Tribal Leaders Diabetes Committee

Meeting Summary

June 20–21, 2007

Washington, DC

(Approved February 7, 2008)

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Contents

TLDC Members Present

Dr. Kelly Acton (Federal co-chair)

Carlton Albert Sr. (Albuquerque Area)

Alice Benally (Navajo Area)

Dr. Judy Goforth Parker (Oklahoma City Area)

Linda Holt (Portland Area)

Buford Rolin (Tribal co-chair; Nashville Area)

(Members not present: Aberdeen, Alaska, Bemidji, Billings, California, Phoenix, and Tucson Areas)

Others in Attendance

Sierra Abe
Stacy Bohlen
AJ Bownas
Michelle Bulls (via phone)
Lisa Bumpus
Elaine Dado
LeMyra DeBruyn
Joe Finkbonner
Karen Funk
Clayton Hanson
Adrienne Hillery
Matt Johnson
Kitty Marx
Robert Nakai
Anthia Nickerson
Charles North
C. Juliette Pittman
Madan Poudel
Geoff Roth
Phillip Roulain
Brenda Shore
Randall Simmons
Jesse Sixkiller
P. Benjamin Smith
Lorraine Valdez

Abbreviations

ADA	American Diabetes Association
AI/AN	American Indian and Alaska Native
ADC	Area Diabetes Consultant
BIA	Bureau of Indian Affairs
CAM	complementary and alternative medicine
CDC	Centers for Disease Control and Prevention
CHR	community health representative
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
CRIHB	California Rural Indian Health Board, Inc.
DDTP	Division of Diabetes Treatment and Prevention
DETS	Diabetes Education in Tribal Schools
DGO	Division of Grants Operations
DHHS	U.S. Department of Health and Human Services
DPP	Diabetes Prevention Program
FY	fiscal year
GUI	graphical user interface
IHCIA	Indian Health Care Improvement Act
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IT	information technology
JDRF	Juvenile Diabetes Research Foundation
NCUIH	National Council of Urban Indian Health
NDWC	Native Diabetes Wellness Center
NIH	National Institutes of Health
NIHB	National Indian Health Board
NPAIHB	Northwest Portland Area Indian Health Board
RFA	Request for grant application
RPMS	Resource and Patient Management System
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children's Health Insurance Program
SDPI	Special Diabetes Program for Indians
TLDC	Tribal Leaders Diabetes Committee
TTAG	Tribal Technical Advisory Group

Abbreviations (continued)

WHO .....World Health Organization

UFMS.....Unified Financial Management System

Summary of Motions

- Motion carried to approve the TLDC meeting summary from the March 2007 TLDC meeting. (Page 28)

Summary of Action Items

Action Item	Timeline	Person Responsible	Notes
TLDC members, SDPI programs, and the IHS DDTP need to submit information and supporting materials on SDPI youth activities to the NIHB and ADA by June 22, 2007. (Page 8)	June 22, 2007	TLDC, SDPI grant programs, and IHS DDTP	Complete
The IHS DDTP will review past meeting minutes to obtain information on potential content for a TLDC policies and procedures document. The IHS DDTP will also work with Linda Holt and Judy Goforth Parker to develop a draft. (Page 11)		IHS DDTP	
The Hill Group will provide the TLDC orientation binder to TLDC alternates (page 11).		The Hill Group	
The Hill Group will revise the TLDC orientation binder to include sub-tabs within major sections of the binder. (Page 27)		The Hill Group	
The Hill Group will revise the TLDC orientation binder with (page 12): – Mr. Rolin's title as Chairman of the Poarch Band of Creek Indians. – Sub-tabs within major sections of the binder. – A brief description of the contents of each tab on the Table of Contents page. – A copy of the actual SDPI legislative language.		The Hill Group	

Action Item	Timeline	Person Responsible	Notes
Michelle Bulls will send a request to the IHS DGO to provide the IHS DDTP with spreadsheets on existing SDPI balances for each Area and the urban program. The spreadsheets will include a column that indicates what budget cycle the grant program is on. The IHS DDTP will provide the reports to the TLDC. (Page 13)		Michelle Bulls, IHS DDTP, and IHS DGO	
Michelle Bulls will work with Phyllis Wolfe to provide reports on existing SDPI balances for the urban program. (Page 13)		Michelle Bulls and Phyllis Wolfe	
Michelle Bulls will work with IHS DGO to ensure that they contact the USET directly regarding grant programs that are subcontractors of the USET SDPI grant. (Page 13)		Michelle Bulls and IHS DGO	
The Hill Group will send the SDPI PowerPoint binder to TLDC alternates. (Page 14)		The Hill Group	
The Hill Group will add the following statement to the SDPI PowerPoint speaker's notes: "Scientific research shows that a one-unit decrease in A1C translates into a 40% decrease in diabetes complications." (Page 15)		The Hill Group	
The Portland and Albuquerque Area representatives recommended that the IHS DGO and Office of Grants Policy consult with the TLDC before any SDPI offsets are implemented. (Page 18)		IHS DGO, IHS Office of Grants Policy, IHS DDTP, and TLDC	
The NCUIH representative requested that the TLDC consider the urban programs as an additional IHS Area when SDPI funding recommendations are made to Dr. Grim. (Page 18)		TLDC	
The IHS DDTP will provide the TLDC with regular updates on the progress of the Chronic Care Initiative. (Page 27)	Ongoing	IHS DDTP	
Mr. Rolin and Dr. Acton will discuss travel support for the new TLDC advisors with Dr. Grim. (Page 28)		Buford Rolin and Kelly Acton	
Mr. Rolin and Dr. Acton will discuss with Dr. Grim how to notify the national organizations about making appointments to the TLDC. (Page 28)		Buford Rolin and Kelly Acton	

Action Item	Timeline	Person Responsible	Notes
The IHS DDTP will provide the TLDC with guidelines from previous SDPI Tribal consultations. (Page 28)		IHS DDTP	
Mr. Rolin will send a letter to Dr. Acton requesting her attendance at two SDPI Tribal consultation meetings between June and October 2007. (Page 28)		Buford Rolin	
The next TLDC meeting will be November 7–8, 2007, in Atlanta, Georgia. (Page 29)	Scheduled	TLDC	
The IHS DDTP will work with the NIHB to pay for TLDC travel to the Demonstration Project meeting in Denver on October 17, 2007. (Page 29)		IHS DDTP and NIHB	

Tribal Leaders Diabetes Committee Meeting

Meeting Summary

Day One: June 20, 2007

Subject	Discussion	Action
Welcome and update on the *Special Diabetes Program for Indians* reauthorization activities JDRF Children's Congress SDPI reauthorization activities in Washington, DC Adding SDPI reauthorization to the SCHIP legislation	Meeting called to order at 1:28 p.m. Mr. Rolin welcomed the TLDC members and audience, asked for introductions, and offered the prayer. Mr. Rolin and Dr. Acton reviewed the TLDC's SDPI reauthorization activities from June 18–20: – The JDRF held its Children's Congress, for which it invited 150 youth from across the U.S., including two Tribal members from the Oklahoma Area. One of the AI/AN delegates met with the TLDC. – The Senate Finance Committee held a staffers' briefing on the SDPI reauthorization on June 19. – Dr. Acton presented on the SDPI and the forthcoming *SDPI Report to Congress* at the Congressional Diabetes Caucus and Native American Caucus briefing, which was sponsored by the ADA, JDRF, and NIHB on June 19. • The *SDPI Report to Congress* is currently being reviewed by the DHHS. • Dr. Acton noted that the reaction from staffers to her presentation was positive. – Ms. Marx reported that one legislative strategy for the SDPI reauthorization is to add the SDPI to the SCHIP legislation. The NIHB and ADA requested that SDPI grant programs, TLDC, CDC NDWC, and IHS DDTP submit information and supporting materials on SDPI youth activities by June 22. This information will help strengthen the connection between the SDPI and SCHIP. – TLDC members noted that Congressman Kildee, Senator Kennedy, Senator Dorgan, and Senator Baucus were supportive of the SDPI reauthorization. – Dr. Acton and Ms. Marx noted that it is imperative that the type 1 diabetes funding and SDPI funding remain linked.	TLDC members, SDPI programs, CDC NDWC, and the IHS DDTP need to submit information and supporting materials on SDPI youth activities to the NIHB and ADA by June 22, 2007.
CDC Native Diabetes Wellness Center Vision and goals	Dr. DeBruyn provided an update on the CDC NDWC. Background on the CDC NDWC: – Vision of the NDWC: Healthy communities, healthy nations—Indian Country free of diabetes. – Goals: Working in partnership with the TLDC and IHS DDTP; addressing social justice and health disparities; respecting Native	

Subject	Discussion	Action
	and western science and art; and finding, designing and adapting, and sharing information.	
Legislative history	– Legislative history: NDWC was formed as part of the Balanced Budget Act of 1997 to establish traditionally and culturally relevant programs and products.	
Funding	– Funding: The CDC receives $2 million per year as part of its base budget to support the NDWC. The IHS DDTP funds the NDWC with an additional $1 million per year through an interagency agreement.	
Tribal consultation	– Tribal consultation: The NDWC consults with the TLDC and follows the CDC Tribal consultation policy. The NDWC also works with the CDC Tribal Consultation Advisory Committee, whose members include Sally Smith, Linda Holt, and Jerry Freddie.	
	Eagle Books:	
Eagle Books exhibit at the Smithsonian Museum of the American Indian	– The *Eagle Books* will be on display at the Smithsonian Museum of the American Indian starting in January 2008 as part of the museum's first health exhibit. The original *Eagle Books* artwork was on display at the CDC Global Odyssey Museum in 2006.	
Future plans for the *Eagle Books*	– The NDWC plans to develop two new *Eagle Books* that will target older children and may focus on issues related to diabetes, such as cardiovascular disease, depression, tobacco use, and behavioral health issues. (The first books targeted children aged 4–9.) The NDWC also plans to produce animated versions of the books.	
Eagle Books and the DETS Curriculum	– The *Eagle Books* will be a part of the Kindergarten–grade 4 curriculum for the DETS Project.	
Eagle Books CDs	– TLDC discussion: • Dr. Goforth Parker asked whether CDs of the *Eagle Books* are available. The NDWC can provide the CDs by request.	
Distribution plan	• Mr. Roth asked about the *Eagle Books* distribution process. Programs can obtain a set of books by contacting the CDC information line or the NDWC. Books can also be ordered directly from the IHS DDTP website. • Mr. Roth recommended that books be send to the 1,400 Department of Education Indian education grant programs.	
Traditions of Gratitude poster series	*Traditions of Gratitude* poster series: – The *Traditions of Gratitude* poster series features the artwork of Sam English to honor the AI/AN participants of the DPP and other diabetes studies, the work of community health workers and CHRs, and the diabetes talking circles. – The posters are currently in concept clearance with the CDC, and should be ready for distribution in the fall of 2007.	

Subject	Discussion	Action
Traditions of Gratitude poster series (continued)	– The poster titles are: • "They Changed the World!: A Tribute to the Participants of the Diabetes Prevention Program and Other Diabetes Studies" • "Standing Tall for 40 Years: Honoring Community Health Representatives, 1968–2008" • "Around the Fire: Talking Circles for Diabetes Care and Prevention"	
Diabetes Talking Circles	Diabetes Talking Circles Program: – The NDWC supports the salary of Lorelei DeCora to conduct diabetes talking circles trainings around the country. – The NDWC is working with the Seva Foundation to conduct the evaluation of the program.	
Environmental Community Indicators for Diabetes Prevention grant programs	Environmental Community Indicators for Diabetes Prevention grant programs: – The NDWC funds eight grant programs at $100,000 per year: Two urban programs, one Tribal college, and five Tribal programs. – The program is currently in its second of three years. – The grant programs focus on creating an "environment built for change" by changing community indicators in four areas: • Nutrition and diet: Revising school, after-school, and restaurant menus; changing vending machine options; and changing program policies. • Lifestyle and exercise: Creating walking paths and holding special events like walks, powwows, and dances. • Both nutrition and lifestyle: Developing community gardens. • Communication and collaboration: Developing educational media messages through newsletters, newspapers, and TV and radio shows. – The grant programs evaluate the community indicators (e.g., Do more people use the walking trails and how often?). – The NDWC is working with a contractor to evaluate the program. – The NDWC plans to release a second RFA in 2008 to fund five new grant programs.	
Update on the *Special Diabetes Program for Indians*	Ms. Valdez provided an update on the SDPI annual continuation applications: – This is the last round of continuation applications for the current five-year term of the SDPI. – The Demonstration Projects have completed all of their continuation applications. All of the Demonstration Projects	

Subject	Discussion	Action
Annual continuation applications	received "acceptable" on their continuation applications. – Ms. Valdez noted that the success of the Demonstration Projects was due, in part, to the involvement of the Project Officers. – The Community-Directed Diabetes Programs follow four different continuation application and budget cycles. The first cycle starts October 1. Grant programs must submit their application three months before their cycle start date. The application is now available on grants.gov. – If the SDPI is reauthorized, the Community-Directed Diabetes Programs will follow only one continuation application and budget cycle.	
TLDC orientation binder	Ms. Valdez distributed a draft of the TLDC orientation binder to the members for their review and input. – The binder includes: • Contact information for the TLDC and ADCs. • Travel reimbursement policies and procedures. • Background information on the TLDC, IHS DDTP, and AI/AN statistics. • Copies of letters from Congress providing guidance and direction on the SDPI. • Information on how to order materials from the IHS DDTP website. • A copy of the TLDC charter. • A placeholder for TLDC policies and procedures, which may be developed in the future. The IHS DDTP will review past meeting minutes to obtain information on potential content for the policies and procedures. Dr. Acton suggested that Linda Holt and Judy Goforth Parker, who volunteered to assist with the TLDC orientation binder, may be able to assist in developing a draft of the policies and procedures. • A copy of the meeting summary from the September 2006 TLDC meeting. • Fact sheets on the SDPI. • A copy of the SDPI PowerPoint presentation. • A copy of the October 2006 issue of the quarterly newsletter "SDPI e-Update: Sharing Our Success". • A copy of the Demonstration Projects newsletter. • Information on other TLDC initiatives, including the Chronic Care Initiative, DETS Program, and *Eagle Books*. • A copy of the TLDC self-evaluation. – The Hill Group will provide the TLDC orientation binder to TLDC alternates.	The IHS DDTP will review past meeting minutes to obtain information on potential content for a TLDC policies and procedures document. The IHS DDTP will also work with Linda Holt and Judy Goforth Parker to develop a draft. The Hill Group will provide the TLDC orientation binder to TLDC alternates.

Subject	Discussion	Action
TLDC orientation binder (continued) IHS DDTP and SDPI fact sheets	– The TLDC members noted several changes that the Hill Group will make to the binder: • Change Buford Rolin's title to Chairman of the Poarch Band of Creek Indians. • Add sub-tabs within each section of the binder. • Add a brief description of the contents of each tab on the Table of Contents page. • Include a copy of the actual SDPI legislative language. Ms. Valdez and Dr. Acton distributed the IHS DDTP and SDPI fact sheets folders to the members: – The fact sheets are available through the IHS DDTP website. The IHS DDTP can provide hard copies of the fact sheets if TLDC members need them for meetings, presentations, and conferences. – The TLDC reviewed the draft Oklahoma state fact sheet, which provides information on the SDPI programs in Oklahoma, including funding information, outcome data, and program highlights. – The IHS DDTP will produce state fact sheets for the other states, including the states represented on the Senate Finance Committee.	The Hill Group will revise the TLDC orientation binder with: – Mr. Rolin's title as Chairman of the Poarch Band of Creek Indians. – Sub-tabs within major sections of the binder. – A brief description of the contents of each tab on the Table of Contents page. – A copy of the actual SDPI legislative language.
Update from the IHS Division of Grants Operations New director of IHS DGO SPDI carryover and offsets	Ms. Bulls joined the meeting by conference call. Ms. Bulls informed the TLDC that the new director of the IHS DGO is Kimberly Pendleton, who will begin June 24. Ms. Pendleton has experience in working with AI/AN programs through her previous work with SAMHSA and NIH. Ms. Bulls updated the TLDC on the status of SDPI carryover and the potential for offsetting funds from grant programs with large unboligated balances to grant programs that need additional funds: – Not many SDPI grant programs have large unobligated balances (i.e., carryover; the authorized amount on the notice of grant award minus the amount that the grant program has expended from the authorized amount). – Ms. Bulls felt that offsetting grant programs with large balances and providing those funds to grant programs that need assistance would: • Benefit the overall SDPI. • Help ensure that the SDPI does not appear to have excess funds. • Demonstrate good financial stewardship over Federal funds. • Follow Federal grants requirements.	

Subject	Discussion	Action
Personnel costs and offsets	– Ms. Bulls noted the IHS Office of Grants Policy and IHS DGO will work to ensure that funds for personnel costs are not included in any offsets.	
Keeping grant funds within IHS Areas	– Mr. Albert asked if the offset funds could be kept within the IHS Area where they were originally awarded. Ms. Bulls stated that this is a reasonable and, most likely, doable request. Dr. Acton noted that this is Dr. Grim's hope as well.	
Timelines and procedures	– The TLDC and Ms. Bulls discussed the timeframe and procedures for potentially offsetting grant funds: • Ms. Bulls stated that offsets may occur in the next fiscal year. The IHS Office of Grants Policy would need to work with both the IHS DDTP and IHS DGO to develop a timeline. • Ms. Benally asked if the IHS will discuss the possibility of offsets with grant programs that would be affected. Ms. Bulls stated that the IHS would notify the grant programs of the plan to offset funds, but would need to work internally and with the TLDC to determine a communications process.	Michelle Bulls will send a request to the IHS DGO to provide the IHS DDTP with spreadsheets on existing SDPI balances for each Area and the urban program. The spreadsheets will include a column that indicates what budget cycle the grant program is on. The IHS DDTP will provide the reports to the TLDC.
Reports on existing SDPI balances for each Area	– Ms. Benally requested a list of the grant programs with large unobligated balances. • Ms. Bulls will send a request to the IHS DGO to provide the IHS DDTP with spreadsheets on existing SDPI balances for each Area. • The spreadsheets will include a column that indicates what budget cycle the grant program is on. • The IHS DDTP will provide the reports to the TLDC.	
Carryover and offsets for the urban programs	– Mr. Roth asked if the unobligated balances for urban programs are calculated on an Area basis or calculated for the urban program as a whole. • Ms. Bulls responded that the urban program is treated as a whole. • Mr. Roth requested a spreadsheet on existing SDPI balances for the urban program. Ms. Bulls stated that she will work with Phyllis Wolfe to provide the report.	Michelle Bulls will work with Phyllis Wolfe to provide reports on existing SDPI balances for the urban program.
Nashville Area concerns	– Mr. Rolin and Ms. Shore raised several concerns on behalf of the Nashville Area: • Mr. Rolin asked Ms. Bulls if the IHS Office of Grants Policy or IHS DGO has discussed the possibility of the seven new Tribes joining the Nashville Area. Ms. Bulls responded that she will need to discuss this possibility with the OGC or DRA. • Ms. Shore requested that the IHS DGO contact the USET directly regarding grant programs that are subcontractors of the USET SDPI grant.	Michelle Bulls will work with IHS DGO to ensure that they contact the USET directly regarding grant programs that are subcontractors of the USET SDPI grant.

Subject	Discussion	Action
	• Ms. Shore requested that the USET be able to continue their master grant for the Nashville Area if the SDPI is reauthorized.	
***Special Diabetes Program for Indians* PowerPoint slides** Binder contents	Dr. Acton distributed the binder titled, "*Special Diabetes Program for Indians* PowerPoint Presentation". – The IHS DDTP and Hill Group created the binder in response to a TLDC request for SDPI PowerPoint slides members could use. – The binder provides slides for a one-hour presentation. However, TLDC members may use as many or few of the slides as they need. – The binder includes a letter from Dr. Acton explaining the contents, PowerPoint instructions, the PowerPoint presentation on a CD, a printout of the speaker's notes for each slide, and a color printout of the presentation and speaker notes. – The speaker's notes include statements that are bolded. The IHS DDTP feels that these statements are particularly important to stress during a presentation. – The presentation uses the SDPI identity plan (i.e., SDPI colors, logo, and fonts). – Dr. Acton recommended that the TLDC members save a master version of the PowerPoint presentation to their computer and "save as" a new PowerPoint file anytime they make changes to the master version. – Dr. Acton noted that SPDI funds can never be used for construction. – Ms. Shore requested that the Hill Group provide the SPDI PowerPoint binder to the TLDC alternates.	The Hill Group will send the SDPI PowerPoint binder to TLDC alternates.
Overview of the SDPI PowerPoint presentation	Dr. Acton reviewed the presentation with the TLDC: – Introductory slides: Include space for the TLDC member's name and organization. – Photographs: Give the audience a sense of the wide diversity and geography of the SPDI. – Background on the diabetes epidemic: Data on diabetes prevalence, prevalence maps, comparisons with the general U.S. population and other racial and ethnic groups, statistics on diabetes and youth, and statistics on diabetes mortality. – Information on the NIH DPP study. – Background on the SDPI: *Report to Congress*, legislative history, Congressional direction, and key elements of the SPDI (e.g., community-based grant programs). – Key players: TLDC, ADCs, and IHS DDTP. – Strategies used by the SDPI grant programs: Supported by the	

Subject	Discussion	Action
Overview of the SDPI PowerPoint presentation (continued)	diabetes literature, cost-effective, and cost-savings. – Results from the SDPI: Improvements in caring for people with diabetes, blood sugar control, and preventing or delaying kidney disease. The Hill Group will add the following statement to the SDPI PowerPoint speaker's notes: "Scientific research shows that a one-unit decrease in A1C translates into a 40% decrease in diabetes complications." – Special topics in diabetes: Nutrition, diabetes education, physical activity, children and youth, and weight management. Dr. Acton noted that one of the most important slides shows the increase in prevention activities for children and youth. – Lessons learned: Local priorities and ownership and sharing information among grant programs. – Importance of the basics of good diabetes care: Foot care, eye care, getting people to walk, and getting people to test their blood sugar. – Partnerships.	The Hill Group will add the following statement to the SDPI PowerPoint speaker's notes: "Scientific research shows that a one-unit decrease in A1C translates into a 40% decrease in diabetes complications."

Tribal Leaders Diabetes Committee Meeting

Meeting Summary

Day Two: June 21, 2007

Subject	Discussion	Action
Update from the National Indian Health Board NIHB Annual Consumer Conference Nike Air Native wellness shoe NIHB public health department Job openings at the NIHB New address Quarterly newsletter Tribal shares and financial support	Meeting called to order at 9:06 a.m. Ms. Bohlen provided an update on the NIHB Annual Consumer Conference: – The conference will be held September 24–28 in Portland, Oregon. – NPAIHB is co-hosting the conference, and the IHS DDTP has provided financial support for the conference. – The conference theme is "Hope, Healing Our People Everywhere" with a focus on mental health, substance abuse, addiction, recovery, and HIV and drug use. – The second day of the conference will focus on fitness, disease prevention, and health promotion with an emphasis on diabetes. As part of the day's activities, Nike will unveil its Air Native wellness shoe for AI/AN. Notah Begay and Vanessa Shortbull will speak at the product launch. – Ms. Bohlen called for nominations for the NIHB national, local, and community impact awards. Ms. Bohlen updated the TLDC on changes within the NIHB: – New NIHB public health department: • Staff include Director Lawrence Shorty and Deputy Director Lisa Neel. • The department will work closely with the CDC, IHS, EpiCenters, and private foundations and businesses. – Job openings at the NIHB: • CMS Legislative and Policy Associate: This is a new position for a person who will work closely with Kitty Marx on CMS issues. • Legislative Assistant: This person will work on policy analysis and assist the TLDC and TTAG. – The NIHB will relocate to its new location at 926 Pennsylvania Avenue SE by the end of 2007. – The NIHB will distribute a new quarterly newsletter in July. – Because the NIHB does not charge membership fees, it is sending letters to Tribes to encourage them to leave their shares with the NIHB. Other than Tribal shares, the Annual Consumer Conference is the only other major source of financial support for the NIHB.	

Subject	Discussion	Action
Update on the IHCIA Update on the SCHIP	Ms. Bohlen provided an update on the IHCIA and SCHIP: – IHCIA: • The IHCIA has made it through most of the major committees. • The NIHB is waiting for the mark-up from the Senate Finance Committee, which has moved the mark-up back four times because it is focusing on the SCHIP. • The House Committee on Energy and Commerce has held a hearing on the IHCIA, but has not marked-up the bill. – SCHIP: • Ms. Bohlen reported that the SCHIP legislation must move this year and is beneficial to AI/AN. • The NIHB has been working closely with the Kellogg Foundation and the National Child School-Based Healthcare Association to craft an SCHIP bill that creates a path for Medicaid to pay for school-based health care services for AI/AN children. This will alleviate some of the burden on the IHS budget. • Dr. Acton reported that Senator Baucus's staff is considering adding the SDPI reauthorization onto SCHIP.	
***Special Diabetes Program for Indians* carryover and offsets** Availability of funds until expended Keeping grant funds within the Areas Federal grants regulations	Dr. Acton asked the TLDC to discuss their thoughts on the Day One discussion with Michelle Bulls on potential offsets for SDPI Community-Directed Diabetes Programs with large carryover amounts: – Ms. Holt asked how the grant funds could be offset if the legislative language required that the funds be available to the program until expended. Dr. Acton clarified that the funds are to be available to the overall SDPI—not individual grant programs—until expended. – Ms. Holt voiced her support for keeping the offset funds within the IHS Area where they were originally awarded. • She recommended that the Area health boards help the grant programs with large carryover expend the funds before the funds are offset. • She also noted that the NPAIHB and CRIHB will hold a joint meeting in July and will put this issue on the agenda. • Mr. Albert recommended that the successful grant programs in each Area provide assistance to the grant programs that are struggling and may need help using their SDPI funds. – Mr. Albert voiced concern that the Tribes may blame the decision to offset grant funds on the TLDC. Dr. Acton noted that the decision will not be made by the TLDC; the decision on offsetting grant funds will be based on Federal grants regulations.	

Subject	Discussion	Action
The need for cultural sensitivity and flexibility	– Ms. Holt asked if the IHS DGO would exercise cultural sensitivity and flexibility when authorizing grant programs to use funds on cultural activities (e.g., youth canoe project). Dr. Acton replied that educating the IHS DGO on cultural sensitivity is an ongoing effort and that she and Ms. Valdez will meet with the new IHS DGO Director to discuss this issue.	
Cooperative agreements and report language	– Dr. Acton noted that the IHS DDTP, TLDC, and Ms. Bulls are strongly in favor of using cooperative agreements—rather than grants—if the SDPI is reauthorized. • Ms. Bohlen suggested that instructions on using cooperative agreements be written into the report language. • Ms. Holt recommended that moving to a cooperative agreement mechanism should be integrated into the SDPI reauthorization effort. • Dr. Acton noted that the TLDC will need to make recommendations to Dr. Grim on preferred methods of distributing SDPI funds.	
Timelines	– Mr. Albert asked about the timeline for possibly implementing offsets. Ms. Holt strongly recommended—and Mr. Albert agreed—that the IHS DGO and Office of Grants Policy consult with the TLDC before any offsets are implemented.	The Portland and Albuquerque Area representatives recommended that the IHS DGO and Office of Grants Policy consult with the TLDC before any SDPI offsets are implemented.
Concerns with the UFMS and competitive grants	– Mr. Smith noted several issues with the new UFMS: • The UFMS locks grant programs' accounts if funds are not withdrawn, barring access to any grant funds. • The UFMS classifies grants and cooperative agreements as "continuous competitive grants". • Mr. Smith recommended informing Dr. Grim that the TLDC needs information from the IHS DGO on why the grants and cooperative agreements are being considered "continuous competitive grants" in the UFMS because the IHS should avoid having the SDPI funds classified as "competitive". • Ms. Shore voiced concern about introducing competitiveness into the Community-Directed Diabetes Programs, noting that competition among Tribes for diabetes funds within and between Areas would be a negative outcome. She also noted that the USET has mechanisms in place to address large carryover balances among its grant programs. • Ms. Holt noted that the competitive process tends to harm small Tribes and self-governance Tribes.	
Considering the urban programs as an additional IHS Area	– Mr. Roth asked the TLDC to consider the urban programs as an additional IHS Area when SDPI funding recommendations are made to Dr. Grim.	The NCUIH representative requested that the TLDC consider the urban programs as an additional IHS Area when SDPI funding recommendations are made to Dr. Grim.

Subject	Discussion	Action
Traditional medicine and diabetes Background Studies on the use of traditional medicine in AI/AN clinics	**[Refer to the PowerPoint slideshow presentation at the end of this summary.]** At the TLDC's request, Dr. Acton gave a presentation titled, "Alternative and Complementary Approaches to Diabetes: What Is the Evidence for the Native American Population?": – Background: • Traditional Indian medicine practices date to precolonial times. • One aspect of the assimilation policies of the late 1800s involved banning Tribal spiritual and health care practices. • Attitudes toward traditional Indian medicine have changed, as evidenced by coverage in mainstream books and media. • Studies on the use of "complementary and alternative medicine" (CAM) among the U.S. and Canadian general population usually do not include AI/AN. • Because of the high use and the continuity of Indian medicine practices from precolonial times, Novins *et al*. prefer the WHO's designation of "traditional medicine" rather than CAM. The WHO says that: "Traditional medicine refers to health practices, approaches, knowledge, and beliefs incorporating plant, animal, and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose, and prevent illnesses or maintain well-being." – Studies on the use of traditional medicine in AI/AN clinics: • Interviews with 150 adults from 30 different Tribes in an urban clinic in Milwaukee: – 38% reported using a healer in addition to a physician. – More females than males saw healers. – More of the older population saw healers than the younger population. – For those that did not see a healer, 86% reported that they would consider it in the future. – Healers most frequently used were spiritual healers, herbalists, and medicine men. – The most common treatments were sweat lodge ceremonies, herbal remedies, and spiritual healing. • Cross-sectional interviews of 300 adults on the Navajo reservation in New Mexico: – 62% of patients used a traditional healer at least	

Subject	Discussion	Action
Studies on the use of traditional medicine in AI/AN clinics (continued)	once in their life, and 39% had used a healer in the past year. – 23% of patients saw a medical provider for diabetes care, and over half of these patients also used a traditional healer. – The users of traditional healers equaled the non-users in age, education completed, income, fluency in English, number of clinic visits and hospitalizations, and self-reported compliance with medical provider instructions. – The only difference between users and non-users of traditional medicine was in religion. The people who reported being Pentecostal used traditional medicine less than all other faiths. – Barriers to using a traditional healer included cost and lack of availability of enough healers. • Study of 869 patients at an urban Indian clinic in Seattle: – 70% of patients reported using a traditional healer for health reasons within the past year. – More males than females sought a traditional healer. – Greater use of traditional healing practices was associated with more than high school education, having visited friends or relatives on a reservation, and following a "Native way of life". – Over half the patients reported that the use of traditional healing practices resulted in a significant improvement in their health. Pain of indeterminate origin, such as back pain or arthritis, was the only condition that distinguished users from non-users of traditional medicine. – There was no difference between users and non-users of traditional medicine for diabetes care.	
Studies on the use of traditional healers in community settings	– Studies on the use of traditional healers in community settings: • Novins, *et al*., point out that not everyone receives care at a medical clinic, and it is therefore important to conduct community-based studies. • Study in two AI/AN communities: one in the Southwest and one in the Northern Plains. – 2,595 randomly-selected patients between the ages of 15 and 57, living on or near a reservation. – In the Southwest, over 50% used only biomedical services for physical services, nearly 25% used only traditional healers for physical problems, and 25% used combined services. – In the Northern Plains, 85% used only biomedical	

Subject	Discussion	Action
Studies on the use of traditional healers in community settings (continued)	services for physical problems, 4% used only traditional healing, and 11% used combined services for physical problems. – People who identified more with American Indian culture reported higher uses of traditional medicine. – This study pointed out two important things. First, community-based studies are important because 25% of the population would have been left out of the clinic-based studies because they do not receive care in the clinic. Second, studies need to include multiple Tribes; you cannot do a study in one Tribe and make assumptions that the results apply to the AI/AN population.	
Characteristics and value of traditional medicine	– Characteristics and value of traditional medicine: • True traditional medicine is a profound system that is far more deeply rooted and complex than is generally understood. • Pre-eminent among characteristics of Indian medicine is the degree to which it includes religion and a realm of spirits that are capable of doing either good or harm. • A traditional healer possesses special power to communicate with spirits, heal the sick, and foretell future events. The power is transcendentally obtained through a trancelike state or through dreams. The power of the medicine man or healer is not considered a personal attribute; rather it is a higher power that is invoked by the practitioner. • Despite access to biomedical care on reservations, traditional Indian healing will remain of value to Tribes for several reasons: – Traditional medicine is a holistic approach; to many American Indians, an illness may not be cured, even if the symptoms go away, by biomedical medicine. – Traditional medicine concerns itself with the cultural beliefs about the disease etiology, the folklore, the taboos, and the religion of the Tribe. – The traditional healer may be the best person to deal with psychological and social aspects of the illness. – Traditional medicine provides useful social functions. Its effectiveness is seen in the eyes of the patient, family, and community. The belief in the system offers patients hope that the illness may be healed or cured. – Traditional medical systems are valuable to people as a part of their culture and religion, and they persist because they complement modern medicine,	

Subject	Discussion	Action
Characteristics and value of traditional medicine (continued)	not replace it or compete with it. • One researcher pointed out, "Scientific medicine has failed to acknowledge that psychological and bodily processes can profoundly affect each other…. All illnesses have implications that may give rise to noxious emotions, raise moral dilemmas, damage the patient's self esteem, and estrange him from others…. The insensitivity of scientific medicine to the effects of these issues…impels the sick to seek out forms of healing which operate on a different premise."	
Types of traditional healing practices	– Types of traditional healing practices that vary widely among Tribes: • The sun dance ceremony is where a medicine man sponsors the event in each community, and it requires an intensely individual spiritual appeasement in the rituals of prayers, discipline, vision quest, and communication with the Creator. • The sweat lodge usually occurs before and after another major ritual or it may stand alone. • A wide variety of plant and herbal remedies used by many Tribes, and most of them are not described in written format. • Other ceremonies, blessings, and rituals that are unique to each Tribe.	
Diabetes-related use of traditional medicine	– Diabetes-related use of traditional medicine: • Dr. Melvina McCabe conducted a study with 203 Navajo patients and compared herbal therapies and diabetes: – 30% of patients used traditional herbs. – Sage and cedar/juniper were the most common herbs used. – The use of herbs was not associated with any adverse interaction with diabetes control. – Herb use was not significantly associated with age, sex, duration of diabetes, or insulin use. – Herb use was associated with how long it took to get to clinic. If you lived more than 60 minutes away, you were much more likely to use herbs (44% of them reported they used herbs) versus if you lived less than 30 minutes away from a clinic (only 22% reported that they used herbs). – There was no difference in A1C between the herb users and the non-herb users. • The Pascua Yaqui Tribe of Arizona developed an alternative medicine clinic that has been in place for 10 years and includes a traditional healer, naturopath,	

Subject	Discussion	Action
Diabetes-related use of traditional medicine (continued)	acupuncturist, chiropractor, and community health nurse. The clinic is conducting a study of 34 patients with diabetes and 432 control patients (for comparison). – The clinic is looking at the patients' treatments—including botanicals, vitamins, supplements, homeopathic remedies, chiropractic adjustments, and acupuncture—and A1C levels. – The clinic has not analyzed the A1C levels yet, but has found that people who use CAM therapies report that their sense of well-being and health care is as good as the people who are using biomedical medicine only. • A Southwest Tribe is studying attitudes and beliefs regarding biomedicine and traditional healing for diabetes: – The study compares A1C levels in patients receiving care from the medicine man versus biomedical care. – 53% of the people used only biomedicine, and 47% used a traditional healer as well as biomedicine. – The users of traditional medicine were older, self-identified as "living a traditional lifestyle", completed fewer years of school, were more likely to use insulin, and were more likely to report that they were compliant with what their medical doctor had told them to do with diabetes. – Of the users of traditional medicine, 66% said they did so for diabetes, and 98% said it made them feel better. – The barriers to traditional medicine use were cost, trouble locating a healer, and the belief that diabetes is incurable. • An evaluation of Lorelei DeCora's Diabetes Wellness: American Indian Talking Circles Project: – Pre- and post-tests found that talking circles increased people's knowledge about diabetes. – Talking circles also offer group support and a forum for community action regarding diabetes.	
Diet and diabetes	– Diet and diabetes: • Many Tribes believe that a "modern" diet leads to adverse health effects, and that a return to a traditional diet might prevent diabetes and reverse the adverse metabolic consequences of modernization. • Short-term studies in both Australian Aborigines and Pima Indians have shown that a return to a traditional diet is associated with improvements in metabolic abnormalities, including glucose tolerance, cholesterol levels, triglyceride	

Subject	Discussion	Action
Diet and diabetes (continued)	levels, and insulin levels. • Studies in the Pima Indians showed that obesity and type 2 diabetes were less prevalent among people of Pima heritage living a "traditional" lifestyle in the mountains of Mexico than among Pima living in a more modernized, "affluent" environment in Arizona. • Long-term studies in the Pima Indians have shown that people eat mostly an Anglo diet are 2.5 times more likely to develop diabetes during a six-year period. People who have a mixed traditional and Anglo diet are 1.3 times more likely to get diabetes than the people who ate a traditional diet.	
Examples of traditional health and medicine programs	– Examples of traditional health and medicine programs: • Tohono O'odham Tribe's Native Seeds Project: Establishes community and individual gardens; teaches people about growing, preparing, and using traditional foods; and promotes physical activity through participation in cultural activities. • Eastern Band of Cherokee's Cherokee Choices Program: Offers stress management courses and uses an intergenerational grief and healing approach. • Pima Pride Study: Compared structured diet and exercise programs (called the "Pima Action" group) with a group called "Pima Pride" that met to talk about their cultural heritage and cultural issues that they could take pride in. At the end of 12 months, both groups had increased their physical activity, but the Pima Action had actually gained more than the Pima Pride group, and the Pima Pride group had decreased their starch intake and decreased their waist circumference.	
Differing Tribal views and explanations about diabetes	– Differing Tribal views and explanations about diabetes: • This is important because understandings and beliefs about the origins of diabetes will affect how and why one seeks treatment. • Navajo: Diabetes comes from being out of balance and may be brought by outside influences. • Iroquois-speaking Seneca: Diabetes is an attack on Indians with a source that is conscious, malevolent, and calculatedly aggressive. • Ojibway in Canada: Diabetes is a white man's sickness due to the disruption of the Tribal way of life and contamination of the environment and food supply by whites. • Northern Ute: Diabetes as an entity that takes possession of the person to do evil and may be a result of witchcraft or breach of Tribal taboos.	

Subject	Discussion	Action
Differing Tribal views and explanations about diabetes (continued) Traditional healing may be incompatible with scientific measures	• From the Dakotas: Diabetes comes from a loss of traditional ways or change in diet. • Other Plains Tribes: Diabetes is a consequence of a loss of traditional ways, not living a "right life", or breaking a spirit-imposed taboo. • In the Southwest: Among youth from four different Tribes, over half of them believed that diabetes is contagious, and one-third believe it happens to weak people. – Dr. Acton concluded by noting that: • Maybe we are asking the wrong question in looking for medical evidence for traditional medicine's value based on biomedicine's measures. • Attempting to measure the effectiveness of a religious and cultural belief system using scientific measures may be nonsensical. • Until modern science finds ways to better measure a sense of wellbeing, balance, harmony, and spiritual healing, perhaps this is an area that we should leave unstudied. After all, these two systems exist side-by-side in many Tribal communities and do not appear to be in conflict or competition, as evidenced by the large numbers of American Indian people who use both systems.	
Meeting with the IHS Acting Chief Medical Officer Chronic Care Initiative	Dr. North, Acting CMO for the IHS, joined the TLDC meeting and updated members on the Chronic Care Initiative: – The Chronic Care Initiative is one of Dr. Grim's three initiatives. Dr. North reported that it has the most support from Dr. Grim, and is the most mature, best funded, and most likely to succeed of the initiatives. – Dr. North also noted that he believes the initiative will transform the way the Indian health system provides chronic care by: • Redesigning the system so that patients have more effective interactions with providers. • Fostering better relationships between patients and doctors. • Reducing dependency on doctors by expanding team-based approaches to care. • Moving resources to the patient, such as having an RD or diabetes educator visit the patient during the medical appointment, bringing the A1C machine into the clinic for point-of-care testing, and downloading A1C monitor data at the time of the visit. • Building community partnerships. – The Chronic Care Initiative is working with the IHI to integrate	

Subject	Discussion	Action
Clinical focus areas of the Chronic Care Initiative	seven clinical focus areas into chronic care: • Colorectal screening. • Tobacco use assessment and smoking cessation. • Nutrition and exercise education. • Inhaled steroid use for asthmatics. • Alcohol misuse screening. • Diabetes comprehensive care measures. • Childhood immunizations. • Dr. North noted that integrating pharmacy and behavioral health into chronic care is particularly important for diabetes care.	
Pilot sites	– The Chronic Care Initiative includes 14 pilot sites around the country that represent urban and Tribal programs, as well as large clinics and hospitals. • Each pilot site has a rapid change team that is working on improving chronic care. • Each pilot site also has an advisory board that includes Tribal leadership and CHRs. • The pilot sites have attended two group learning sessions in Dallas and Boulder with the IHI.	
Spreading chronic care improvements	– The Chronic Care Initiative also aims to determine how to spread chronic care improvements to the rest of the Indian health system.	
Improvements in preventing chronic kidney disease	– Dr. North noted that Dr. Narva, the former nephrologist for the IHS, recently presented data that showed that SDPI interventions (e.g., screening for microalbumin and kidney function, intervening early, controlling blood sugar, and adding ACE inhibitors to the regimen) have made a difference in the progression to chronic kidney disease.	
Lack of patient-centered care	– Mr. Nakai voiced concern about the lack of patient-centered care in the IHS, particularly lack of flexibility with appointments and refilling prescriptions. Dr. North responded that the major goal of the Chronic Care Initiative is to redesign the Indian health system so that it is less doctor-centered and more patient-centered.	
Funding for diabetes versus chronic care	– Mr. Nakai asked if diabetes funding would eventually be swept into funding for the Chronic Care Initiative. • Dr. North responded that he did not think so, noting that the SPDI and the Chronic Care Initiative are complementary programs that both aim to improve diabetes care. • Dr. North further noted that the initiative may help the Indian health system attract additional diabetes funding because the IHS will have better data and be able to demonstrate improved efficacy. – Ms. Pittman asked Dr. North to review the Chronic Care Initiative	

Subject	Discussion	Action
Budget for the Chronic Care Initiative TLDC role in the Chronic Care Initiative Educating providers on the diabetes standards of care	budget: • $1.5 million supports the initiative from the Director's discretionary budget. • $500,000 is budgeted for capacity building, developing an IHS improvement curriculum, and the group learning sessions in Dallas and Boulder. • $200,000 is budgeted for evaluation. • $200,000 is budgeted for infrastructure support (e.g., salary, travel, and contracts). • $600,000 is budgeted for IT support to develop iCare, which is a GUI for RPMS. • Additional funds for spreading the improvements will be included in the FY 2008 budget request. – Dr. Acton noted that Dr. Grim asked the TLDC to advise him on the Chronic Care Initiative. Ms. Holt requested that the TLDC receive routine reports on the progress of the Chronic Care Initiative and the pilot sites. – Ms. Holt raised a concern about the lack of awareness of the diabetes standards of care among contract health care providers: • Dr. North suggested that Tribes could work with insurance administrators to provide financial incentives for health care providers to follow the standards of care. • Dr. Acton suggested that Tribes contact their ADC, who can meet with health care providers and educate them on the standards of care.	The IHS DDTP will provide the TLDC with regular updates on the progress of the Chronic Care Initiative.
Future directions for the TLDC and meeting wrap-up Newly recognized Tribes in the Nashville Area Travel support for new members to the TLDC TLDC charter	Mr. Rolin facilitated a discussion on the potential for seven new Tribes in the Nashville Area: – One Tribe in Massachusetts has been recognized; five small Tribes in Virginia and the Lumbee Tribe of North Carolina await Congressional decision on recognition. – If all the Tribes obtain recognition, 75,000 people would be added to the Nashville Area; the Lumbees alone would add 70,000 people. – Ms. Shore noted that four Tribes in New York that have been historically recognized, but have not received services from the IHS, are setting up new service unit accounts. – Mr. Rolin voiced concern about how the additional people will strain resources in the Nashville Area. Ms. Shore noted that Congress does not always appropriate additional funding when it recognizes a new Tribe. Dr. Acton announced that the TLDC charter has been signed by Dr. Grim and is now official. A signed copy of the charter was distributed to the TLDC:	

Subject	Discussion	Action
Travel support for new TLDC advisors	– Dr. Acton noted that Athena Elliott informed her that the IHS plans to use the TLDC charter as a model for other committees. – The TLDC discussed travel support for the new TLDC advisors from the national organizations: • Mr. Rolin noted that an additional $50,000 in funds would be necessary to support travel costs for five new advisors to the TLDC ($2,000 per advisor x 5 advisors x 4 meetings per year). • Dr. Acton noted that Dr. Grim capped the TLDC budget at $150,000 per year in accordance with Tribal consultation. • Mr. Rolin and Dr. Acton will discuss travel support for the new TLDC members with Dr. Grim. • Mr. Smith advised the TLDC to prepare a travel budget for Dr. Grim. • Ms. Holt recommended that Mr. Rolin and Dr. Acton stress to Dr. Grim that the addition of the advisors was his request.	Mr. Rolin and Dr. Acton will discuss travel support for the new TLDC advisors with Dr. Grim.
Asking the national organizations to make appointments to the TLDC	– Mr. Rolin and Dr. Acton will discuss with Dr. Grim how the TLDC should notify the national organizations about making appointments to the committee.	Mr. Rolin and Dr. Acton will discuss with Dr. Grim how to notify the national organizations about making appointments to the TLDC.
SDPI reauthorization Tribal consultation process	The TLDC discussed the consultation process that would take place if the SDPI was reauthorized: – Ms. Holt recommended that the TLDC meet to develop guidelines for the Area health boards to follow when organizing Area consultations. – Ms. Shore recommended that the IHS DDTP provide guidelines from the previous SDPI Tribal consultation for TLDC review. – Mr. Roth asked for assurance that NCUIH would be included in the consultation process. – Because of concerns with UFMS travel requirements, Mr. Rolin will send a letter to Dr. Acton requesting her attendance at two SDPI Tribal consultation meetings between June and October 2007 in the event that the SDPI is reauthorized before the next TLDC meeting.	The IHS DDTP will provide the TLDC with guidelines from previous SDPI Tribal consultations. Mr. Rolin will send a letter to Dr. Acton requesting her attendance at two SDPI Tribal consultation meetings between June and October 2007.
Focus on youth	Ms. Holt recommended that the TLDC include a focus on youth in its future activities.	
Partnership with the Dental Support Centers	Mr. Finkbonner recommended that the TLDC work with the Dental Support Centers to improve diabetes care.	
Review of the TLDC meeting summary from March 2007	Ms. Holt made a motion to approve the summary from the March 2007 TLDC meeting. – Mr. Albert seconded the motion.	Motion carried to approve the TLDC meeting summary from March 2007.

Subject	Discussion	Action
TLDC meeting schedule SDPI Demonstration Project poster session	– The motion carried to approve the meeting summary. The next TLDC meeting will be November 7–8 in Atlanta. The SDPI Demonstration Projects will hold a poster session in Denver on October 17. – Dr. Acton requested that TLDC members attend the poster session and meet with the grant programs. – The IHS DDTP will work with the NIHB to pay for TLDC travel to the meeting and poster session. – Dr. Grim will try to attend the meeting and poster session. **Meeting adjourned at 1:30 p.m.**	The next TLDC meeting will be November 7–8, 2007, in Atlanta, Georgia. The IHS DDTP will work with the NIHB to pay for TLDC travel to the Demonstration Project meeting in Denver on October 17, 2007.

Alternative and Complementary Approaches to Diabetes: Where Is the Evidence for the Native American Population?

Presentation by Kelly Acton, MD, MPH, FACP

(Summary pages: 19–25)

Traditional Medicine Approaches to Diabetes: Evidence for the Native American Population

- Use of traditional medicine
- Characteristics of traditional medicine
- Diabetes-related use of traditional medicine

Use of Native Healers in an Urban Native American Health Center

- Structured interviews, n=150 adults from 30 tribes seen in an urban clinic in Milwaukee, WI
- 38.0% patients reported seeing a healer in addition to a physician
  - females 42%> males 30%
  - older 47% > younger 30%
- Of those not seeing a healer, 86% report that they would consider it in the future
- Healers most frequented were spiritual healers (51%), herbalists (42%), and medicine men (28%)
- Most common treatments were sweat lodge ceremonies (58%), herbal remedies (55%), and spiritual healing (53%)

Marbella et al, Arch Fam Med Vol 7 No 2 1998

Navajo Use of Native Healers

- Cross-sectional interviews, n=300 adults seen consecutively in a rural IHS hospital/ clinic in New Mexico
- 62% patients used traditional healer at least once in life and 39% had used healer in past year
- Users = non-users in age, education completed, income, fluency in English, # of clinic visits and hospitalizations, and self-reported compliance with medical provider instructions
- Only difference was in religion (Pentecostal=less use than all other faiths)

Kim & Kwok, Arch Int Med 158:2245-2249 1998

Patterns of Navajo Use of Native Healers

- 23% saw a medical provider for diabetes; 12% of those also saw a traditional healer
- perceived conflict in medical provider and traditional healer instructions was rare
- "For diseases such as diabetes, native healers were viewed as an adjunct rather than a substitute for medical provider care"
- One patient said: "The doctors give me pills for my body; the medicine man gives me songs for my spirit."

Kim & Kwok, Arch Int Med 158:2245-2249 1998

Use of Traditional Health Practices among Native Americans in an Urban Primary Care Setting

- Self-report surveys, n=869 adults seen in an urban clinic in Seattle, WA
- 70% patients reported use of traditional healing practices for health-related reasons in past year
  - males 79%> females 65%
  - greater use associated with more than high school education, having visited friends/relatives on reservation, and following "Native way of life"
- 52% reported that use resulted in a significant improvement in their health
- Pain of indeterminate origin only condition that distinguished users from non-users of traditional medicine

Buchwald et al, Medical Care Vol 38 No 12 pp 1191-1199 2000

Use of Biomedical Services and Traditional Healing Options among American Indians

Southwest	Northern Plains
55% use only biomedical svc for physical problems	85% use only biomedical svc for physical problems
22% use only traditional healing for physical problems	4% use only traditional healing for physical problems
23% use combined services for physical problems	11% use combined services for physical problems

Novins et al, Medical Care Vol 42 No 7, 2004

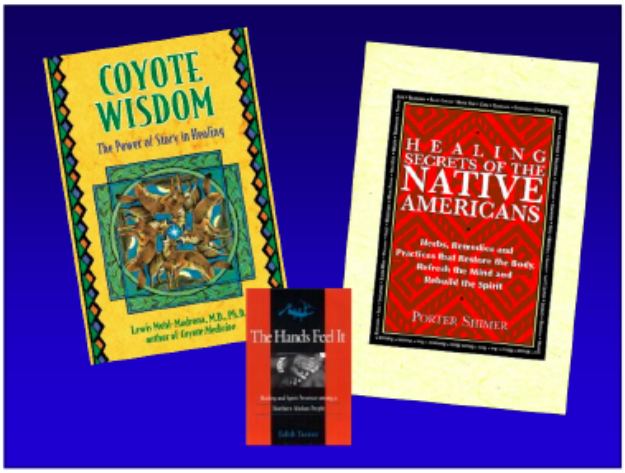
2006 American Diabetes Association
Scientific Sessions

Alternative and Complementary Approaches to Diabetes:
Where is the Evidence for the Native American Population?

Kelly Acton, MD, MPH, FACP
Director, IHS Division of Diabetes
Treatment & Prevention
Albuquerque, New Mexico
www.ihs.gov/medicalprograms/diabetes

"Another great hindrance to the civilization of the Indians is the influence of the medicine men.... While they profess to cure diseases by the administration of a few simple remedies, still they rely mainly on their art of conjuring... [that] prevent people from abandoning their heathenish rites and customs.... [The medicine man's] services are not required even for the administration of the few simple remedies they are competent to recommend, for the Government supplies the several agencies with skillful physicians..... Steps should be taken to compel these imposters to abandon this deception and discontinue their practice, which are not only without benefit to the Indians but positively injurious to them."

Letter from H.M.Teller, Secretary of the Interior, to Hiram Price, Commissioner of Indian Affairs, December 2, 1882



Complementary /Alternative Medicine

vs

Traditional American Indian Medicine

Traditional Indian and Western Medicine

- *Western medicine or biomedicine* generally refers to the application of scientific principles initially promulgated by Euro-American cultures, centered on *disease* as a concept
- *Traditional medicine* is generally used to describe the healing practices and beliefs of the Indian population.

Rhoades ER & Rhoades DA. American Indian Health: innovations in Health Care, Promotion & Policy, pp 401-417, 2003

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Characteristics of Traditional Indian Medicine

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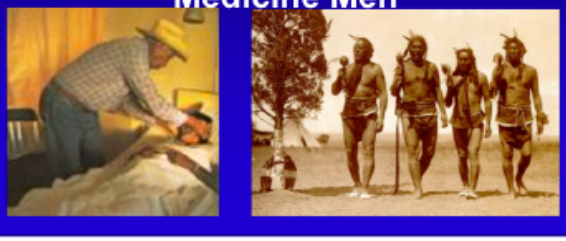
Rhoades ER & Rhoades DA. American Indian Health: Innovations in Health Care, Promotion & Policy. pp 401-417. 2000

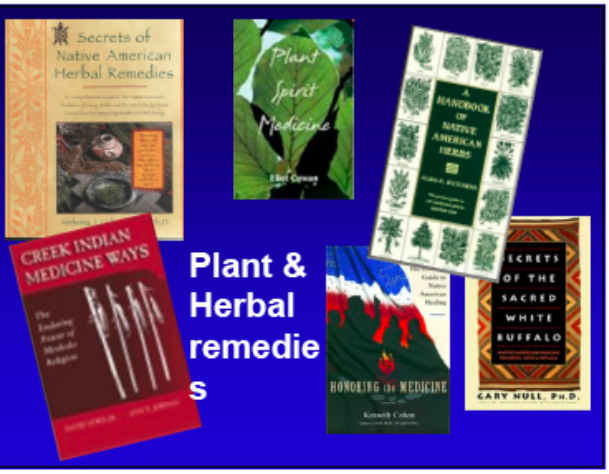
Medicine Men



Sun Dance
50th Anniversary
Crow Indian Sun Dance

Sun Dance Ceremony

Sweat Lodge



Plant & Herbal remedies

Traditional Medicine Approaches to Diabetes: Evidence for the Native American Population

- Use of traditional medicine
- Characteristics of traditional medicine
- Diabetes-related use of traditional medicine

Herbal Therapies and Diabetes in Navajo Indians

- Randomized controlled trial, n=203
- Traditional herbs are widely used by Navajos with diabetes (30%)
- Sage (15%) and cedar/juniper (10%) most common herbs used
- No difference in Alc (8.4 vs 8.35) or performance or frequency of SMBG
- Use of herbs not assoc with any measurable adverse interaction with diabetes control (A1c and SMBG practices)

McCabe et al 2005 Diab Care 28:1534-1535

Pascua Yaqui Tribe Alternative Medicine Program

- Alternative Medicine clinic since 1997
- Case control study in type 2 DM to characterize CAM users from non–users
- average age = 54.7 yrs
- More female users (79%) than male users (21%)
- Results: no difference in A1c values for biomedicine (8.1), both (8.4), or CAM alone (8.3)
- 83% of CAM users with diabetes also saw an MD

Olson K et al. NARCH grant, U of AZ

Traditional Indian Medicine and Diabetes in a Southwest Tribe

- Ongoing current study requested by Medicine Man Association
- Structured interviews regarding attitudes and beliefs regarding biomedicine and traditional healing for diabetes
- 53% - use biomedicine only; 47% - use both
- Characteristics of users: older, self identified as "traditional", completed fewer years of school, more likely to use insulin, more self-reported compliance with biomedicine
- Of users of traditional medicine, two thirds did so for diabetes. 98% report feeling better.

Olson K et al. NARCH grant, U of AZ

Talking Circles

Struthers et al Qual Health Res Vol 13 No 8 Oct 2003

Traditional Diet

- In short term studies, adoption of traditional diet associated with improvement in metabolic abnormalities
- Obesity and type 2 diabetes less prevalent in Pima living "traditional" vs "affluent" lifestyle
- Long term study in Pima suggests adoption of Anglo diet associated with 2.5X greater risk of developing diabetes

O'Dea. Diabetes 33(6) 1984; Swinburn. J Clin End Met 73, 1991
Ravussin et al Diab Care 17(9), 1994
Williams Diab Care 24(5), 2001

Native Seeds Project, Tohono O'odham Tribe, Tucson, Arizona

Cherokee Choices Program in North Carolina

Pima Pride Study

- Purpose: pilot RCT to test adherence to specific lifestyle interventions in Pima Indians
- n=95 normoglycemic Pima men & women
- randomized to 2 intervention groups: Pima *Action* & Pima *Pride*
- Results: at 12 mos both groups reported increased physical activity; *Action* had ↑ BMI and gained more weight than *Pride* (2.5 kg vs 0.8 kg); Pride had ↓ starch intake and ↓ waist circumference

Narayan V et al. Diabetes Med 15:66-72, 1998

Tribal Models of Understanding for Diabetes

- Navajo: out of balance (physical, emotional, spiritual, kinship network); brought by outside influences (white man)
- Iroquois-speaking Seneca: attack on Indians with a source that is conscious, malevolent and calculatedly aggressive
- Ojibway (Canada): "white man's sickness" due to disruption of tribal way of life & contamination of the environment (& food supply) by whites
- Northern Utes: diabetes is an entity which takes possession of the person to do evil. Result of witchcraft or breach of tribal taboos
- Dakota: loss of traditional ways & change in diet
- Other Plains tribes: consequence of loss of traditional ways, not living a "right life" or breaking a spirit-imposed taboo
- Southwest AI Youth (4 tribes): over half believe diabetes is contagious and one third believe it happens to weak people

"Not everything that can be counted counts, and not everything that counts can be counted."

Albert Einstein