12 IHS areas

- Selected by the respective IHS Area Director in consultation with Area Tribes:
  - One Tribal leader member, defined as an elected or duly-appointed official of a Federally Recognized Tribe from each area
  - One Tribal leader alternate from each IHS Area

1 Federal Appointee

- Appointed by the IHS Director
- Alternate appointed by the IHS Director

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QUESTIONS?