

## Appendix I

# THE EPIDEMIC OF TYPE 2 DIABETES

**D**iabetes is a serious problem for American Indians and Alaska Natives (AI/ANs), who suffer from the highest rates of diabetes in the world. Virtually unknown 60 years ago, diabetes and its complications are now major contributors to morbidity and mortality in every AI/AN community. The Balanced Budget Act of 1997 and the Consolidated Appropriations Act of 2001 provided much-needed funding for the Indian health system to address this epidemic.

### *A. The Epidemic of Type 2 Diabetes*

#### **Demographics of American Indians and Alaska Natives**

AI/ANs are often lumped into one group, but the needs and issues of each community and region are variable. The federal government recognizes more than 560 tribes, and approximately 40% of the 2.5 million AI/ANs live on federal and state reservations or in Alaska Native villages.<sup>1</sup> Although most tribal communities are located in rural areas, each community has unique characteristics that affect the health care that its members receive. For example, some tribes have large hospitals with a team of doctors and specialists, whereas other tribes have a small clinic staffed by only a mid-level practitioner or community health aide. Some tribes are located near an urban center making access to specialty care relatively easy for patients, whereas other tribes are located in remote rural areas where accessing even basic health care is difficult.

More than 60% of the 2.5 million AI/ANs currently live in urban areas.<sup>2</sup> During the 1950s, government policies and programs, as well as economic conditions, resulted in the relocation of many AI/ANs to urban centers.<sup>3</sup> Urban Indians are not always able to escape poverty, inadequate education, alcoholism, and drug dependence, which often make life difficult in some tribal communities. Furthermore, many urban Indians move frequently and often do not have a regular source of medical care.<sup>4</sup>

Although most tribal communities are located in rural areas, each community has unique characteristics that affect the health care that its members receive.

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Although rural and urban Indians have variable needs and issues, they often share the problem of inadequate access to health care and the burden of poor living conditions. These factors have contributed to the poor health status of AI/ANs, regardless of their residence on reservations or in urban centers.

### Emergence of the Diabetes Epidemic in AI/ANs

Diabetes is a relatively new problem for AI/ANs, and is the consequence of drastic lifestyle and cultural changes that have occurred since World War II. Prior to World War II, reports of diabetes were rare in the AI/AN population. Throughout the 1950s and 1960s, the reports of diabetes among AI/ANs were increasing. By the late 1970s, it became evident that an epidemic of diabetes had emerged in the AI/AN population.<sup>5</sup>

Much of our information about the nature and impact of diabetes in AI/AN communities comes from ongoing cooperative studies with the Pima Indians of Arizona that have been funded by the National Institutes of Health for over 25 years. The Pima Indians have the highest rates of diabetes in the world. More than half of adult Pima Indians have diabetes, and the mortality rate due to diabetes is more than 10 times greater than that of Caucasians. The Pima Indian studies and data from other tribes show that the major factors contributing to diabetes in AI/ANs are obesity, family history, and high levels of insulin in the blood, which results in a forerunner of diabetes called insulin resistance.<sup>6</sup>

### Diabetes Prevalence

Of all U.S. racial and ethnic groups, AI/ANs have the highest rates of diabetes prevalence. In fact, AI/ANs now have the highest published prevalence of diabetes in the world. In 2000, 15.1% of AI/ANs aged 20 years or older had diagnosed diabetes, compared to 7.8% for non-Hispanic whites.<sup>7</sup> In some tribes, notably the Pima Indians of Arizona, over half of the adults have diabetes.<sup>8</sup> However, the American Diabetes Association estimates that the actual prevalence of the disease may still be one-third higher in many communities because of undiagnosed cases.<sup>9</sup>

Diabetes is increasing in prevalence among all AI/AN communities and age groups. IHS studies show that between 1997 and 2001, the prevalence of diabetes increased 33% in all major regions served by the agency. Among adults, AI/AN adults between the ages of 20–34 years experienced the highest increase in diabetes prevalence (an increase of 52% from 1997 to 2001).

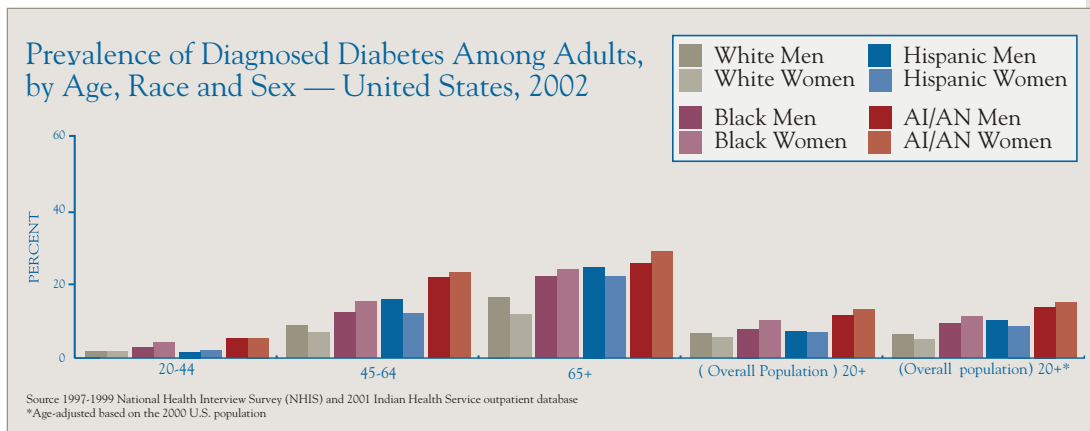
Most alarming is the increase in diabetes prevalence in children and adolescents. Type 2 diabetes was previously thought to be a disease of adults

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and was considered exceedingly rare in children and adolescents. Among all age groups, the highest increase in prevalence has occurred among AI/AN adolescents aged 15–19 years, with a 106% increase from 1990 to 2001.<sup>10</sup> Because these young people have acquired diabetes at such an early age, they will experience more years of disease burden and a higher probability of developing serious diabetes-related complications—complications that will threaten life expectancy, reduce quality of life for themselves and their families, and lower productivity during the prime years of their lives.

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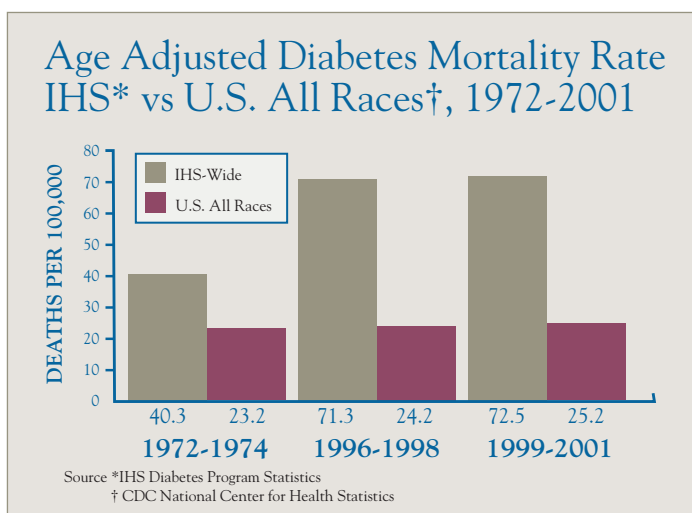


The IHS can now more accurately compare the prevalence of diabetes among AI/ANs compared to other racial and ethnic groups.

## Diabetes Mortality

Diabetes mortality is reportedly three times higher in the AI/AN population than in the general U.S. population. Most experts agree, however, that true diabetes mortality is underestimated in national statistics for two reasons. First, many decedents with diabetes do not have diabetes listed on their death certificates. Second, AI/AN heritage is not always apparent on death certificates. For these two reasons, the actual death rate attributable to diabetes among AI/ANs is believed to be 4.3 times higher than in the general U.S. population.<sup>11</sup>

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The IHS can now more accurately measure diabetes mortality in AI/ANs over time and compared to other races.

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## Complications of Diabetes

The problem of diabetes is made more complex by the fact that it leads to disabling and life-threatening complications that affect virtually every system of the body. Because AI/ANs have higher rates of diabetes, they also suffer from higher rates of long-term diabetes complications. AI/ANs also develop these complications sooner since they develop diabetes earlier in their life compared to the general U.S. population.

The chronically high levels of blood sugar that are associated with diabetes cause severe damage to the blood vessels—from the tiny blood vessels found in the eyes or kidneys to the major blood vessels that nourish the heart, brain, and extremities. Over time, the tissues nourished by these blood vessels are permanently damaged, resulting in diverse and numerous complications:<sup>12</sup>

- **Kidney disease**, or diabetic nephropathy, which can lead to kidney failure.
- **Diabetic eye disease**, or retinopathy, which can lead to blindness.
- **Heart** (cardiovascular) **disease**, including heart attack and heart failure.
- **Stroke** (cerebrovascular disease).
- Damage to the **nervous system**, or **neuropathy**. Peripheral neuropathy causes pain and loss of sensation, contributing to increased risk of limb infection, ulceration, and amputation. Autonomic neuropathy may lead to heart arrhythmias, poor blood pressure control, digestive dysfunction, and sexual dysfunction.
- **Dental** and oral complications, such as mucosal infections, periodontitis, salivary gland dysfunction leading to difficulty swallowing and speaking, and neuropathies such as burning tongue or mouth.
- **Pregnancy** complications for both mother and baby.

Complications that are classified as *microvascular complications* damage the small blood vessels of the body that nourish organs like the kidneys and eyes.

Microvascular complications are serious, debilitating, and often deadly. For example, from 1975 to 1984, kidney disease, or diabetic nephropathy, was the leading cause of non-traumatic death among the Pima Indians of Arizona. Rates of diabetes-related kidney failure in Southwest AI/ANs are six times higher than in the general U.S. population. Although more than three dozen reservation-based dialysis centers have been established, many AI/ANs living on reservations or in remote areas still travel great distances (e.g., more than one hour in each direction) to receive treatment. They are also less likely than Caucasians to receive a kidney transplant. Similarly, AI/ANs suffer

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disproportionately from diabetic eye disease. Some tribes have rates of diabetic eye disease that reach nearly 50%.<sup>13</sup>

Complications that are classified as *macrovascular complications* are responsible for the majority of diabetes-related deaths. These complications lead to cardiovascular disease, strokes, and limb and foot amputations, and they can shorten the average lifespan by up to 15 years.<sup>14</sup> Cardiovascular disease, which refers to diseases involving the heart or blood vessels, is the leading cause of death for AI/ANs, and the rates are increasing.<sup>15</sup> Even if other risk factors are not present, diabetes is a strong independent risk factor for cardiovascular disease. In AI/ANs, diabetes is the strongest risk factor for cardiovascular disease.<sup>16</sup>

## Obesity

Overweight and obesity are found worldwide, and the prevalence of these conditions in the U.S. ranks high along with other developed nations.<sup>17</sup> Obesity prevalence is particularly high in AI/ANs. In 1991, obesity prevalence was 13.8% for AI/AN males over the age of 18 years (compared to 9.1% for U.S. all races), and was 16.6% for AI/AN females over the age of 18 years (compared to 8.2% for U.S. all races).<sup>18</sup> Obesity (Body Mass Index > 30) is a major risk factor for diabetes.

Over the last century, many AI/ANs have transitioned from traditional subsistence food sources and the activities required to hunt and harvest them to a “modern” or “western” lifestyle.<sup>19</sup> Federal food programs, such as Food Distribution Programs on Indian Reservations (FDPIR) and food stamps, designed to decrease food insecurity (i.e., hunger), have contributed to the move away from traditional diets. Even today, access to quality foods, such as fresh fruits and vegetables, is limited or available only at a great distance due to the remoteness of many AI/AN communities. In addition, during these modern times, television and the media have influenced food choices. American households throughout the U.S., including AI/AN households, have increased their consumption of store-bought, convenience and prepared foods, as well as fast foods. The adoption of this westernized lifestyle has resulted in an increase in diets that are high in calories and fat and a decrease in physical activity. This combination of environmental factors and genetic susceptibility has resulted in high obesity rates in indigenous peoples throughout North America, as well as other indigenous populations throughout the world.<sup>20</sup>

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## B. Scientific Evidence for the Prevention of Diabetes

Recent studies indicate that it is possible to prevent or delay type 2 diabetes. These studies have brought hope to AI/AN communities that the epidemic of diabetes can be reversed.

### Results of the Diabetes Prevention Program

In 2001, the results of the Diabetes Prevention Program demonstrated that the onset of diabetes can be prevented or delayed. The Diabetes Prevention Program was a randomized, controlled trial funded by the NIH. The goal of the study was to determine if diabetes could be prevented in overweight people who are at high-risk for developing diabetes. Overall, 3,234 overweight participants who had impaired glucose tolerance, now called pre-diabetes, were included in the study. Forty-five percent of the participants were from ethnic minority groups, including 171 AI/ANs. The study found that diet and exercise resulting in a 5% to 7% weight loss lowered the incidence of diabetes by 58%.

Participants lost weight by reducing fat and calories in their diets and by exercising (most participants chose walking) at least 30 minutes a day, five days a week. The same study found that taking the oral diabetes drug, metformin (Glucophage®), reduces diabetes risk by 31%. Because the participants had pre-diabetes when they began the Diabetes Prevention Program, the study showed that modest lifestyle changes through improved diet and increased exercise can effectively turn back the clock, returning individuals to healthy levels of blood sugar and preventing diabetes.<sup>21</sup>

### Results of Other Diabetes Prevention Studies

Several other studies conducted in the U.S. and other countries indicate that lifestyle and medical interventions can effectively prevent diabetes:

- The Diabetes Control and Complications Trial<sup>22</sup>, Kumamoto Study<sup>23</sup>, and United Kingdom Prospective Diabetes Study<sup>24</sup> indicate that prompt and intensive medical treatment can reduce the onset of diabetes related complications.
- The United Kingdom Prospective Diabetes Study found that lower A1C levels resulted in a lower incidence of retinopathy, nephropathy, amputations, cataracts, congestive heart failure, myocardial infarctions, and stroke.<sup>25</sup>

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- The Da Qing Impaired Glucose Tolerance and Diabetes Study found that people with impaired glucose tolerance who underwent a lifestyle intervention consisting of diet and exercise reduced their risk of diabetes.<sup>26</sup>
- The Finnish Diabetes Prevention Study found that lifestyle changes aimed at reducing weight and fat intake, while increasing fiber intake and physical activity, resulted in a 58% reduction in the risk of developing diabetes in individuals with impaired glucose tolerance.<sup>27</sup>
- Researchers at the National Institute of Diabetes and Digestive and Kidney Diseases investigating the association between breastfeeding and diabetes in the Pima Indians found that exclusive breastfeeding for the first two months of life is associated with a significantly lower rate of subsequent diabetes.<sup>28</sup>
- The Nurses' Health Study followed nearly 85,000 female nurses from 1980 to 1996 to examine the combined effects of dietary and lifestyle factors on the risk of developing diabetes in females. The study found that the vast majority of cases of diabetes could be prevented by the adoption of a healthy lifestyle that included exercise, a healthy diet, and abstinence from smoking and alcohol use.<sup>29</sup> A related study examined the role of moderate-intensity activities, such as walking, in reducing the risk of developing diabetes. The study found that a faster walking pace was associated with decreased risk of developing diabetes. The data suggest that greater physical activity level is associated with a substantial reduction in risk of diabetes, including physical activity of moderate intensity and duration.<sup>30</sup>

Despite the alarming trends and formidable challenges of combating diabetes, the results of the Diabetes Prevention Program and other prevention studies have given our nation hope that we can effectively combat diabetes. Science once told us we could **treat** diabetes, but now science says that we can **prevent** diabetes.

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**“Diabetes is a big problem on the reservation. If we can do something to help the children so that they take care of themselves without even thinking, that’s our goal.”**

Lori Lossie (Eastern Band of Cherokee)



## Appendix II

# THE CHRONIC CARE MODEL

The Special Diabetes Program for Indians enabled the Indian health system to further improve how it deals with diabetes as a chronic disease. The Special Diabetes Program for Indians funding has allowed many programs to implement basic elements of quality diabetes care that were not present prior to the funding. The IHS National Diabetes Program has promoted a “best practices” approach to preventing and treating diabetes during the Special Diabetes Program for Indians initiative, and as a result, programs have implemented new activities that address a variety of aspects of addressing diabetes as a chronic disease. The IHS National Diabetes Program used the Chronic Care Model as an evaluation tool to assess how the Indian health care system has implemented essential elements of quality diabetes care as a result of the Special Diabetes Program for Indians.

The Chronic Care Model was developed in the past decade by Group Health Cooperative of Puget Sound, WA with funding from the Robert Wood Johnson Foundation to help health systems develop the basic elements for improving care at the community, health system, provider, and patient levels.<sup>1</sup> The IHS National Diabetes Program has actually been implementing components of this national model for years, but the Special Diabetes Program for Indians has helped expand the number of programs that have been able to better provide this type of quality diabetes care.

**Science:** The Chronic Care Model, when implemented through multifaceted interventions, can improve process and outcome measures for diabetes.<sup>2</sup> Using the Chronic Care Model has been shown to reduce short-term costs through reduced hospital admissions, emergency department visits, and physician consultations in people with diabetes.<sup>3</sup> Other studies have shown that improved glycemic control through implementing elements of the model is associated with short-term reductions in hospital stay and reduced hospital and outpatient use compared with usual care.<sup>4</sup>

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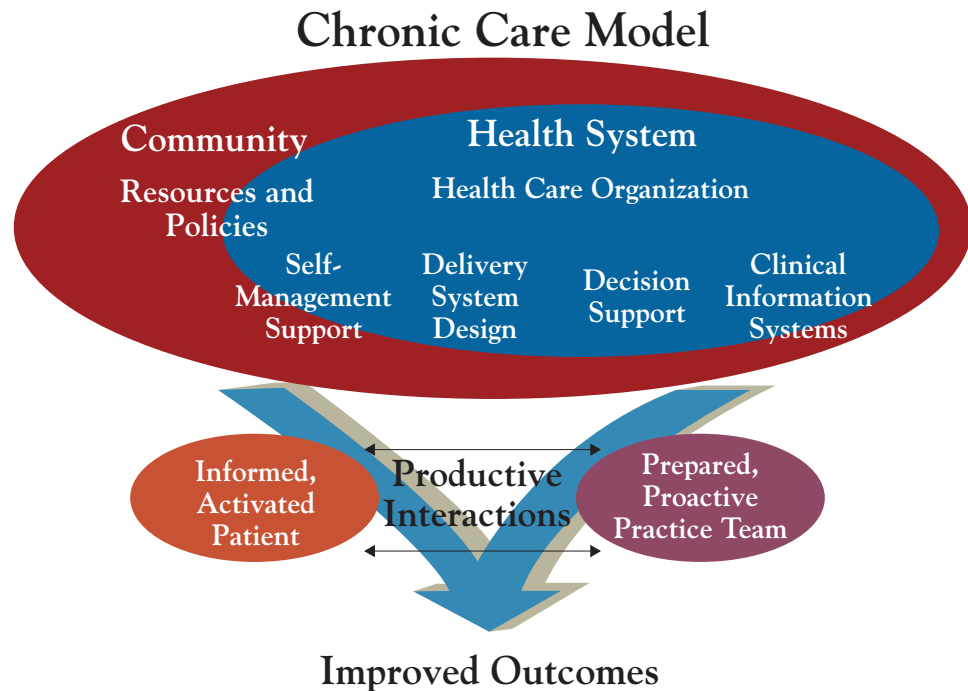
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*The Chronic Care Model*

## A. Components of the Chronic Care Model

The essential elements of a health care system that encourage high quality care for chronic diseases include the following:

1. Community Resources and Policies
2. Health System Organization
3. Self Management Support
4. Delivery System Design
5. Decision Support
6. Clinical Information Systems



Implementation of these elements – at the community, organization, provider, and patient levels – is associated with better outcomes of chronic disease care.

## B. Evaluation using the Chronic Care Model

The Special Diabetes Program for Indians enabled the Indian health system to serve as an example of a large health system that includes most strategies recommended in the high quality care of individuals with chronic conditions. A recent review of the Special Diabetes Program for Indians grant program using the Chronic Care Model's *Assessment of Chronic Illness Care, Version 3*, revealed that the Special Diabetes Program for Indians and the IHS National Diabetes Program scored in the highest level for most components of the model (Table 1).

**Table 1.**  
**Evaluation of the Indian Health System**  
**using the Chronic Care Model.**

A description of each component of the Chronic Care Model, how the Special Diabetes Program for Indians helped implement elements in each component, and examples or data are presented below.

Chronic Care Model Components	Description	SDPI Program Activities	Examples or Data
COMMUNITY RESOURCES AND POLICIES	Health system links and partners with community and regional resources	SDPI primarily funded tribes, and enabled greater partnerships between IHS programs and tribal communities.	258 (81%) of the 318 grant programs are managed by tribes  Program reports of participation of tribal leaders and tribal health directors in planning and implementation of diabetes activities increased from 14% before the grants to 73% in 2002
		SDPI enabled more local community partnerships	Location community partnerships for diabetes activities increased with: <ul style="list-style-type: none"> <li>• Tribal recreation wellness programs</li> <li>• Tribal health boards/councils</li> <li>• Social services programs</li> <li>• Tribal economic, cultural, religious programs or organizations</li> </ul>
		SDPI enabled more partnerships with outside organizations	Partnerships with outside organizations increased: <ul style="list-style-type: none"> <li>• Local schools systems</li> <li>• Colleges or universities</li> <li>• Local ADA affiliates</li> <li>• State and local cooperative extension services</li> <li>• State diabetes control programs</li> </ul>
		SDPI enabled more national partnerships	National collaborations and partnerships were formed: <ul style="list-style-type: none"> <li>• Federal agencies</li> <li>• AI/AN organizations</li> <li>• Diabetes expert organizations</li> <li>• Academic institutions</li> <li>• Other organizations</li> </ul>
		SDPI led to the creation of the Tribal Leader Diabetes Committee, a group of tribal leaders focusing on addressing diabetes	TLDC formed in 1998, quarterly meetings since then, consultation on distribution of grant funds each year, partnerships with federal agencies and organizations, advisory on diabetes related activities, national advocacy

Chronic Care Model Components	Description	SDPI Program Activities	Examples or Data
HEALTH SYSTEM ORGANIZATION	Leadership, organizational strategy, and chronic care promotion	<p>IHS National Diabetes Program has promoted coordinated care on all levels since 1979 through the national office, Area Diabetes Consultants, and network of diabetes programs</p> <p>SDPI promoted chronic care according to standards through technical assistance and the sharing of Best Practices</p> <p>Tribal Leaders Diabetes Committee promotes chronic care</p>	<p>IHS National Diabetes Program with 11 staff, 13 Area Diabetes Consultants, and 19 model programs, manages the grant program for 318 grantees, sets standards of care, promotes comprehensive care of diabetes with a public health approach</p> <p>Eight Regional Meetings allowed programs to share information and obtain technical assistance</p> <p>TLDC was the first tribal group to meet and work on a chronic disease</p>

Chronic Care Model Components	Description	SDPI Program Activities	Examples or Data
SELF MANAGEMENT SUPPORT	Self management services provided and documented	<p>Diabetes education services documented</p> <p>SDPI allowed programs to implement and enhance diabetes education services and provide a variety of new types of diabetes education</p> <p>SDPI enabled programs to adopt National Standards for diabetes Education Services</p> <p>SDPI enabled IHS to apply and receive deeming authority for certification by CMS for diabetes education reimbursement</p>	<p>IHS Diabetes Care and Outcomes Audit documents diabetes education services received each year</p> <p>Availability of organized diabetes education programs increased from 27% before the grants to 90% in 2002</p> <p>Types of diabetes education expanded since the SDPI:</p> <ul style="list-style-type: none"> <li>• Diabetes support groups</li> <li>• Community and behavioral health services</li> <li>• Culturally appropriate diabetes education materials</li> <li>• TV, radio, PSAs, written materials, videos, school based curricula</li> <li>• Community based diabetes education was provided – health fairs, traditional methods, diabetes camps, group classes, workshops</li> <li>• Settings for diabetes education included clinics, groups and support groups</li> <li>• Staged diabetes management</li> <li>• Case management</li> </ul> <p>Diabetes education staff were hired</p> <ul style="list-style-type: none"> <li>• 58% of diabetes grant programs hired diabetes educators</li> <li>• Availability of RDs, PHNs, Medical Nutrition Services, and nutrition activities for family members increased</li> </ul> <p>88 Programs completed the IHS Integrated Standards for Diabetes Education rankings (AHRQ Project) – of those, 79 ranked level 1 or less, 4 ranked level 2, and 5 ranked level 3.</p> <p>Level 2 programs can apply to IHS to obtain certification for reimbursement from CMS for diabetes education services</p>

Chronic Care Model Components	Description	SDPI Program Activities	Examples or Data
DELIVERY SYSTEM DESIGN	Providers organized to proactively provide care via teams, care system	SDPI enabled Indian health programs and tribes to develop or enhance a team-based system of care	<p>Use of key elements of care increased with the SDPI:</p> <ul style="list-style-type: none"> <li>• Diabetes registries (98%)</li> <li>• Diabetes teams (94%)</li> <li>• Diabetes clinics (69%)</li> <li>• Diabetes flowsheets (77%)</li> </ul> <p>Multidisciplinary team staff were hired:</p> <ul style="list-style-type: none"> <li>• RDs/PHNs (49%)</li> <li>• Diabetes educators (58%)</li> <li>• Medical specialists (podiatrists = 40%)</li> <li>• Physical activity specialists (40%)</li> </ul> <p>Availability of routine examinations and laboratory tests increased:</p> <ul style="list-style-type: none"> <li>• Foot examinations</li> <li>• Eye examinations</li> <li>• Dental examinations</li> <li>• A1C testing</li> <li>• Lipid testing</li> <li>• Tests for microalbuminuria</li> <li>• Urinalysis</li> </ul>
DECISION SUPPORT	Care organized around guidelines	SDPI enabled the IHS Standards of Diabetes Care (Guidelines) to be further implemented in Indian health programs	<p>IHS Standards of Care were updated</p> <p>Staged Diabetes Management was used by 47% of the diabetes grant programs</p> <p>14 Best Practices models were developed</p> <p>IHS Integrated Standards for Diabetes Education Programs were updated in 2002</p> <p>Availability of diabetes related continuing education programs increased for health professionals and parahealth professionals</p>



Chronic Care Model Components	Description	SDPI Program Activities	Examples or Data
CLINICAL INFORMATION SYSTEMS	Tracking patient care through registries, documentation, and feedback of ongoing care	<p>SDPI enabled more programs to develop registries, use the IHS Diabetes Care and Outcomes Audit, and track national data through the annual grantee survey</p> <p>A compendium of all program activities is in development</p> <p>Funding was used to improve diabetes data, including baseline data for prevalence, mortality, and to track complications</p>	<p>Programs increased their use of registries and flowsheets to track patient care</p> <p>More programs participated in the IHS Diabetes Care and Outcomes Audit since the SDPI:</p> <ul style="list-style-type: none"> <li>• 239 programs participated in the 2002 Audit representing 19,999 patients</li> <li>• Reports are available for feedback on the local, Area, or national levels</li> <li>• Intermediate outcomes of care have improved since the SDPI – A1C, blood pressure, lipid levels, cardiovascular risk factors, elements of care to prevent kidney disease</li> </ul> <p>SDPI funding was used in each IHS Area to improve prevalence and mortality data</p> <p>The IHS Diabetes Data Warehouse was established to enable tracking of long-term complications using IHS RPMS data</p>



## Appendix III

# COLLABORATIONS AND PARTNERSHIPS

The Indian Health Service (IHS) National Diabetes Program developed and built upon partnerships and collaborations with federal and private organizations as a result of the Special Diabetes Program for Indians. These partnerships with organizations involved in diabetes-related programs and activities added to the already extensive Indian health system diabetes network. This chapter highlights the many new and strengthened partnerships and collaborations that resulted from the Special Diabetes Program for Indians.

### *A. Partnerships with Department of Health and Human Services Agencies*

#### **Centers for Medicare and Medicaid Services**

##### **IHS National Diabetes Program Became a Deeming Entity for Diabetes Education Certification**

In March 2002, the Centers for Medicare and Medicaid Services approved the IHS National Diabetes Program as a deeming entity for diabetes education recognition. As a result, the IHS National Diabetes Program, with agency and tribal leader support, established an IHS Integrated Diabetes Education Recognition Program. The program certifies Indian health diabetes education programs, allowing them to seek Medicare reimbursement for diabetes education. Thus far, eight programs have been certified by the IHS National Diabetes Program, and several new applications are under review.

##### **Medical Nutrition Therapy and Diabetes Self-Management Training for Medicare**

The IHS National Diabetes Program disseminated information on Medical Nutrition Therapy and Diabetes Self-Management Training for Medicare beneficiaries who have diabetes or kidney disease to IHS, tribal, and urban Indian health programs. The IHS National Diabetes Program also provided technical assistance and consultation to IHS, tribal, and urban Indian programs on the following third party billing activities:

**In March 2002, the Centers for Medicare and Medicaid Services approved the IHS National Diabetes Program as a deeming entity for diabetes education recognition.**

APPENDIX

*Collaborations and Partnerships*

- Electronic billing
- Medical records documentation
- Claims tracking
- Reimbursements
- Examination of the outcomes and cost-effectiveness of services

These activities will benefit tribes and tribal communities by increasing access to diabetes education, nutrition services, and other primary prevention activities.

## **National Institutes of Health**

### **National Diabetes Education Program**

The National Diabetes Education Program (NDEP) is a program sponsored by the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC). NDEP aims to improve the treatment and outcomes for people with diabetes, to promote early diagnosis, and to prevent the onset of type 2 diabetes. The Director of the IHS National Diabetes Program served as a member of the NDEP Steering and Evaluation committees. In addition, IHS National Diabetes Program staff served on the NDEP American Indian Campaign, Diabetes Prevention Program Lifestyle Tools, and the Diabetes in Children and Adolescents workgroups. The IHS National Diabetes Program also distributed NDEP materials to IHS, tribal, and urban Indian programs.

### **The Diabetes Prevention Program**

The NIH sponsored the Diabetes Prevention Program (DPP), which demonstrated that type 2 diabetes can be prevented or delayed in high-risk groups, including American Indians and Alaska Natives (AI/ANs). The IHS National Diabetes Program disseminated and translated information on the DPP for the diabetes grant programs to help them expand upon their diabetes prevention efforts. The Director of the IHS National Diabetes Program served as a member of the Translation Committee of the DPP.

### **Diabetes Education in Tribal Schools**

In FY 2001, at the request of the Tribal Leaders Diabetes Committee (TLDC), the Diabetes Education in Tribal Schools project was developed to encourage AI/AN students to pursue careers in biomedical research and diabetes. The IHS National Diabetes Program collaborated with the National Institute of Diabetes and Digestive and Kidney Diseases, CDC, and American Indian Higher Education Consortium to develop a multicultural, science-based diabetes education curriculum for AI/AN students from kindergarten through high

school. By engaging AI/AN youth in the biomedical sciences at an early age, the IHS National Diabetes Program hopes that AI/AN youth will be motivated to work toward a career in health care and research.

### **Diabetes Mellitus Interagency Coordinating Committee**

The Director of the IHS National Diabetes Program serves as a member of the Diabetes Mellitus Interagency Coordinating Committee (DMICC). The committee includes representatives from Federal departments and agencies whose programs are relevant to diabetes and its complications. The DMICC membership includes representatives of 23 Federal organizations, including the IHS National Diabetes Program, and liaison representatives from the American Diabetes Association and the Juvenile Diabetes Research Foundation.

The DMICC was authorized by Public Law 93-354 and established in the fall of 1974. It facilitates cooperation, communication, and collaboration among agencies that conduct or support diabetes-related activities. These activities may range from support for biomedical research to direct provision of health care services. Current DMICC meetings and projects focus on bringing together in-depth information from the varied programs represented by the member organizations, serving as the catalyst for the initiation of projects, and guiding the progress of projects involving several agencies. The DMICC publishes an annual report that summarizes the diabetes-related activities of the organizations represented on the DMICC. The IHS National Diabetes Program has presented data from the Special Diabetes Program for Indians to the DMICC on several occasions for discussion and guidance.

### **Diabetes Research and Training Centers**

The Diabetes Research and Training Centers (DRTCs) are centers of diabetes excellence for diabetes translation funded by the NIH and located at universities throughout the U.S. DRTC professionals at the University of Indiana and the University of Michigan have provided guidance and input on the Special Diabetes Program for Indians to the IHS National Diabetes Program and the TLDC.

### **Head Start Bureau**

Since 1999, the IHS National Diabetes Program has coordinated an obesity and diabetes prevention initiative targeting Head Start children (up to five years old), Head Start families, Head Start staff, and AI/AN communities. Five tribal Head Start pilot sites, in collaboration with their respective community health partners and the IHS National Diabetes Program, developed obesity and diabetes prevention interventions in their local communities. Each of the pilot sites developed and implemented a community action plan that focused on

healthy eating, physical activity, healthy behavior, and community partnerships. The IHS National Diabetes Program is expanding the initiative to include a breastfeeding initiative for Early Head Start programs.

## **Centers for Disease Control and Prevention Division of Diabetes Translation**

### **CDC Epidemiologist Assigned to the IHS**

The CDC Division of Diabetes Translation provided diabetes epidemiologic support to the IHS National Diabetes Program through one full-time epidemiologist. The CDC epidemiologist automated the program's prevalence and complications surveillance system and calculated and adjusted diabetes prevalence data from 1999 through 2001. The IHS National Diabetes Program disseminated this data to the TLDC, IHS Area Directors, Area Diabetes Consultants, and others.

### **National Diabetes Prevention Center**

The IHS National Diabetes Program and the TLDC worked with the CDC Division of Diabetes Translation in FY 2001 to restructure the National Diabetes Prevention Center (NDPC) in Gallup, New Mexico.

The goal of the restructuring efforts was to ensure that the NDPC provided diabetes outreach, information, and technical assistance to tribes throughout the U.S. To achieve this goal, the NDPC, IHS National Diabetes Program, TLDC, and CDC have developed the following:

- A variety of tools, resources, curricula, and data approaches to assist diabetes care and prevention efforts.
- A series of reports about information technology, community diabetes care, prevention planning activities, and educational resources.
- The *Health for Native Life* magazine, which is a publication developed for members of tribal communities who have diabetes and their families.

The NDPC also established the Tribal College Initiative to address President Bush's Initiative on Tribal Colleges and Universities, which directed federal agencies to work in partnership with tribal colleges and universities. Partners in the Tribal College Initiative included the National Indian Council on Aging, American Indian Higher Education Consortium, Association of American Indian Physicians, Native American Diabetes Program at the University of New Mexico, NIH, and Department of Health and Human Services Office of Minority Health.



### State Diabetes Control Programs

Several IHS Area Diabetes Programs formed partnerships with CDC's State Diabetes Control Programs (DCP) to share skills, resources, and training. For example, in 1997, the Montana DCP, the IHS Billings Area Diabetes Program, and each of the diabetes grant programs in Montana, formed partnerships to identify the burden of diabetes among Montana AI/ANs, evaluate the effectiveness of diabetes prevention activities, and identify opportunities to improve care for people with diabetes. The Montana DCP provided technical and epidemiologic support to help the diabetes grant programs address surveillance, health system, and health communications.

## B. *Partnerships with American Indian and Alaska Native Organizations*

### American Indian Higher Education Consortium

The IHS National Diabetes Program collaborated with the American Indian Higher Education Consortium (AIHEC) to build capacity and infrastructure for diabetes training and program activities at tribal colleges and universities. As described earlier, the IHS National Diabetes Program also collaborated with AIHEC, as well as the National Institute of Diabetes and Digestive and Kidney Diseases and the CDC, to develop a program to encourage AI/AN youth to pursue careers in biomedical research and health science.

### National Indian Council on Aging

The IHS National Diabetes Program formed a partnership with the National Indian Council on Aging (NICOA) to translate and disseminate diabetes data to tribal communities and tribal leaders. The partnership:

- Developed the Diabetes Monograph Series to address diabetes and other health issues in AI/AN communities. Recent issues included *A Critical Issue: Blood Sugar Control*; *Diabetes among Alaska Natives: An Emerging Epidemic*; *What Kills Indian Elders*; and *Lung Cancer Deaths and Smoking among American Indians*.
- Developed a newsletter series titled CLEAR VISIONS, which provided updates on the Special Diabetes Program for Indians to the diabetes grant programs.
- Collaborated with Cimarron Medical Informatics to automate the IHS Diabetes Care and Outcomes Audit.
- Produced a video titled *Diabetes and Indian Elders*, which shares Medicare beneficiary information with the AI/AN elder population.

## **Association of American Indian Physicians**

In 1998, the CDC awarded a grant called the “National Minority Organizations, Strategies for the Prevention and Control of Diabetes,” to the Association of American Indian Physicians (AAIP). The grant allowed AAIP to launch and coordinate the NDEP American Indian Campaign. The purpose of the campaign was to provide culturally-appropriate diabetes education and awareness materials to AI/AN communities and the diabetes grant programs. The IHS National Diabetes Program served on the NDEP American Indian Campaign Workgroup to help develop culturally-appropriate diabetes messages and provide diabetes expertise and guidance.

## **National Indian Health Board**

The National Indian Health Board (NIHB) has a long history of collaboration with the IHS. The NIHB advocated for the passage of the Balanced Budget Act of 1997 and the Consolidated Appropriations Act of 2001. In addition, the NIHB formed partnerships with the Juvenile Diabetes Research Foundation and the American Diabetes Association to advocate for the Special Diabetes Program for Indians. Two former and the current Chairperson of the NIHB serve on the TLDC.

## **American Indian Epidemiology Centers**

The IHS National Diabetes Program collaborated with several tribal epidemiology centers to promote diabetes data improvement at the local level. For example, the Northwest Portland Area Indian Health Board, located in Portland, Oregon, used Special Diabetes Program for Indians data improvement funds to establish the Western Tribal Diabetes Project in 1998. The project developed and implemented a sustainable and systematic approach to capture diabetes data among AI/AN communities located in the Northwest and California by providing technical assistance on data improvement activities. Tribal epidemiology centers in the Nashville and Bemidji Areas are using data improvement funds to develop similar types of projects. In addition, the Seattle Indian Health Board, located in Seattle, Washington, used data improvement funds to develop and produce a web-based diabetes survey and audit tool for diabetes grant programs that delivered non-clinical services. The IHS National Diabetes Program also collaborated with the tribal epidemiology centers to compile the Special Diabetes Program for Indians Compendium Report, which documented the individual activities and accomplishments of 66% of the diabetes grant programs.

## Urban Indian Nurses Association

Many members of the Urban Indian Nurses Association played a major role in coordinating the diabetes grant programs at their urban Indian health centers. The IHS National Diabetes Program provided diabetes-related information and programmatic guidance to this association.

## C. Partnerships with Diabetes Expert Organizations

### Juvenile Diabetes Research Foundation

The Juvenile Diabetes Research Foundation (JDRF) is the world's leading non-profit, non-government diabetes research funding organization. The JDRF was established to help define research priorities and to lead advocacy efforts in research for the prevention of juvenile diabetes and diabetes-related complications. The IHS National Diabetes Program and the JDRF collaborated on efforts, such as the National Diabetes Education Program, to educate the public on diabetes its complications. The JDRF also served as an important advocate for the Special Diabetes Program for Indians.

### American Diabetes Association

The American Diabetes Association (ADA) is the nation's leading non-profit health organization providing diabetes information, advocacy, and research. The mission of the ADA is to prevent and cure diabetes, and to improve the lives of all people affected by diabetes. The IHS National Diabetes Program collaborated with the ADA, as well as the University of New Mexico Native American Diabetes Program, to launch and support a national AI/AN outreach campaign called *Awakening the Spirit: Pathways to Diabetes Prevention and Control*. This campaign provided tribal communities and the diabetes grant programs with a research-based, community diabetes education curriculum and information on the resources and networking opportunities available through the ADA. The ADA also advocated for the Special Diabetes Program for Indians at the Congressional level.

### Joslin Diabetes Center

#### Joslin Vision Network Teleophthalmology Project

In FY 2002, Congress provided \$1.5 million to address diabetic retinopathy among AI/ANs. In collaboration with the Joslin Diabetes Center, the IHS National Diabetes Program developed a project to evaluate AI/ANs for diabetic retinopathy using the Joslin Vision Network (JVN). The JVN is a telemedicine system that uses low-level illumination and no-pupil dilation to diagnose diabetic retinopathy. IHS, tribal, and urban Indian clinics can electronically send retinal images to a reading center, which returns analyses of the level of diabetic retinopathy to the clinics.

The IHS National Diabetes Program deployed imaging sites at the Phoenix Indian Medical Center, Sells Public Health Service Indian Hospital, Tuba City Indian Medical Center, Parker Indian Hospital, Hopi Health Care Center, and the Chief Andrew Isaac Health Center. Certified readers at the IHS/JVN National Reading Center in Phoenix evaluated the retinal images acquired from these sites. Since entering its clinical phase, the program has evaluated more than 1,500 patients that had not met the prescribed level of care. Between ten and fifteen additional sites will be deployed during the next year at locations throughout Indian Country.

### **Comprehensive Diabetes Management Program**

The IHS National Diabetes Program collaborated with the Joslin Diabetes Center in development of the Comprehensive Diabetes Management Program (CDMP). The CDMP is a web-based system that uses the case management model to track diabetes care and education. The CDMP includes clinical assessment, behavioral assessment, and education and reinforcement modules. The goal of this project is to integrate the CDMP with the IHS electronic medical record.

### **American Association of Diabetes Educators**

In 1999, the American Association of Diabetes Educators (AADE) formed a taskforce to explore the role of the lay health worker (i.e., paraprofessionals, such as community health representatives and community health aides) in diabetes education. The taskforce included representatives from a variety of health care organizations including the IHS National Diabetes Program, which hosted the *Lay Health Workers Summit* in April 2002.

### **American Academy of Pediatrics**

The IHS National Diabetes Program served as the IHS liaison to the American Academy of Pediatrics (AAP) Committee on Native American Child Health. In partnership with the IHS National Diabetes Program, the committee:

- Offered its expertise to individuals and groups concerned about issues facing AI/AN children.
- Conducted annual site visits to IHS Areas.
- Developed programs that support healthy lifestyles and optimal physical, mental, and social health in AI/AN children.
- Identified challenges in AI/AN child health care and suggested innovative ways to solve them.

- Developed guidelines for the prevention, identification, and treatment of diabetes among AI/AN children. The IHS National Diabetes Program will disseminate these guidelines through the extensive Indian health diabetes network once they are published.

The AAP widely circulated information on the breastfeeding intervention of the Phoenix Indian Medical Center's Diabetes Center of Excellence through its *Breastfeeding: Best for Baby and Mother* newsletter. The AAP distributed the newsletter to AAP Chapter Breastfeeding Coordinators, members of the AAP Breastfeeding Promotion in Pediatric Office Practices program, and members of the AAP Provisional Section on Breastfeeding.

The IHS National Diabetes Program also served on the AAP Indian Health Special Interest Group. The mission of the group is to identify, prioritize, and promote education and training opportunities related to AI/AN health issues. In the fall of 2002, the group sponsored an education program on childhood obesity and diabetes in AI/AN youth at the *AAP Annual Conference and Exhibition Meeting* in Boston.

### **International Diabetes Center**

The International Diabetes Center based in Minneapolis, Minnesota, runs an outpatient clinic for people with diabetes, trains and educates health care professionals who care for people with diabetes, develops methods to improve diabetes screening practices, and educates the public about diabetes.

The Center has been an important partner for the IHS National Diabetes Program in several ways. A diabetes expert from the Center served on the original Indian Health Diabetes Workgroup, which was formed by the Director of the IHS in 1997 to develop recommendations on the distribution of funds from the Special Diabetes Program for Indians. The Center provided training and technical assistance to AI/AN communities on the use of Staged Diabetes Management in the clinical treatment of people with diabetes. The Center also developed a complete diabetes education curriculum, called Type 2 Diabetes BASICS, which has been utilized by many AI/AN communities.

### **MacColl Institute of Group Health Cooperative of Puget Sound**

The MacColl Institute of the Group Health Cooperative of Puget Sound developed the Chronic Care model to help health systems develop the basic elements necessary to improve care at the community, health system, provider, and patient levels. The IHS National Diabetes Program used the Chronic Care Model to evaluate the effectiveness of its systems of care in dealing with diabetes as a chronic disease. Although the IHS National Diabetes Program

has successfully implemented elements of the Chronic Care Model to improve diabetes care and management since the 1980s, the Special Diabetes Program for Indians allowed more Indian health programs, particularly tribal programs, to build the infrastructure needed to implement the model. The Special Diabetes Program for Indians also enabled these programs to measure their effectiveness in implementing the system changes recommended by the model.

## *D. Partnerships with Academic Institutions*

### **University of New Mexico**

#### **Native American Diabetes Project**

The Native American Diabetes Project (NADP) at the University of New Mexico developed a community-based diabetes curriculum and training program called *Strong in Body and Spirit*. NADP provided training and assistance to the diabetes grant programs.

#### **Earth Data Analysis Center**

Using information provided by the IHS National Diabetes Program, the Earth Data Analysis Center at the University of New Mexico used Geographic Information Systems (GIS) mapping technology to map the sites of the diabetes grant programs based on location and funding amount.

### **University of Arizona College of Public Health**

The IHS National Diabetes Program collaborated with the University of Arizona College of Public Health and other organizations to coordinate the *Diabetes Prevention in American Indian Communities: Turning Hope Into Reality* Conference, held December 11–13, 2002, in Denver, Colorado. Yvette Roubideaux, MD, MPH, Assistant Professor in the University of Arizona College of Public Health, coordinated the conference and planning committee.

The conference celebrated and disseminated the results of the Diabetes Prevention Program, and highlighted the Special Diabetes Program for Indians. Each plenary session and the majority of workshops showcased the diabetes prevention and treatment activities implemented by the diabetes grant programs. Over 700 diabetes grant program coordinators and staff members, health professionals, and tribal leaders attended the conference.

### **University of Southern California**

The IHS National Diabetes Program collaborated with the Statistical Consultation & Research Center Department of Preventative Medicine at the University of Southern California to integrate statistical, epidemiological and computing resources to conduct public health evaluation of the SDPI.



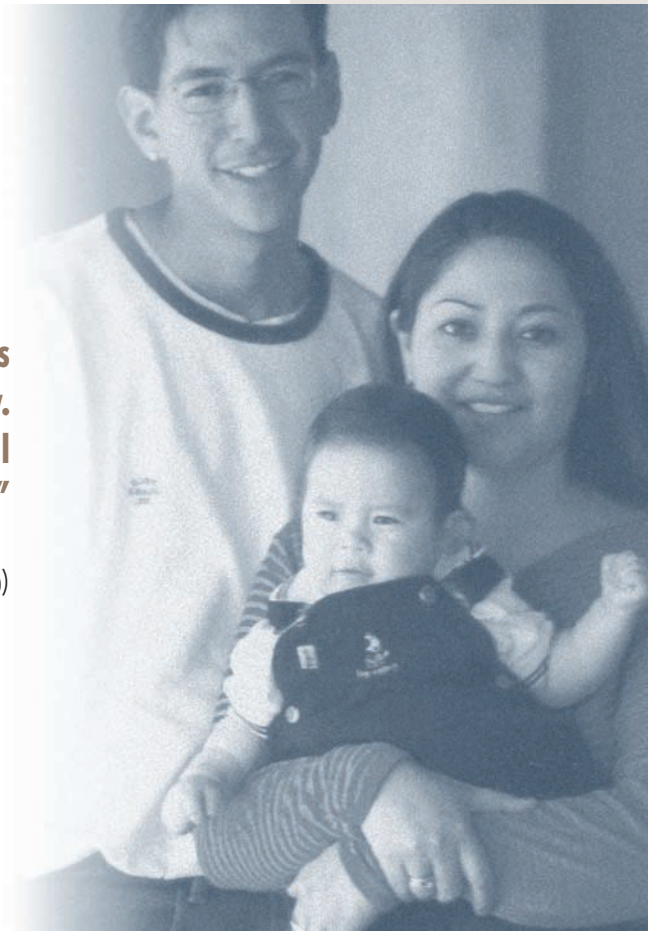
## *E. Partnerships with Other Organizations and Agencies*

### **U.S. Department of Agriculture**

The IHS National Diabetes Program and the U.S. Department of Agriculture Special Nutrition Programs developed intervention projects to address the rising prevalence of overweight, obesity, and diabetes in AI/AN children and youth. The two agencies are currently formulating interagency agreements that will enable them to implement the interventions.

**“Diabetes is in our family. We eat a lot of fruits and vegetables. Our son doesn’t eat much candy. And, he’s always running around, always active. I hope it will help him to prevent diabetes.”**

Shay Jaramillo (Isleta Pueblo)





*Appendix IV*  
INDIAN HEALTH  
BEST PRACTICE MODELS

APPENDIX

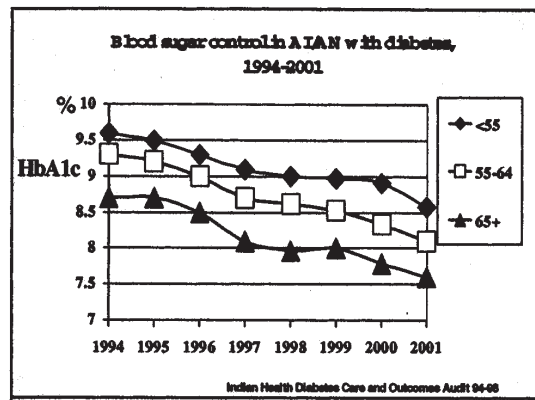
*Best Practice  
Models*

## Indian Health Best Practice Model

## Basic Diabetes Care and Education-A Systems Approach

**Why is this important?**

Indian health and national studies show that diabetes programs using a systems approach to diabetes care and education can make a difference! Indian health diabetes programs have helped define the elements that point to quality diabetes care and education systems within American Indian/Alaska Native communities. A systems approach includes case management, information management, diabetes team, diabetes clinics and protocols, self-care management education, professional training, and resources for care of diabetes complications. Programs looking to improve any part of the way they deliver care and education can use the systems approach.

**What measures are used?**

► The **Diabetes Quality Improvement Project (DQIP)** is a national diabetes performance and outcome measurement set. DQIP will help health care systems across the U.S. improve diabetes care.

► **Indian Health Diabetes Care and Outcomes Audit** is very similar to the DQIP measures. The graph shows a steady improvement in blood sugar control in Indian health patients with diabetes (lower HbA1c means better blood sugar control). Diabetes teams who improve systems of care will see positive outcomes.

**Basic Diabetes Care and Education**

- **Assess your local diabetes care and education programs. What types and level of services are you providing? Does the diabetes team accept diabetes care and education standards?**
- **Does your clinic participate in the Diabetes Care and Outcomes Audit? How do the audit measures compare with the Indian Health trends, DQIP measures and Healthy People 2010 objectives? What system improvements can the diabetes team make?**

You may find that your program wants to modify or create new systems of diabetes care and education. Here are some things to consider:

- What elements of medical care do you provide in your program? What kinds of diabetes care systems are in place? What systems would you like to modify or add?
- Do you have staffing for the services you would like to provide? Does your program use a team approach to care? Is training provided for team members on a regular basis?
- Assess your diabetes self-management education program. Does it follow a defined curriculum? Does it teach coping skills? Does it offer support groups?
- Consider using the *Integrated Diabetes Education and Clinical Standards for American Indian and Alaska Native Communities* to assess your local diabetes care and education programs. This document will help you assess your program according to levels and determine what is working and where improvements are needed. Certification is now available that allows your program to receive Medicare reimbursement for eligible patients.

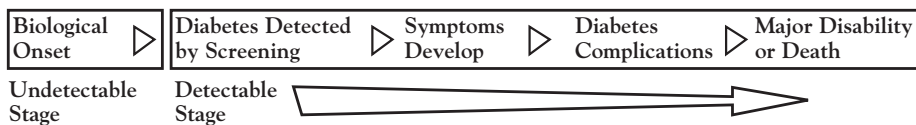
## Indian Health Best Practice Model

## Diabetes Screening Programs

**Why is this important?**

Type 2 diabetes has reached epidemic proportions in American Indian and Alaska Native (AI/AN) communities. AI/AN have nearly three times greater chance of dying from diabetes and its complications than non-Hispanic whites. Yet, many people with diabetes, about 33% according to national estimates, remain undiagnosed. Blood vessel damage from high blood sugar can begin before diabetes is diagnosed, leading to early problems with the eyes, nerves, kidneys, and heart.

Stages Important to screening for diabetes. Early screening and treatment can help reduce the risk of diabetes complications

**What do we know?**

- ▶ Major risk factors for type 2 diabetes such as a family history of diabetes, obesity, impaired glucose tolerance, and a history of gestational diabetes are well known, and the criteria for diagnosis of diabetes are established.
- ▶ A large clinical study, the Diabetes Prevention Program (DPP), was ended a year early in July 2001. The purpose of this study was to find out if people at high risk for type 2 diabetes with a condition known as prediabetes could decrease or delay the onset of diabetes through lifestyle changes and/or use of medicine. Participants who made lifestyle changes reduced their risk of getting type 2 diabetes by **58%**. Those on metformin, a medicine used to treat diabetes, reduced their risk of getting type 2 diabetes by **31%**.
- ▶ A recent study in Finland also showed that healthy lifestyles changes reduced the chance of getting type 2 diabetes by 58%.
- ▶ The **Healthy People 2010** objective advises that 80 percent of adults aged 20 years and older are screened for diabetes.

**Diabetes screening in your community**

- ▶ **Find out the kinds of screening programs and methods operating in your community. Can you make any improvements?**
- ▶ **Do your screening programs include diabetes awareness and education?**

**Your program may want to develop or improve a diabetes-screening program. Here are some things to consider:**

- ▶ Find out acceptable methods and approaches for screening in your community. Work with your tribal administration and health care providers to set up appropriate screening programs.
- ▶ Screening for pre-diabetes in your community may best be done through the use of a risk assessment questionnaire, prior to subjecting your patients to blood testing.
- ▶ Facilitate and ensure access to screening services.
- ▶ Provide education to your community about the symptoms of and risk factors for diabetes and the importance of early diagnosis. Involve community leaders in the process.
- ▶ Develop a system for tracking and providing follow-up for people with abnormal screening results or with one or more risk factors for diabetes.
- ▶ Develop a complete program including screening for diabetes, and screening for other factors that contribute to diabetes complications (lipids, blood pressure, foot exams, etc.).

## Indian Health Best Practice Model

## Community Advocacy - Winning Support for Your Diabetes Program

**Why is this important?**

Community support is vital for your program success. Involving tribal leaders, elders, religious or traditional leaders, people with diabetes, youth leaders, community health representatives (CHRs) and other community advocates is the best way to gain support. Community members who are involved as partners, advocates or participants in activities can help listen, influence, identify gaps, and find solutions to the many challenges in diabetes care. They can also help blend traditional or local ways of sharing information and learning with current science and medical knowledge. Honoring traditions and local knowledge can help protect and promote health for the entire community.



**“Education is the biggest part of dealing with diabetes. Getting the people to understand and it’s their own native people that are going to have to educate us. If somebody comes from off the reservation I guess they don’t take them seriously.”**

Lawrence Bedeau, Red Lake Band of Chippewa, 55 years old, diagnosed with diabetes in 1974

**What can you do?**

Work with community members to help create and **fine tune** diabetes program activities.

- ▶ Encourage, train and use community members to lead diabetes program activities.
- ▶ Community members can lead support groups, organize screening programs, teach cooking classes, help with home visits and increase community awareness for diabetes prevention and treatment.
- ▶ Create partnerships with other health care programs in your community.

**Your community**

- ▶ **What efforts has your community made to support lifestyle change?**
- ▶ **Do you plan activities according to seasons or events important to the people in your community?**
- ▶ **How is your program developing and supporting leadership within the community?**
- ▶ **What special efforts has your program made to help people learn in the way they are most comfortable with?**

**You can involve your community in many ways. Here are some things to consider:**

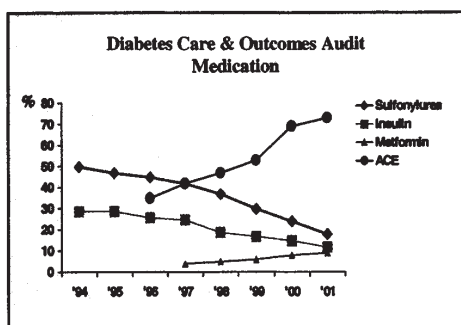
- ▶ Listen to your community. What does your community want? Ask how to involve people, programs or leadership in program planning, developing, and implementation. Invite participation from all levels in your community.
- ▶ Involve your tribal health advisory system and other tribal health programs (Head Start, WIC, School health, Elder, Youth, etc). Create diabetes prevention and care programs that are complementary not competitive.
- ▶ Find ways to share information with the community as your program progresses.
- ▶ Consider developing a diabetes advocate program to help support and sustain your community linkages. Adopt or modify diabetes advocate models known to work.
- ▶ Consider partnerships with tribal colleges or other education systems in your region. They can help educate and train youth, advocates and other community members.

## Indian Health Best Practice Model

## Medications for Diabetes Care

**Why is this important?**

Most people with diabetes need medicines to lower blood sugar and prevent diabetes complications. In recent years, a number of new, more effective, drugs have been developed for type 2 diabetes. These drugs act in different ways to lower blood sugar and improve insulin usage. New drugs to control blood pressure and blood lipids are also available to help reduce the risk for heart and kidney disease. Unfortunately, the cost of these drugs may inhibit their widespread use in American Indian/Alaska Native communities with large numbers of people who have diabetes. Indian health pharmacy budgets remain flat line while drug costs increased 25% last year alone. To provide quality diabetes care, health care providers must have access to the necessary tools, including effective medicines.

**What measures are used?**

► The **Indian Health Diabetes Care and Outcomes Audit** measures the number of people using medicine for blood sugar control and to protect their kidneys. The graph shows the trends in medicine use.

► The **average cost of drugs** for one person with diabetes is about \$2,000 per year. These are drugs used to lower blood sugar, blood pressure and blood lipids and to protect kidney function. Other drugs for heart, mental health or other problems are not included.

**How does your program compare?**

- Find out your clinic's current budget for diabetes related drugs. Is it enough?
- Is your health care team limiting the use of certain drugs due to high cost?
- Look at your audit trends, would the outcomes be better if other medicines were available?

**Contributing grant funds to the pharmacy budget may help with diabetes care in your community. Here are some issues you may want to consider:**

- How much does your program spend on diabetes medicines per person, per year? If you had more funds, would more people receive needed medicines? Would more funds impact the availability of medication?
- Is your present pharmacy program meeting the needs of your community? Are all people with diabetes who need blood pressure or lipid lowering drugs receiving them? How would more funds affect these needs?
- Are the new drugs for type 2 diabetes available in your pharmacy?
- Are people with diabetes receiving adequate education/information on how to take their medicines?
- Is your clinic staff, including physicians and pharmacists, up-to-date on new medicines and how to prescribe them?

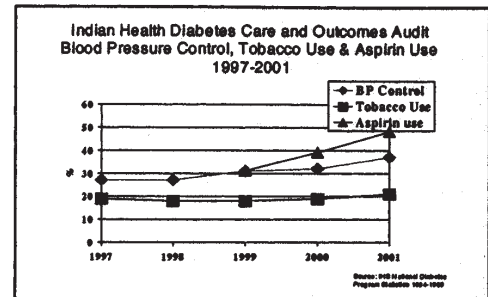
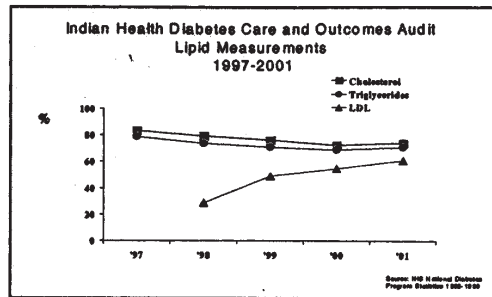


## Indian Health Best Practice Model

### Cardiovascular Disease and Diabetes—Screening, Treatment & Follow-up

#### Why is this important?

People with diabetes are at 2 to 4 times higher risk for heart disease compared to people without diabetes. They also are more likely to die after a first heart attack. Cardiovascular disease (CVD) is the leading cause of death in American Indians and Alaska Natives over age 55. Risk factors for CVD include high lipid levels, high blood pressure, tobacco use, obesity, and low physical activity.



#### What measures are used?

- ▶ The **Indian Health Diabetes Care and Outcomes Audit** measures total cholesterol, LDL, triglycerides, blood pressure (BP), tobacco use and recommendation or referral for tobacco counseling; use of low-dose aspirin; and baseline ECG. The graphs show the reported trends in CVD risk factor measurements, for Indian health clinics that report data.
- ▶ The **Healthy People 2010** objective calls for a 10 percent reduction in cardiovascular deaths in people with diabetes.

#### How does your program compare?

- ▶ Find out your clinic audit results for CVD risk factors in people with diabetes.
- ▶ What percentage of people with diabetes have their lipid numbers in the target range?
- ▶ What percentage have their blood pressure in the target range?
- ▶ What percentage use tobacco?
- ▶ How many take low dose aspirin?

Your grant program may want to develop a CVD risk screening and treatment program. Here are some things to consider:

- ▶ Assess local diabetes care for CVD screening and treatment services. Are there unmet needs?
- ▶ Identify ways to reach your target populations for assessment and treatment.
- ▶ Develop lifestyle, counseling and education programs to lower CVD risk.
- ▶ Develop a system of care that includes screening, treatment and follow-up services for CVD risk factors (i.e., lipids, blood sugar, blood pressure, and tobacco use).
- ▶ Include lifestyle change (nutrition, physical activity, tobacco cessation) programs.
- ▶ Promote a team approach in your clinic that involves primary care providers and allied health care staff such as pharmacists, nutritionists, health educators and physical therapists.

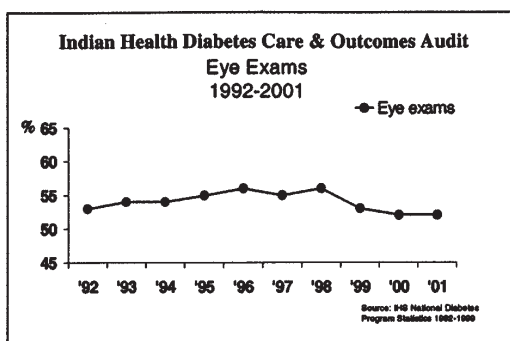


## Indian Health Best Practice Model

### Eye Care for People with Diabetes – Screening, Treatment, and Follow-Up

#### Why is this important?

Diabetic eye disease (retinopathy) is the leading cause of adult blindness in the U.S. Damage to the eyes can begin even before diabetes is diagnosed. All people with type 2 diabetes should receive a dilated eye exam at diagnosis and every year thereafter. Yearly dilated eye exams need to be done by an ophthalmologist, optometrist or specially trained technician. This annual exam screens for retinopathy. Without treatment, people with diabetes who have eye disease have a 50 percent chance of blindness in 5 years. With laser treatment, the chance of serious vision loss is reduced to less than 2 percent in these same people with high-risk diabetic eye disease.



#### What measures are used?

► The **Indian Health Diabetes Care and Outcomes Audit** measures the number of people with a documented dilated eye exam or fundus photograph within the past year. The graph shows the reported trends in yearly-dilated eye exams for all Indian health clinics that report audit data.

► The **Healthy People 2010** objective advises that at least 75 percent of people with diabetes receive a yearly-dilated eye exam.

#### How does your program compare?

► How do your numbers clinic audit results for eye exams during the last few years?

► Find out your numbers in here: \_\_\_\_\_% FY97 \_\_\_\_\_%FY98 \_\_\_\_\_%FY99  
\_\_\_\_\_%FY2000 \_\_\_\_\_%FY2001

► How do your numbers compare to the Indian health trends?

► How do your numbers compare to the Healthy People 2010 objective?

If your numbers are low, your diabetes grant program may want to develop an eye care program. Here are some things to consider:

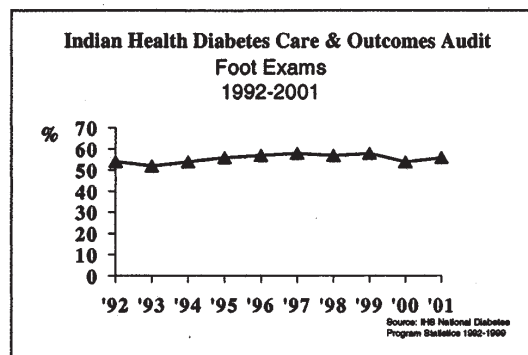
- Assess your local eye care program for people with diabetes. Are there unmet needs?
- Identify ways to increase the number of dilated eye exams. (media, eyeglasses, off site screening, telemedicine, etc.)
- Ensure easy access to eye exams, including staffing, space, equipment, or off-site facilities for community-based screening.
- Provide education to people with diabetes and their families about the need for yearly eye exams.
- Provide timely treatment of eye disease including laser therapy, corrective eyeglasses, and other treatments if needed.
- Establish and maintain tracking and monitoring programs for people with diabetes to help track diabetes care and treatment needs.

## Indian Health Best Practice Model

### Foot Care for People with Diabetes – Screening, Treatment, and Follow-up

#### Why is this important?

Lower-extremity amputations are a major cause of morbidity and mortality for people with diabetes, especially in American Indian and Alaska Native communities. Most amputations result from problems with foot ulcers. We can prevent amputations by screening and managing the risk factors for foot ulcers. All people with diabetes should receive a complete foot exam at least once a year to identify high-risk foot problems. A complete foot exam includes recording any history of foot problems, a visual check, testing for nerve problems and blood vessel problems.



#### What measures are used?

► The **Indian Health Diabetes Care and Outcomes Audit** measures the number of people with a complete foot exam within the past year (includes assessment of nerve and blood vessel status). The graph shows the reported trends in yearly foot exams for all Indian health clinics that report audit data.

► The **Healthy People 2010** objective advises that 75 percent of people with diabetes receive a complete foot exam each year.

#### How does your program compare?

- Find out your clinic audit results for foot exams during the last few years.
- Write those numbers in here: \_\_\_\_% FY97 \_\_\_\_%FY98 \_\_\_\_%FY99  
\_\_\_\_%FY2000 \_\_\_\_%FY2001
- How do your numbers compare to the Indian health trends?
- How do your numbers compare to the Healthy People 2010 objective?

If your numbers are low, your diabetes grant program may want to develop a foot care program. Here are some things to consider:

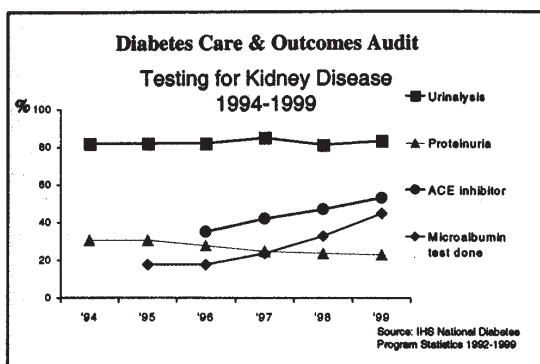
- Assess your local foot care programs for people with diabetes. Are there unmet needs?
- Identify ways to reach your target populations to increase the number of foot exams.
- Provide education on the importance of daily foot care, preventing minor foot trauma, shoe selection and use, and reporting any foot problems.
- Develop a comprehensive foot care program that includes screening and risk assessment, preventive care, wound management and follow-up.
- Provide staffing and training for foot care programs, including CHRs, primary care providers, nurse educators, podiatrists, wound care specialists, and pedorthists.
- Promote case management and treatment of other health conditions such as high blood sugar, tobacco cessation programs and blood vessel disorders.

## Indian Health Best Practice Model

### Kidney Disease – Screening, Prevention, Treatment and Follow-up

#### Why is this important?

Diabetes is the most common single cause of kidney failure in the U.S. The presence of protein in the urine marks the beginning of kidney damage that progresses over time. People with diabetes need yearly urine and blood tests to screen for early kidney disease. Improving blood sugar control, using aggressive treatment to control high blood pressure, and using medicines called ACE inhibitors can protect kidney function.



#### What measures are used?

► The **Indian Health Diabetes Care and Outcomes Audit** measures screening for protein in the urine (urinalysis & micro albumin tests). The audit measures the percentage of people with diabetes who have protein in the urine ( $\geq 300$  mg/dl), and the percentage of people with diabetes being treated with ACE inhibitors. The graph shows the reported trends in testing for kidney disease, for all Indian health clinics reporting audit data.

► The **Healthy People 2010** objective is to increase the number of people with diabetes who obtain an annual urine test for micro albumin (small amounts of protein in urine).

#### How does your program compare?

- Find out your clinic audit results for kidney disease screening during the last few years.
- Write those numbers in here: \_\_\_\_% FY97 \_\_\_\_%FY98 \_\_\_\_%FY99 \_\_\_\_% FY2000 \_\_\_\_%FY2001
- How do your numbers compare to the Indian health trends?
- How do your numbers compare to the Healthy People 2010 objective?

If your numbers are low, your diabetes grant program may want to develop a diabetes kidney program. Here are some things to consider:

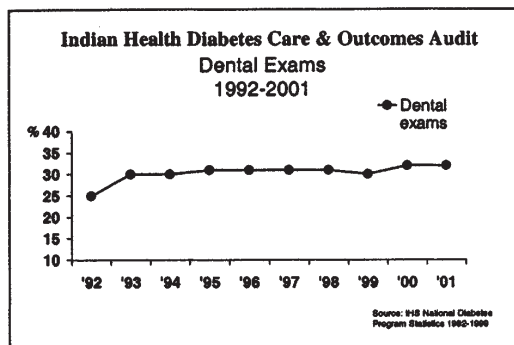
- Assess your local kidney screening programs. Are there unmet needs?
- Identify ways to reach your target populations for annual screening for kidney disease
- Educate people with diabetes and their families about the need for blood pressure control including lifestyle modifications and medications to control blood pressure.
- Implement a “staged kidney management” approach in your clinic, with protocols for education, interventions and management at each stage. The National Kidney Foundation as the Kidney Disease Outcomes Quality Initiative is developing standards of care for chronic kidney disease.
- Provide training in kidney disease screening, treatment and follow-up to all members of the team.
- Promote case management and treatment of other conditions that affect kidney health such as high blood pressure and high blood sugar.

## Indian Health Best Practice Model

### Dental Care for People with Diabetes – Screening, Treatment, and Follow-up

#### Why is this important?

Periodontal (gum) disease poses a serious threat to dental health and is the leading cause of adult tooth loss in the U.S. Periodontal disease is often present before the diagnosis of diabetes. All people with diabetes should have a dental exam at diagnosis and continue with an annual exam that screens for gum disease and other dental problems, thereafter. Taking care of the dental needs of people with diabetes can prevent gum disease and tooth loss.



#### What measures are used?

►The **Indian Health Diabetes Care and Outcomes Audit** measures the number of people with a dental exam within the past year. The graph shows the reported trends in yearly dental exams (for all Indian health clinics reporting audit data).

►The **Healthy People 2010** objective advises that 75 percent of people with diabetes receive an annual dental exam.

#### How does your program compare?

- Find out your clinic audit measures for dental exams during the last few years.
- Write those numbers here: \_\_\_ % FY97 \_\_\_ % FY98 \_\_\_ % FY99  
\_\_\_ % FY2000 \_\_\_ % FY2001
- How do your numbers compare to the Indian health trends?
- How do your numbers compare to the Healthy People 2010 objective?

**If your numbers are low, your diabetes grant program may want to develop a diabetes dental program. Here are some things to consider:**

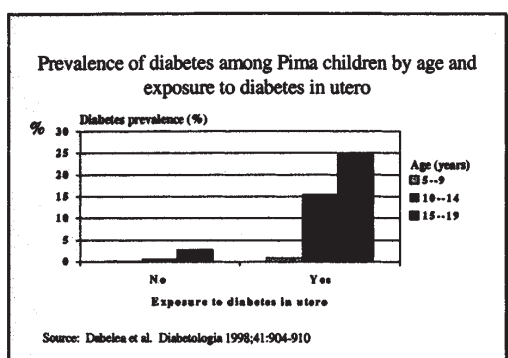
- Assess your local dental care program for people with diabetes. Are there unmet needs?
- Identify ways to increase the number of people who receive yearly dental exams.
- Develop a program that improves access to dental exams, including staffing, (dentists, dental hygienists, assistants) space, equipment and special needs.
- Provide education to people with diabetes and their families about the need for yearly dental exams.
- Provide timely treatment of periodontal (gum) and dental problems, including crowns and bridgework when needed.
- Promote care and treatment of other conditions such as high blood sugar, high blood pressure and tobacco cessation programs.

## Indian Health Best Practice Model

### Pregnancy and Diabetes – Screening, Management and Follow-up

#### Why is this important?

Diabetes in pregnancy poses risks for both mother and baby. Pregnant women with diabetes and their babies are at greater risk for complications during pregnancy than are women without diabetes. Careful management of diabetes during pregnancy, including early screening for gestational diabetes, reduces the risk of complications for mothers and babies. After pregnancy, women who have a history of gestational diabetes and their offspring are at risk for developing type 2 diabetes, obesity, and insulin resistance in later years. Early screening and careful management of diabetes in pregnancy offers the best chance for a healthy mother and baby. Breastfeeding for at least for 2 months may offer some protection against diabetes in the baby.



#### What measures are used?

► Studies in the Pima Indians show the long-term effects of diabetes during pregnancy. This graph shows the percentage of children who developed type 2 diabetes of mothers who had diabetes during pregnancy. The numbers become greater as the youth enter their teen years.

► The **Healthy People 2010** objective is to decrease the proportion of women with gestational diabetes.

#### Diabetes and pregnancy in your community

- Find out your rates of diabetes in pregnancy in your community. What is the trend?
- What are the screening and management practices for diabetes in pregnancy in your clinic?
- What type of follow-up is available for women with gestational diabetes?
- Are support services available for mothers who want to breastfeed?

You may find that your program wants to focus on diabetes in pregnancy. Here are some things to consider:

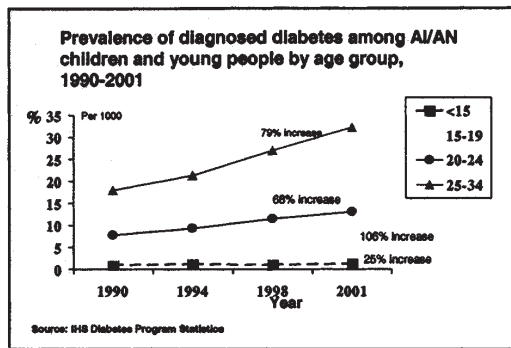
- Develop a program that improves access to pregnancy clinics including staffing, space, equipment, and community-based screening programs.
- Develop diabetes and pregnancy education and awareness programs. Identify ways to reach all women of childbearing age.
- Provide supplies and equipment for blood sugar monitoring.
- Develop programs that provide support, education and reinforcement of lifestyle choices to prevent, manage or treat diabetes in women of childbearing age and their families.
- Establish a multidisciplinary program that includes intense education, management by trained providers, and community involvement. Provide staff training.
- Include community networks that support women and families: preschool programs, feeding programs, Head Start, breast-feeding support groups and WIC.

## Indian Health Best Practice Model

## Type 2 Diabetes in Youth—Prevention and Screening

**Why is this important?**

Type 2 diabetes is occurring with increasing frequency in children and young adults. Although the peak age of occurrence is usually around adolescence, type 2 diabetes has been reported in American Indian children as young as 4 years. Risk factors for type 2 diabetes in children include obesity or being overweight; inactivity; a family history of type 2 diabetes; type 2 diabetes or gestational diabetes in the mother; belonging to a certain ethnic group, including American Indian; and signs of insulin resistance or conditions associated with insulin resistance such as hypertension, high blood lipids, or irregular menses. In addition, **breastfeeding from birth for at least two months has been shown to be protective against the later development of diabetes.**

**What measures are used?**

Finding type 2 diabetes in AI/AN youth is not uncommon. A recent IHS study shows that from 1990-2001:

- ▶ Among AI/AN youth age 15 to 19 years, diabetes increased by 106%;
- ▶ Among AI/AN young adults between 20 and 24 years, diabetes increased by 68%;
- ▶ Among AI/AN young adults age 25 to 34 years, diabetes increased by 79%.

**How does your program compare?**

- ▶ **Look at your diabetes registry. Determine your prevalence rates for type 2 diabetes in youth over the past few years. Look at the registry by age groups, sex and community.**
- ▶ **How do your numbers compare to the Indian health trends?**
- ▶ **Assess your diabetes prevention and screening programs. Are there unmet needs?**

**Your program may want to develop or improve diabetes programs for youth. Here are some things to consider:**

- ▶ Assess your children/youth programs. Encourage information sharing among programs.
- ▶ Develop a screening, tracking and referral program for high-risk children (such as those whose mothers had diabetes during pregnancy).
- ▶ Promote community and family awareness through special programs in schools, camps, tribal events, family health programs, and community gatherings.
- ▶ Provide training programs on type 2 diabetes in youth for health care providers, social service workers, school and camp personnel, and others who work with families.
- ▶ Work with tribal and community leaders, churches, businesses and schools to promote the use of healthy foods and physical activity for all youth in your community.
- ▶ Consider breastfeeding promotion as a primary prevention activity.



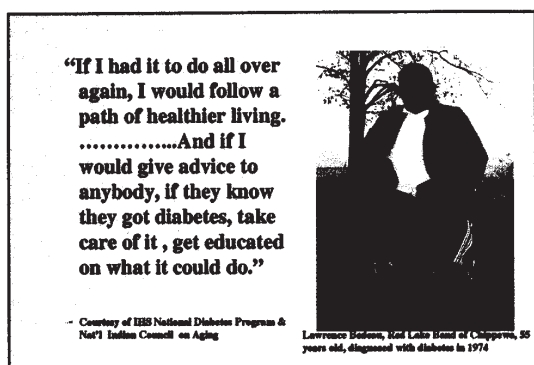
## Indian Health Best Practice Model

### Diabetes Self-Management Education

#### Why is this important?

Diabetes self-management education is a key element of diabetes prevention and treatment. People with diabetes and their families need to learn and practice new lifestyle skills. These skills include monitoring blood sugar, making healthy food choices, being more active and reducing risk for diabetes complications. People with diabetes must be active participants in the educational process, setting learning and behavioral goals that meet his or her physical, emotional, and lifestyle needs.

Incorporating cultural methods of sharing ideas and skills may be the single, best way of helping people with diabetes and their families learn about diabetes self-management practices.



#### What measures are used?

► **The Indian Health Diabetes Care and Outcomes Audit** measures documentation of nutrition, exercise and general diabetes education. Audit trends show that over fifty percent of people with diabetes receive diabetes education each year.

► **The Healthy People 2010** objective advises that 60 percent of people with diabetes receive formal diabetes education.

#### How does your program compare?

- Find out your clinic audit trends for nutrition, exercise and general diabetes education.
- How do your numbers compare to the Healthy People 2010 Objective?
- You can use the Indian Health Integrated Diabetes Education and Care Standards to assess your diabetes education program.

Your diabetes grant program may want to improve diabetes education services within your community. Here are some things to consider:

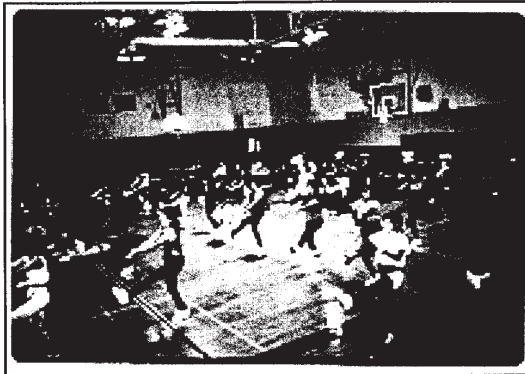
- Assess your diabetes education program. You can use the Indian Health Integrated Diabetes Education and Care Standards as a framework for your assessment, (available through the National Diabetes Program Web site-see below).
- Develop a plan to strengthen your diabetes education program based on community needs.
- Identify ways to reach your target populations. Use a variety of education approaches that work in your community—one-on-one, group classes, support groups, talking circles, cooking classes or activity programs.
- Provide needed resources for quality diabetes education: staffing, materials, training, space, etc.
- Involve spiritual and community networks in educational programs. Use respected ways of teaching tradition, cultural values and behavioral practices. Ask community members to share stories or messages about diabetes.

## Indian Health Best Practice Model

## Nutrition and Physical Fitness Programs for People with Diabetes

**Why is this important?**

Nutrition and physical fitness play major roles in helping people with diabetes and their families stay healthy. Investment of time and resources in nutrition, fitness and lifestyle change promises long-term benefits not only for diabetes, but also in reducing risks for heart disease and promoting overall health. Blending traditional and local nutrition and fitness practices may help with needed lifestyle changes for families and communities.



- ▶ Involve people in the community in planning, staffing, and teaching nutrition and fitness programs.
- ▶ Consider offering programs in schools and work places. Consider offering programs during various times of the day such as after-school, women and infants, elders and other groups.

**Nutrition and fitness in your community**

- ▶ **Look at diabetes rates in your community. What is the trend?**
- ▶ **Look at the diabetes audit measures for overweight and obesity, blood sugar control and other measures that nutrition and fitness programs may impact. What are the trends?**
- ▶ **Look at what program are currently in place. How can you work collaboratively?**

Your diabetes grants program may want to consider a diabetes nutrition and fitness program.

Here are some things to consider:

- ▶ Assess your local nutrition and fitness programs in your community. Are there unmet needs?
- ▶ Facilitate and ensure access to programs including staffing, space, equipment, and off-site facilities for community-based programs.
- ▶ Solicit sponsorship for nutrition and fitness programs from employers, supermarkets, churches, and clubs for young people.
- ▶ Use traditional ways of sharing and learning new information and practices.
- ▶ Train community members as nutrition and fitness leaders.
- ▶ Encourage all nutrition and fitness programs in your community to be collaborative not competitive.

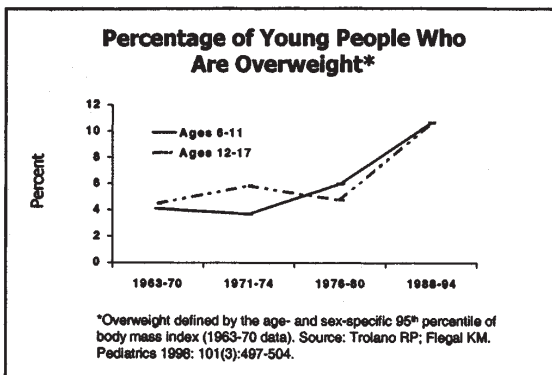


## Indian Health Best Practice Model

## School Health – Physical Activity and Nutrition

**Why is this important?**

The school setting, ranging from preschool to college, can be a successful environment for diabetes prevention activities within the community. Schools can develop effective policies and educational programs that help young people and their families to increase physical activity and to learn and practice healthy eating. Establishing healthy eating and physical activity patterns at a young age is critical. Changing poor eating patterns in adulthood can be difficult.

**What measures are used?**

- ▶ **Type 2 diabetes among adolescents** is linked to the childhood obesity epidemic. According to the American Diabetes Association, more than 85% of all children and adolescents with type 2 diabetes are seriously overweight at the time of diagnosis. The graph shows the increasing percentage of young people who are overweight.
- ▶ Nutrition and physical activity patterns contribute to obesity. More than 84% of young people in the U.S. eat too much fat, and more than 91% eat too much saturated fat. Nearly half of American youth, 12-21 years, are not active.

- ▶ Implement a curriculum that focuses on increased physical activity and healthy eating.
- ▶ Establish non-competitive and competitive physical activity programs for all ages and abilities. Consider after school, summer and family activity programs.
- ▶ The **Healthy People 2010** objective specifies that 90 percent of children and youth receive school health education on increase physical activity and 95 percent receive education on healthy dietary patterns.

**Your Community**

- ▶ **How many of your schools provide healthy eating and physical activity education programs?**
- ▶ **Write those numbers in here:** \_\_\_ Preschool  
\_\_\_ Elementary \_\_\_ Jr. High \_\_\_ High School

**If your numbers are low, your diabetes grant program may want to focus on a school health program. Here are some things to consider:**

- ▶ Assess your local schools. Involve the parents, school staff and community by establishing a school health advisory council to develop a program that works for all.
- ▶ Support parents and caregivers by providing guidance in parenting skills along with tools that encourage healthy eating habits and physical activity.
- ▶ Work with your schools to offer meals and snacks low in fat, sodium, and added sugars.
- ▶ Provide training to teachers and food service staff on obesity and its consequences; especially type 2 diabetes of children and adolescents.



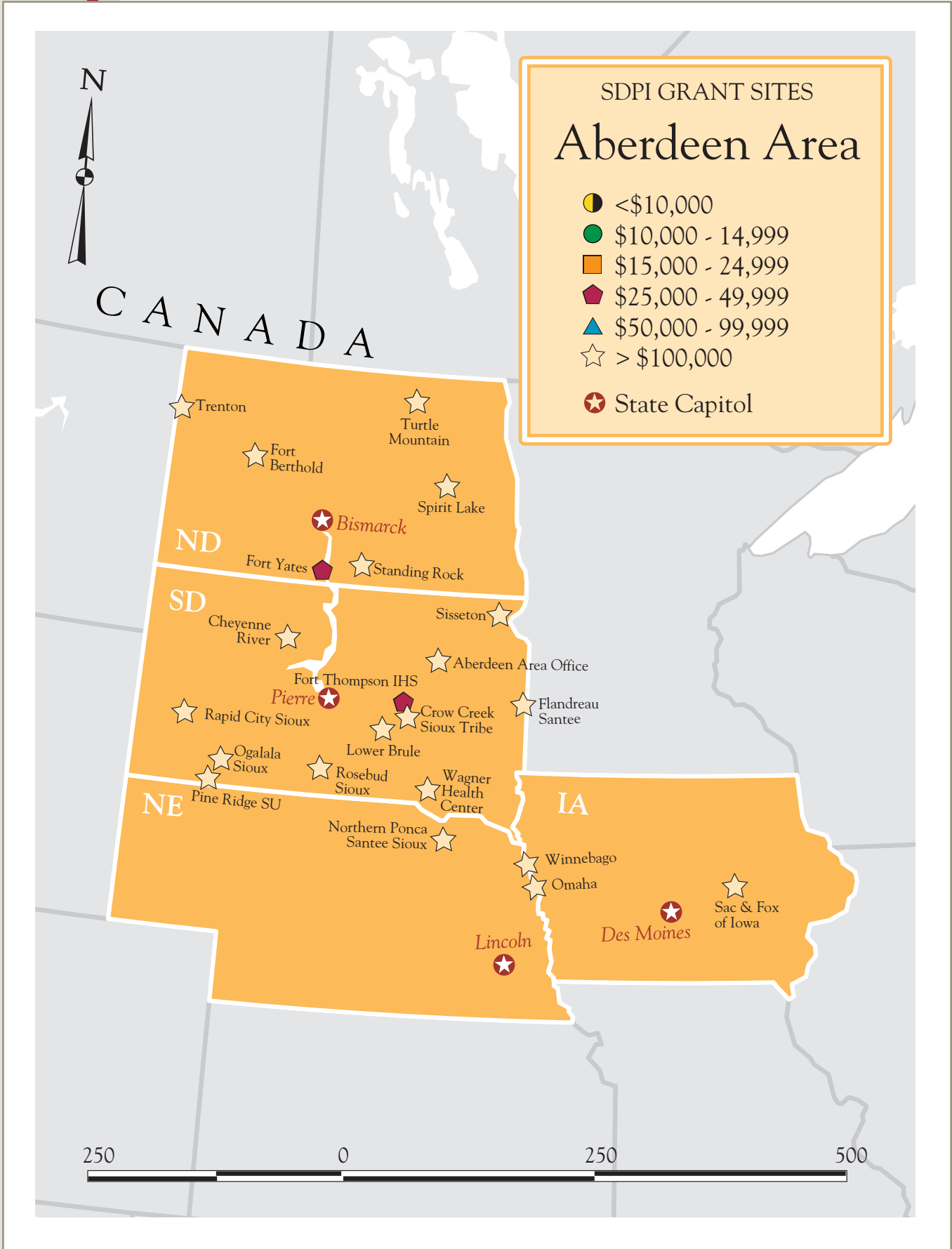
# Appendix IV

## GRANT PROGRAMS BY AREA

SUMMARY OF YR. 01-06 - AWARDED TO T/I/U														
AREA	1997-1998		1998-1999		1999-2000		2000-2001			2001-2002			2002-2003	
	Yr 1	Yr 2	Yr 3	Yr 4	Yr 4	TOTAL	Yr 5	Yr 5	TOTAL	Yr 6	GRAND TOTAL			
	BBA Amt	BBA Amt	BBA Amt	BBA Amt	Supplement	BBA/Supplmt	BBA Amt	CAA AMT	BBA/CAA	CAA				
ABERDEEN	3,163,974	3,163,974	3,130,725	3,130,725	5,832,496	8,963,221	3,130,725	5,534,594	8,896,319	8,695,319	36,013,532			
ALASKA	2,816,838	2,816,838	2,783,589	2,783,589	5,287,865	8,071,454	2,986,900	5,831,198	8,818,098	8,234,947	33,541,764			
ALBUQUERQUE	2,274,460	2,274,460	2,241,204	2,236,103	4,743,134	6,979,237	2,395,559	4,237,791	6,781,686	6,724,242	27,275,289			
BEMIDJI	2,298,507	2,298,507	2,298,507	2,239,564	5,119,020	7,358,584	2,265,348	4,879,742	7,145,090	7,145,050	28,544,245			
BILLINGS	1,709,497	1,709,496	1,676,247	1,485,523	3,105,673	4,674,144	1,593,300	3,213,101	5,393,636	4,806,401	19,969,421			
CALIFORNIA	1,107,729	1,570,591	1,523,245	1,523,245	3,385,873	4,909,118	1,521,765	3,861,006	5,388,771	5,388,371	19,887,825			
NASHVILLE	1,443,864	1,443,859	1,404,462	1,408,547	2,853,330	4,261,877	1,325,677	3,071,938	4,397,615	4,374,871	17,326,548			
NAVAJO	4,320,747	4,320,747	4,287,498	4,287,498	8,657,490	12,944,988	3,874,278	9,039,985	12,914,263	12,914,263	51,702,506			
OKLAHOMA	4,787,735	4,787,735	4,754,486	4,653,752	10,834,273	15,807,468	4,714,930	11,171,298	15,974,238	16,459,656	62,571,318			
PHOENIX	3,798,793	3,798,793	3,765,544	3,682,641	7,645,248	11,582,794	3,713,525	7,691,200	11,523,890	11,523,886	45,993,700			
PORTLAND	1,592,172	1,592,172	1,558,473	1,570,087	3,151,544	4,889,002	1,558,522	3,391,488	4,992,408	4,950,035	19,574,262			
TUCSON	769,542	674,156	736,293	736,293	1,545,367	2,281,660	736,293	1,596,538	2,332,831	2,332,831	9,127,313			
URBAN	1,500,000	1,500,000	1,438,516	1,396,207	3,326,169	4,910,000	1,483,469	3,500,000	5,088,192	5,086,572	19,523,280			
<b>TOTAL</b>	<b>31,583,858</b>	<b>31,951,328</b>	<b>31,598,789</b>			<b>97,633,547</b>			<b>99,647,037</b>	<b>98,636,444</b>	<b>391,051,003</b>			

APPENDIX

Grant Programs  
by Area



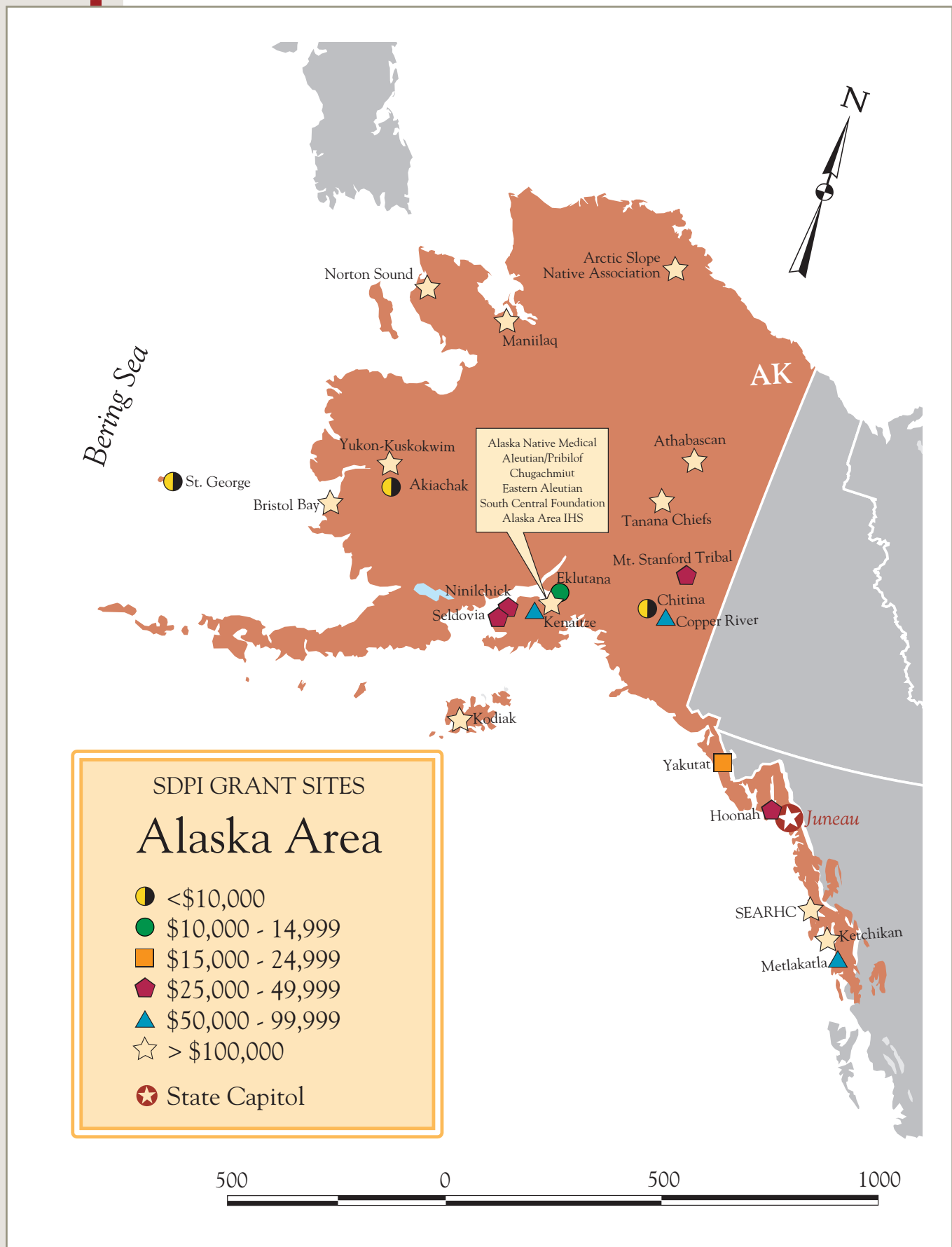


SUMMARY OF YR. 1-6

GRANTS FOR SPECIAL DIABETES PROGRAM FOR INDIANS - ABERDEEN AREA

Tribe IHS Urban	NEW GRANT NUMBER	FORMER GRANT Number	GRANTEE	AWARD 1997-1998			AWARD 1998-1999			AWARD 1999-2000			AWARD 2000-2001			AWARD 2001-2002			AWARD 2002-2003	
				Yr 1 BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 1 BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 4 BBA Amt	Yr 4 Supple- ment	TOTAL BBA/ Suppl	Yr 5 BBA Amt	Yr 5 CAA Amt	TOTAL BBA/ CAA	Yr 6 CAA Amt	GRAND TOTAL			
Tribe	H1D9400024	45HD00001	Cheyenne River, Eagle Butte	172,007	172,007	172,007	172,007	341,629	513,636	172,007	322,151	494,158	494,158	2,017,973						
IHS	H1D9400369	45HD00002	Crow Creek/Ft.Thompson	134,012	134,012	134,012	134,012	229,562	363,574	134,012	219,507	353,519	353,519	1,472,648						
IHS	H1D9400408		Ft. Thompson SU									30,000	30,000	60,000						
Tribe	H1D9400133	45HD00003	Spirit Lake	174,170	174,170	174,170	174,170	252,794	426,964	174,170	240,786	414,956	414,956	1,779,386						
Tribe	H1D9400025	45HD00004	Flandreau Santee	116,058	116,058	116,058	116,058	154,039	270,097	116,058	150,335	266,393	266,393	1,151,057						
Tribe	H1D9400026	45HD00005	Lower Brule	128,911	128,911	128,911	128,911	167,588	296,499	128,911	162,745	291,656	291,656	1,266,544						
Tribe	H1D9400027	45HD00006	Ponca of Nebraska, Niobrara	102,910	102,910	102,910	102,910	151,824	254,734	102,910	148,307	251,217	251,217	1,065,898						
Tribe	H1D9400028	45HD00007	Oglala Sioux, Pine Ridge	313,716	313,716	313,716	313,716	771,405	1,085,121	313,716	715,785	1,029,501	1,029,501	4,085,271						
Tribe	H1D9400029	45HD00008	Omaha Tribe of NB, Macy	135,478	135,478	135,478	135,478	257,933	393,411	135,478	245,493	380,971	380,971	1,561,787						
IHS	H1D9400101	45HD00009	Rapid City Hosp., Rapid City	202,570	202,570	202,570	202,570	412,568	615,138	202,570	387,124	589,694	589,694	2,402,236						
Tribe	H1D9400030	45HD00010	Rosebud Sioux	205,122	205,122	205,122	205,122	506,880	712,002	205,122	473,506	678,628	678,628	2,684,624						
Tribe	H1D9400154	45HD00011	Sac & Fox of Iowa, Tama	106,141	106,141	106,141	106,141	139,711	245,852	106,141	137,212	243,353	243,353	1,050,981						
Tribe	H1D9400031	45HD00012	Santee Sioux, Niobrara	109,026	109,026	109,026	109,026	154,204	263,230	109,026	150,486	259,512	259,512	1,109,332						
Tribe	H1D9400235	45HD00013	Sisseton-Wahpeton	153,686	153,686	153,686	153,686	271,764	425,450	153,686	258,161	411,847	405,847	1,704,202						
IHS	H1D9400407		Sisseton SU									21,000	6,000	27,000						
Tribe	H1D9400325	45HD00014	Standing Rock	259,483	259,483	259,483	259,483	371,976	631,459	259,483	349,945	609,428	572,428	2,591,764						
IHS	H1D9400155	45HD00015	Ft. Berthold SU	171,753	171,753	171,753	171,753	320,999	492,752	171,753	303,255	475,008	475,008	1,958,027						
Tribe	H1D9400033	45HD00016	Trenton Svc Area	110,006	110,006	110,006	110,006	151,257	261,263	110,006	147,788	257,794	257,794	1,106,869						
Tribe	H1D9400161	45HD00017	Turtle Mountain	184,562	184,562	184,562	154,562	437,833	592,395	184,562	446,901	631,463	481,463	2,259,007						
IHS	H1D9400390		Quentin N. Burdick				30,000	40,000	70,000				150,000	220,000						
Tribe	H1D9400278	45HD00018	Winnebago Tribe	140,030	140,030	140,030	140,030	260,600	400,630	140,030	247,935	387,965	387,965	1,596,650						
IHS	H1D9400102	45HD00019	Wagner Health Center	128,180	128,180	128,180	128,180	237,930	366,110	128,180	227,172	355,352	355,352	1,461,354						
IHS	H1D9400172	45HD00020	Aberdeen Area	116,153	116,153	82,904	82,904	200,000	282,904	82,904	200,000	282,904	282,904	1,163,922						
IHS	H1D9400410		Pine Ridge SU									180,000	180,000							
IHS	H1D9400416		Ft. Yates SU										37,000	37,000						
<b>TOTAL</b>				<b>3,163,974</b>	<b>3,163,974</b>	<b>3,130,725</b>			<b>8,963,221</b>			<b>8,896,319</b>	<b>8,695,319</b>	<b>36,013,532</b>						

13 awarded in South Dakota  
 7 awarded in North Dakota  
 3 awarded in Nebraska  
 2 awarded in Iowa





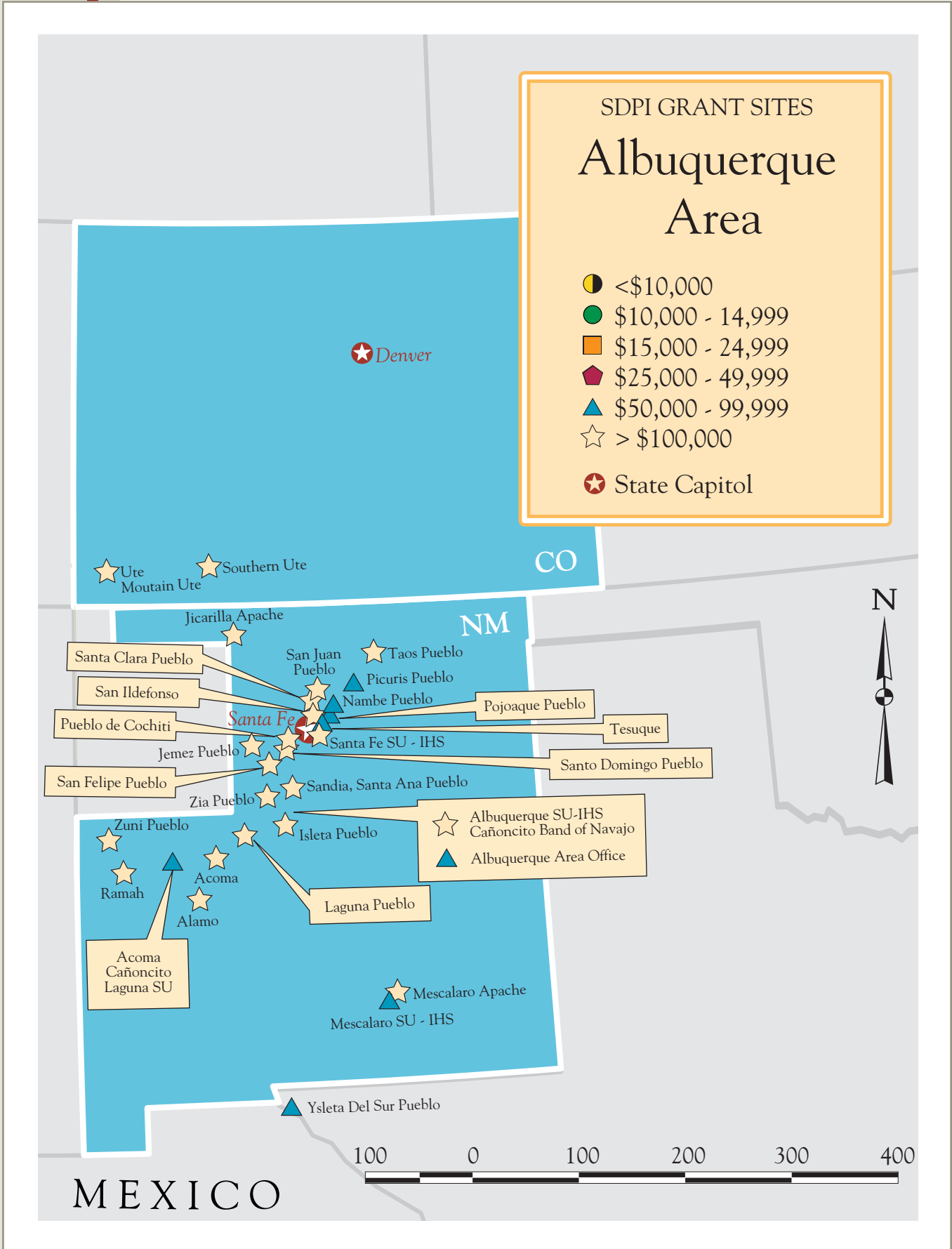
SUMMARY OF YR 1-6

GRANTS FOR SPECIAL DIABETES PROGRAM FOR INDIANS - ALASKA AREA

Tribe	NEW GRANT NUMBER	FORMER GRANT NUMBER	GRANTEE	AWARD 1997-1998			AWARD 1998-1999			AWARD 1999-2000			AWARD 2000-2001			AWARD 2001-2002			AWARD 2002-2003		GRAND TOTAL	
				YR 01	YR 02	YR 03	YR 01	YR 02	YR 03	YR 04	YR 04	TOTAL	YR 05	YR 05	TOTAL	YR 06	YR 06					
				BBA AMT	BBA AMT	BBA AMT	BBA AMT	BBA AMT	BBA AMT	Supplement	BBA AMT	BBA AMT	CAA AMT	BBA/CAA	CAA AMT	CAA AMT						
Tribes	H1D9400063	59HD00001	Akiachak	9,383	9,383	9,272	9,272	9,272	9,272	9,272	9,272	9,272	9,272	9,272	9,272	9,272	9,272	9,272	9,272	9,272	37,310	
IHS	H1D9400265	59HD00002	ANTHC	299,601	299,601	296,061	296,061	296,061	296,061	296,061	300,000	596,061	296,061	300,000	596,061	296,061	300,000	596,061	596,061	2,683,446		
Tribes	H1D9400146	59HD00003	Aleutian/Pribilof Is.	82,015	82,015	45,264	45,264	45,264	45,264	74,604	119,868	45,264	68,992	114,256	45,264	68,992	114,256	114,256	114,256	557,674		
Tribes	H1D9400366	59HD00004	Artic Slope Native Assoc	91,707	91,707	90,625	90,625	90,625	181,775	272,400	90,625	187,762	278,387	278,387	1,103,213							
Tribes	H1D9400148	59HD00005	Athabaskan	37,143	37,143	36,705	36,705	36,705	68,305	105,010	249,288	438,354	687,642	104,609	1,008,252							
Tribes	H1D9400099	59HD00006	Bristol Bay	252,265	252,265	249,288	249,288	249,288	449,001	698,289	249,288	438,354	687,642	687,642	2,827,391							
Tribes	H1D9400064	59HD00009	Chugachmiut	50,245	50,245	49,652	49,652	49,652	98,395	148,047	49,652	101,039	150,691	150,691	599,571							
Tribes	H1D9400350	59HD00010	Copper River	34,971	34,971	34,558	34,558	34,558	55,797	90,355	34,558	50,895	85,453	85,453	365,761							
Tribes	H1D9400368	59HD00012	Eastern Aleutian			35,783	35,783	35,783	63,499	99,282	35,783	61,465	97,248	97,248	329,561							
Tribes	H1D9400065	59HD00013	Eklutna	4,416	4,416	4,364	4,364	4,364	8,257	12,621	4,364	8,282	12,646	12,646	51,109							
Tribes	H1D9400066	59HD00015	Hoonah	10,120	10,120	10,001	10,001	10,001	17,939	27,940	10,001	17,472	27,473	27,473	113,127							
Tribes	H1D9400338	59HD00017	Kenaitze	26,586	26,586	26,272	26,272	26,272	54,604	80,876	26,272	57,472	83,744	83,744	327,690							
Tribes	H1D9400067	59HD00018	Ketchikan	34,559	43,732	43,216	43,216	84,194	127,410	43,216	85,727	128,943	128,943	506,803								
Tribes	H1D9400294	59HD00020	Kodiak	73,452	73,452	72,585	72,585	142,657	215,242	72,585	145,893	218,478	218,478	871,687								
Tribes	H1D9400342	59HD00022	Maniilaq	192,152	192,152	189,884	189,884	368,152	558,036	189,884	373,939	563,823	563,823	2,259,870								
Tribes	H1D9400068	59HD00023	Metlakatla	27,431	27,431	27,107	27,107	43,173	70,280	27,107	39,012	66,119	66,119	284,487								
Tribes	H1D9400069	59HD00024	Mt. Stanford	11,101	11,101	10,970	10,970	21,189	32,159	10,970	21,481	32,451	32,451	130,233								
Tribes	H1D9400070	59HD00025	Nimilchick	8,121	8,121	8,025	8,025	16,367	24,392	8,025	17,041	25,066	25,066	98,791								
Tribes	H1D9400274	59HD00026	Norton Sound	211,718	211,718	209,219	209,219	369,402	578,621	209,219	356,518	565,737	565,737	2,342,750								
Tribes	H1D9400240	59HD00027	SEARHC	294,970	285,797	282,425	282,425	506,593	789,018	282,425	493,419	775,844	775,844	3,203,898								
Tribes	H1D9400071	59HD00028	Seldovia	11,405	11,405	11,270	11,270	20,210	31,480	11,270	19,681	30,951	30,951	127,462								
Tribes	H1D9400293	59HD00029	Southcentral	206,706	206,706	204,266	204,266	834,698	1,038,964	204,266	1,074,069	1,278,335	1,278,335	4,213,312								
Tribes	H1D9400135	59HD00032	Tanana Chiefs	299,613	299,613	296,077	296,077	550,976	847,053	296,077	547,740	843,817	843,817	3,429,990								
Tribes	H1D9400266	59HD00035	Yakutat	7,642	7,642	7,552	7,552	13,546	21,098	7,552	13,194	20,746	20,746	85,426								
Tribes	H1D9400362	59HD00036	Yukon-Kuskokwim	539,516	539,516	533,148	533,148	944,532	1,477,680	533,148	913,397	1,446,545	1,446,545	5,982,950								
Tribes	59HD00007		Chickaloon																			
Tribes	59HD00011		Diomedes																			
Tribes	59HD00014		Fairbanks Native Assoc																			
Tribes	59HD00016		Karluk																			
Tribes	59HD00019		Knik																			
Tribes	59HD00021		Kwinhagak																			
Tribes	59HD00031		Tanana																			
Tribes	H1D5900362	59HD00033	Tyonek																			
Tribes	59HD00034		Valdez																			
<b>TOTAL</b>				<b>2,816,838</b>	<b>2,816,838</b>	<b>2,783,589</b>				<b>8,071,454</b>			<b>8,818,098</b>	<b>8,234,947</b>	<b>33,541,764</b>							

24 Awarded in Alaska









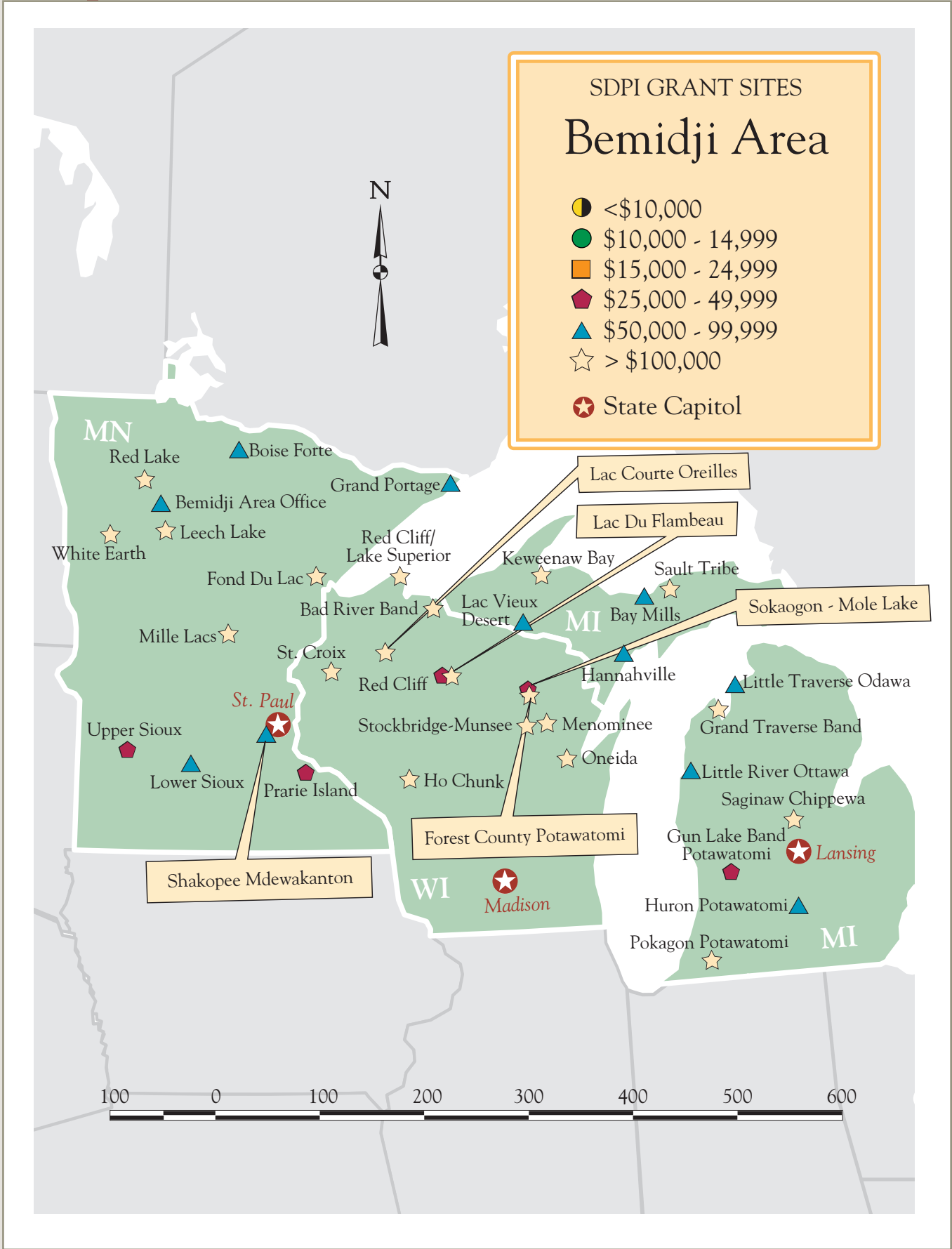
**SUMMARY OF YR 1-6 GRANTS FOR SPECIAL DIABETES PROGRAM FOR INDIANS - ALBUQUERQUE AREA**

Tribe IHS Urban	NEW GRANT NUMBER	FORMER GRANT NUMBER	GRANTEE	AWARDED 1997-1998			AWARDED 1998-1999			AWARDED 1999-2000			AWARDED 2000-2001			AWARDED 2001-2002			AWARDED 2002-2003		GRAND TOTAL	
				Yr 1 BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 4 BBA Amt	Yr 4 Supple- ment	Yr 4 BBA/ Suppl	Yr 5 BBA Amt	Yr 5 CAA Amt	Yr 5 BBA/ CAA	Yr 6 CAA Amt	Yr 6 CAA Amt								
Tribe	H1D9400165	53HD00001	Acoma	78,077	78,077	78,077	78,077	173,011	251,088	78,077	162,811	240,888	240,888	967,095								
Tribe	H1D9400365	53HD00002	Canoncito/AAIHB	51,081	51,081	51,081	new grant numbers & name			new grant numbers & name			153,243									
Tribe	H1D9400124	53HD00003	Laguna	105,290	105,290	105,290	105,290	269,227	374,517	105,290	218,902	324,192	324,192	1,338,771								
Tribe	H1D9400125	53HD00004	Alamo Navajo	109,033	109,033	109,033	109,033	301,742	410,775	109,033	285,159	394,192	394,634	1,526,700								
Tribe	H1D9400052	53HD00005	Isleta	186,706	186,706	186,706	186,706	516,779	703,485	186,706	488,119	674,825	674,825	2,613,253								
Tribe	H1D9400053	53HD00006	Jemez	138,415	138,415	138,415	138,415	381,194	519,609	138,415	361,610	500,025	500,025	1,934,904								
IHS	H1D9400145	53HD00025	Albuquerque SU	255,976	255,976	255,976	255,976	292,334	548,310	255,976	276,369	532,345	150,000	1,998,583								
Tribe		53HD00008	Santa Ana										171,264	171,264								
Tribe		53HD00009	Zia										211,081	211,081								
Tribe	H1D9400054	53HD00007	Sandia	39,889	39,889	39,889	39,889	111,272	151,161	39,889	104,922	144,811	144,811	560,450								
Tribe	H1D9400055	53HD00010	Jicarilla	78,956	78,956	78,956	78,956	174,769	253,725	78,956	164,569	243,525	243,525	977,643								
Tribe	H1D9400056	53HD00011	Mescalero	78,419	78,419	78,419	78,419	173,695	252,114	78,419	163,495	241,914	241,914	971,199								
Tribe	H1D9400118	53HD00012	Nambe	27,263	27,263	27,263	27,263	58,740	86,003	27,263	56,191	83,454	89,580	340,826								
Tribe	H1D9400292	53HD00013	Picuris	19,626	19,626	19,626	24,727	53,668	78,395	24,727	51,119	75,846	75,846	288,965								
Tribe	H1D9400119	53HD00014	Pojoaque	21,457	21,457	21,457	21,457	60,323	81,780	26,558	53,949	80,507	80,507	307,165								
Tribe	H1D9400126	53HD00015	San Felipe	62,750	62,750	62,750	77,033	170,923	247,956	77,033	160,723	237,756	237,756	911,718								
Tribe	H1D9400163	53HD00017	Santo Domingo	83,935	83,935	83,935	103,319	227,709	331,028	103,319	214,960	318,279	318,279	1,219,391								
Tribe	H1D9400057	53HD00018	Taos	49,040	49,040	49,040	60,262	133,167	193,429	59,402	126,376	185,778	185,778	712,105								
Tribe	H1D9400058	53HD00019	Southern Ute	61,907	61,907	61,907	61,907	136,457	198,364	61,907	128,806	190,713	190,713	765,511								
Tribe	H1D9400127	53HD00020	Ute Mt. Ute	84,231	84,231	84,231	84,231	185,319	269,550	84,231	175,119	259,350	259,350	1,040,943								
Tribe	H1D9400059	53HD00021	Ysleta del Sur, TX	31,090	31,090	31,090	31,090	66,394	97,484	31,090	63,845	94,935	94,935	380,624								
Tribe	H1D9400060	53HD00022	Ramah	69,973	69,973	69,973	69,973	152,589	222,562	69,973	144,938	214,911	214,911	862,303								
Tribe	H1D9400061	53HD00023	Zuni	194,546	194,546	194,546	194,546	427,020	621,566	194,546	404,071	598,617	598,617	2,402,438								
Tribe	H1D9400168	53HD00024	A-C-L-SU	37,537	37,537	37,537	37,537	27,556	65,093	37,537	52,975	90,512	90,512	358,728								
IHS	H1D9400128	53HD00026	Mescalero SU	18,451	18,451	18,451	18,451	39,008	57,459	18,451	37,735	56,186	56,186	225,184								
IHS	H1D9400062	53HD00027	Santa Fe SU	274,658	226,478	274,658	160,165	258,873	419,038	274,658		274,658	13,279	1,482,769								
Tribe	H1D9400377	53HD00016	San Juan (SFSU)		48,180		59,402	131,447	190,849	59,402	123,796	183,198	183,198	605,425								
IHS	H1D9400166	53HD00028	Albuq.Area/ADSA	116,154	116,154	82,898	82,898		82,898	82,898		82,898	82,898	563,900								
Tribe	H1D9400365		Canoncito Band of NV				51,081	128,962	180,043	51,081	130,917	181,998	181,998	544,039								
Tribe	H1D9400401		Santa Clara									148,336	148,336	296,672								
Tribe	H1D9400388		Cochiti Tribe					90,956	90,956		40,722	86,315	127,037	345,030								
Tribe	H1D9400414-01		Tesuque										93,836	93,836								
Tribe	H1D9400415		San Ildefonso										103,531	103,531								
<b>TOTAL</b>				<b>2,274,460</b>	<b>2,274,460</b>	<b>2,241,204</b>	<b>6,979,237</b>			<b>6,781,686</b>			<b>6,724,242</b>	<b>27,275,289</b>								

2 awarded in Colorado  
 1 awarded in Texas  
 30 awarded in New Mexico

APPENDIX

Grant Programs  
 by Area—  
 Albuquerque

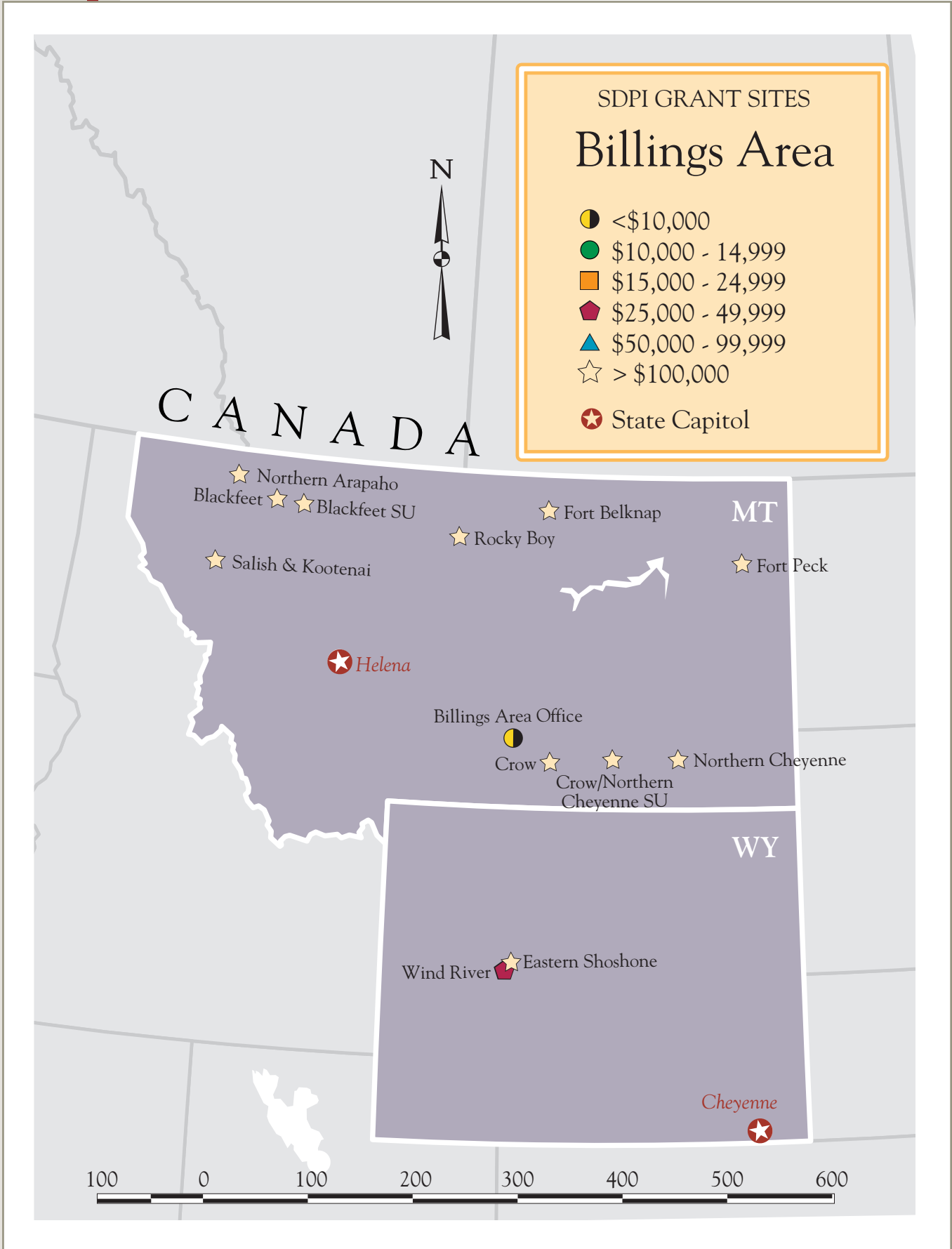




**SUMMARY OF YR 1-6 GRANTS FOR SPECIAL DIABETES PROGRAM FOR INDIANS - BEMIDJI AREA**

Tribe IHS Urban	NEW GRANT NUMBER	FORMER GRANT NUMBER	GRANTEE	AWARDED			AWARDED			AWARDED			AWARDED		GRAND TOTAL
				1997-1998	1998-1999	1999-2000	2000-2001		TOTAL	2001-2002		TOTAL	2002-2003		
				Yr 1 BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 4 BBA Amt	Yr 4 Supple- ment	TOTAL BBA/ Suppl	Yr 5 BBA Amt	Yr 5 CAA Amt	TOTAL BBA/ CAA	Yr 6 CAA Amt	Yr 6 CAA Amt	
Tribe	H1D9400248	46HD00001	Leech Lake	185,365	187,050	187,050	181,740	468,350	650,090	212,341	457,419	669,760	684,530	2,563,845	
Tribe	H1D9400103	46HD00002	Red Lake	150,040	151,400	151,400	147,100	382,890	529,990	169,506	365,144	534,650	528,730	2,046,210	
Tribe	H1D9400104	46HD00003	White Earth	158,890	160,320	160,320	155,780	418,330	574,110	188,249	405,521	593,770	607,250	2,254,660	
Tribe	H1D9400267	46HD00004	Oneida T-III	159,640	161,090	161,090	156,510	426,210	582,720	189,305	407,795	597,100	597,990	2,259,630	
Tribe	H1D9400105	46HD00005	Menominee	140,360	141,630	141,630	137,620	359,740	497,360	161,244	347,346	508,590	513,630	1,943,200	
Tribe	H1D9400034	46HD00006	Ho-Chunk	61,000	61,560	61,560	59,810	170,420	230,230	80,132	172,618	252,750	262,570	929,670	
Tribe	H1D9400137	46HD00007	Bay Mills	38,150	38,410	38,410	37,400	78,260	115,660	30,445	65,585	96,030	98,740	425,400	
Tribe	H1D9400254	46HD00008	Grand Portage	31,000	31,140	31,140	30,390	43,620	74,010	16,767	36,123	52,890	52,900	273,080	
Tribe	H1D9400255	46HD00009	Bad River	42,580	42,930	42,930	41,750	96,840	138,590	41,019	88,361	129,380	128,210	524,620	
Tribe	H1D9400336	46HD00010	St. Croix	41,540	41,860	41,860	40,730	95,880	136,610	39,132	84,298	123,430	124,990	510,290	
Tribe		46HD00011	GLITC(Red Cliff)*	40,040										40,040	
Tribe	H1D9400346	46HD00012	Lac Courte Oreilles	70,740	71,380	71,380	69,350	167,970	237,320	75,497	162,633	238,130	236,130	925,080	
Tribe	H1D9400140	46HD00013	Lac du Flambeau	54,930	55,420	55,420	53,850	145,090	198,940	61,313	132,077	193,390	195,410	753,510	
Tribe	H1D9400336	46HD00014	Upper Sioux	29,450	29,570	29,570	28,879	37,940	66,819	13,969	30,091	44,060	44,390	243,859	
Tribe	H1D9400385	46HD00015	Lower Sioux					44,330	44,330	17,551	37,809	55,360	55,970	155,660	
Tribe	H1D9400256	46HD00016	Prairie Island	29,230	29,350	29,350	28,660	45,530	74,190	16,369	35,261	51,630	47,260	261,010	
Tribe	H1D9400382	46HD00017	Shakopee/Prior Lake				30,180	49,200	79,380	16,816	36,224	53,040	54,380	186,800	
Tribe	H1D9400126	46HD00018	Boise Forte	37,190	37,440	37,440	36,460	97,470	133,930	31,276	67,374	98,650	94,680	439,330	
Tribe	H1D9400107	46HD00019	Keweenaw Bay/L'Anse	46,070	46,460	46,460	46,460	98,970	145,430	43,435	93,565	137,000	139,290	560,710	
Tribe	H1D9400250	46HD00020	Little River Ottawa	30,840	30,970	30,970	Did not Apply, funding to Bemidji Data			19,200	41,360	60,560	59,870	213,210	
Tribe	H1D9400347	46HD00021	Little Traverse Odawa	35,140	35,350	35,350	34,450	61,310	95,760	24,558	52,902	77,460	81,430	360,490	
Tribe	H1D9400268	46HD00022	Nottawaseppi Huron	31,800	31,950	31,950	31,170	47,610	78,780	18,033	38,847	56,880	56,260	287,620	
Tribe	H1D9400257	46HD00023	Stockbridge-Munsee	47,150	47,570	47,570	47,570	96,130	143,700	41,066	88,464	129,530	138,100	553,620	
Tribe	H1D9400258	46HD00024	Saginaw/Mt. Plst.	47,580	48,000	48,000	46,650	106,020	152,670	47,994	103,386	151,380	157,830	605,460	
Tribe	H1D9400106	46HD00025	Sokaogon/Mole Lk.	30,940	31,070	31,070	30,330	42,950	73,280	15,120	32,570	47,690	45,530	259,580	
Tribe	H1D9400337	46HD00026	Forest County Pot.	34,300	34,500	34,500	33,630	71,520	105,150	31,244	67,306	98,550	103,780	410,780	
Tribe	H1D9400037	46HD00027	Hannahville/MI Pot.	35,700	35,920	35,920	35,000	67,200	102,200	27,389	59,001	86,390	84,350	380,480	
Tribe	H1D9400259	46HD00028	Lac Vieux Desert	30,040	30,160	30,160	29,450	44,820	74,270	16,033	34,537	50,570	51,420	266,620	
Tribe	H1D9400296	46HD00029	Pokagon Potawatomi	39,450	39,730	39,730	38,680	78,970	117,650	32,327	69,443	101,770	100,170	438,500	
Tribe	H1D9400109	46HD00030	Fond Du Lac T-III	137,690	138,940	138,940	135,000	364,680	499,680	155,899	335,831	491,730	444,370	1,851,350	
Tribe	H1D9400038	46HD00031	Sault Ste Marie T-III	258,540	260,880	260,880	253,480	548,550	802,030	246,208	530,372	776,580	768,410	3,127,320	
Tribe	H1D9400108	46HD00032	Grand Traverse T-III	42,290	42,620	42,620	41,460	80,700	122,160	41,929	90,321	132,250	136,760	518,700	
Tribe	H1D9400181	46HD00033	Mille Lacs T-III	47,090	47,510	47,510	46,170	155,150	201,320	70,225	151,275	221,500	216,810	781,740	
IHS	H1D9400085	46HD00034	Bemidji Area	133,742	115,987	115,987	114,595	43,660	158,255	26,283	56,617	82,900	82,898	689,769	
Tribe	H1D4600260		Red Cliff/Lake Super		40,340	40,340	39,260	82,710	121,970	34,811	74,989	109,800	110,360	422,810	
Tribe	H1D9400403		MEBNSW (Gun Lake)							12,663	27,277	39,940	39,652	79,592	
<b>TOTAL</b>				<b>2,298,507</b>	<b>2,298,507</b>	<b>2,298,507</b>	<b>7,358,584</b>			<b>7,145,090</b>		<b>7,145,090</b>	<b>7,145,050</b>	<b>28,544,245</b>	

12 awarded in Minnesota  
 13 awarded in Michigan  
 11 awarded in Wisconsin





## SUMMARY OF YR 1-6

## GRANTS FOR SPECIAL DIABETES PROGRAM FOR INDIANS - BILLINGS AREA

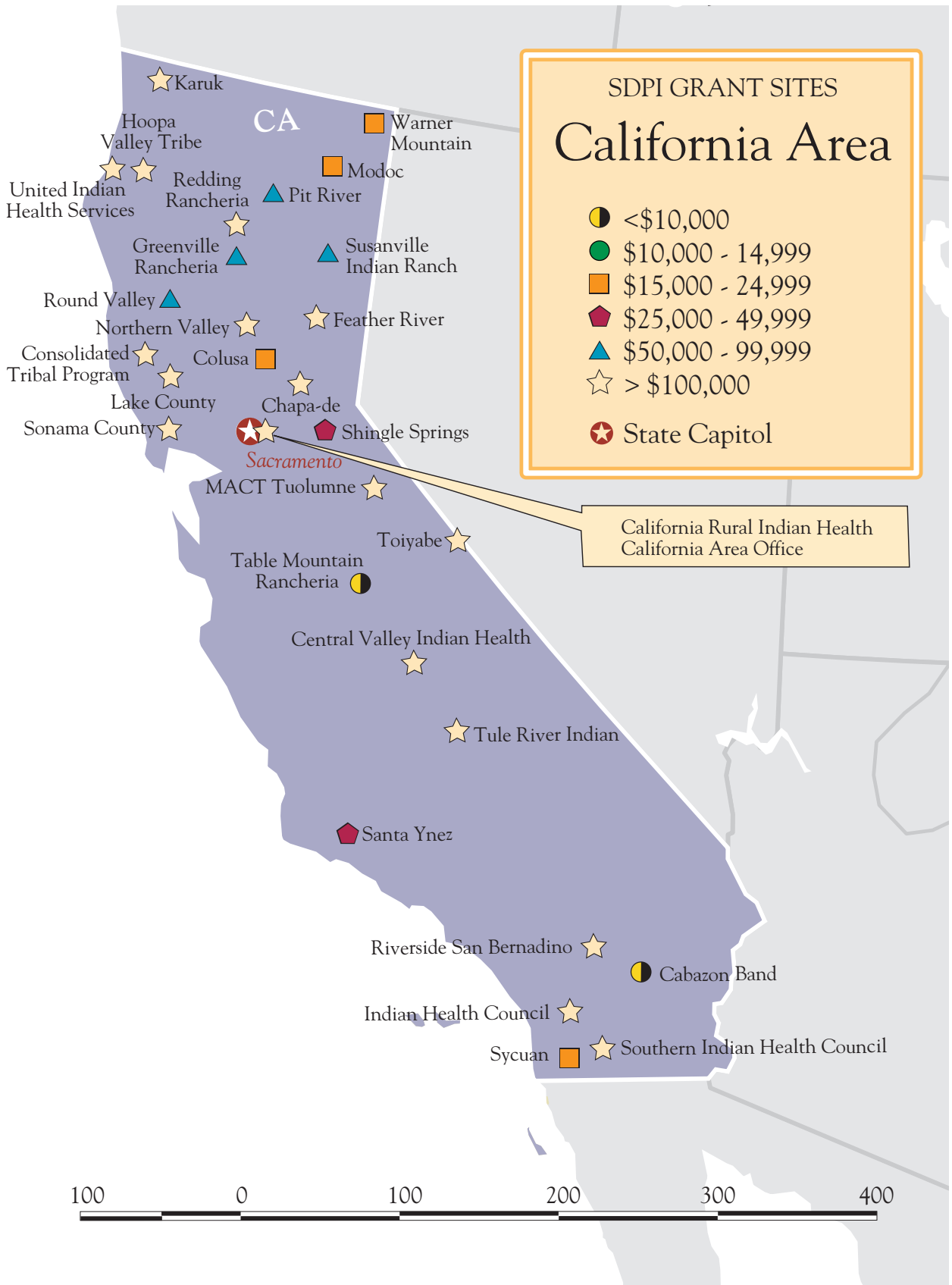
TRIBE	NEW GRANT NUMBER	FORMER GRANT NUMBER	GRANTEE	AWARDED			AWARDED			AWARDED			AWARDED		GRAND TOTAL
				1997-1998	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003	Yr 4	Yr 5	Yr 6			
IHS	URBAN			Yr BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 4 BBA Amt	Yr 4 Supple- ment	TOTAL BBA/ Suppl	Yr 5 BBA Amt	Yr 5 CAA Amt	TOTAL BBA/ CAA	Yr 6 CAA Amt		
Tribe	H1D9400253	47HD00001	Blackfeet Tribal	271,300	271,300	271,300	209,300	609,355	818,655	271,300	526,092	797,392	576,696	3,006,643	
IHS	H1D9400386		Blackfeet Service Unit									143,608	220,696	364,304	
Tribe	H1D9400138	47HD00002	Crow Tribal	264,500	264,500	264,500	264,500	353,988	618,488	264,500	557,986	822,486	489,286	2,723,760	
IHS	H1D9400391		Crow/N. Cheyenne SU									261,400	333,200	594,600	
Tribe	H1D9400297	47HD00003	Confederated Salish	226,100	226,100	226,100	226,100	472,590	698,690	226,100	462,373	688,473	688,473	2,753,936	
Tribe	H1D9400087	47HD00004	Fort Belknap	119,400	119,400	119,400	125,624	253,248	378,872	119,400	249,534	368,934	368,934	1,474,940	
Tribe	H1D9400279	47HD00005	Fort Peck	210,700	210,700	210,700	210,700	427,049	637,749	210,700	411,429	622,129	622,129	2,514,107	
Tribe		47HD00006	Shoshone Bus	239,100				new ID number						239,100	
Tribe	H1D9400277	47HD00007	Northern Cheyenne	162,100	162,100	162,100	162,100	335,649	497,749	162,100	326,876	488,976	297,976	1,771,001	
IHS	H1D9400392		N. Cheyenne SU									182,227	191,000	373,227	
Tribe	H1D9400129	47HD00008	Rocky Boy	100,100	100,100	100,100	100,100	227,159	327,259	100,100	230,828	330,928	330,928	1,289,415	
IHS	H1D9400100	47HD00009	Billings Area ADSA	116,197	116,197	82,948			82,948					398,290	
Tribe	H1D9400349	47HD00010	Northern Arapaho Tribe		154,099	154,099	102,099	262,081	364,180	154,099	293,230	447,329	447,329	1,567,036	
Tribe	H1D9400373		Eastern Shoshone		85,000	85,000	85,000	164,554	249,554	85,001	154,753	239,754	239,754	899,062	
IHS	H1D9400384		Wind River SU												
<b>TOTAL</b>				<b>1,709,497</b>	<b>1,709,496</b>	<b>1,676,247</b>			<b>4,674,144</b>			<b>5,393,636</b>	<b>4,806,401</b>	<b>19,969,421</b>	

11 awarded in Montana

3 awarded to Wyoming

## APPENDIX

Grant Programs  
by Area—Billings





SUMMARY OF YR 1-6

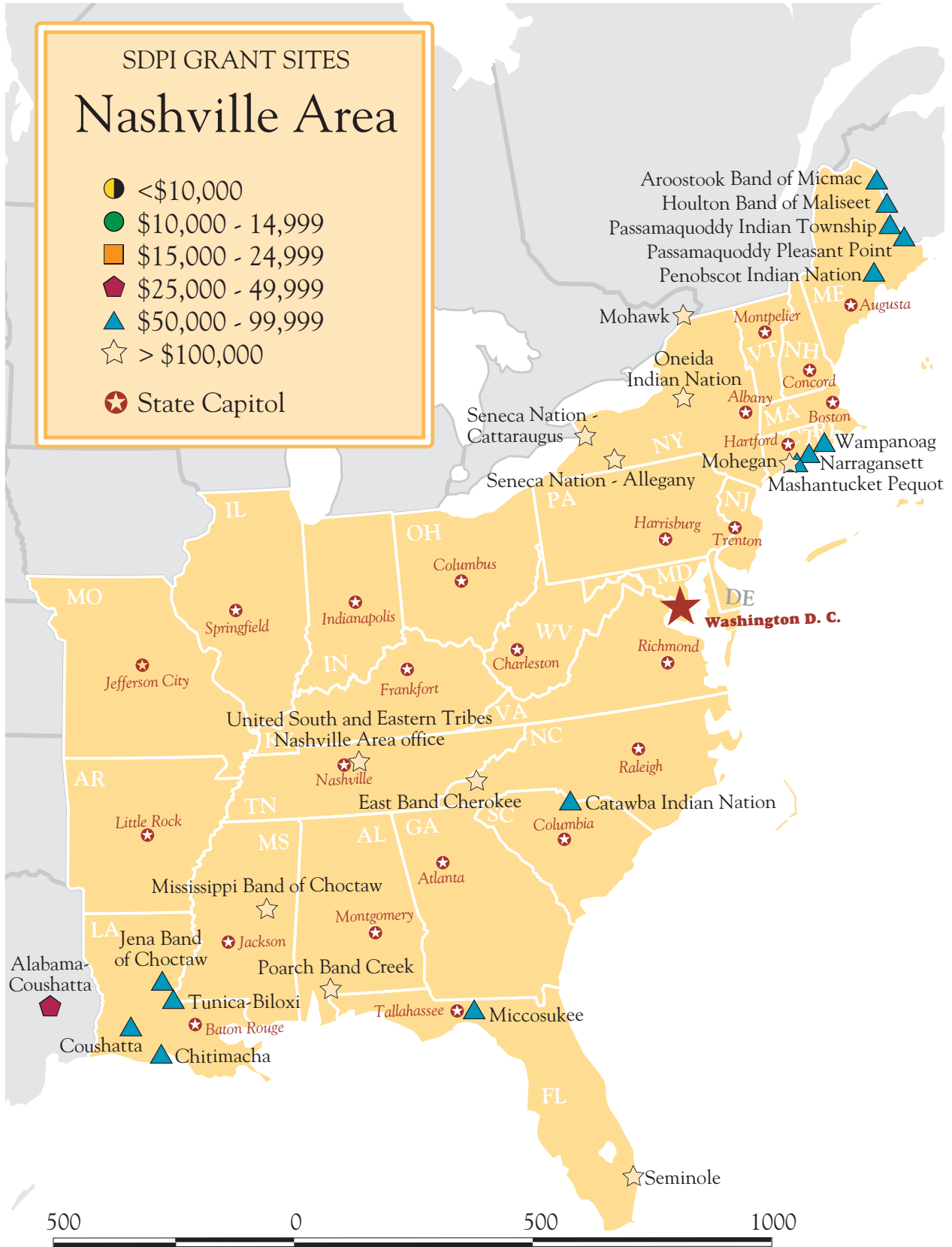
GRANTS FOR SPECIAL DIABETES PROGRAM FOR INDIANS - CALIFORNIA AREA

Tribe	NEW GRANT NUMBER	FORMER GRANT NUMBER	GRANTEE	AWARDED			AWARDED			AWARDED			AWARDED		GRAND TOTAL
				1997-1998	1998-1999	1999-2000	2000-2001	TOTAL	2001-2002	TOTAL	2002-2003				
Urban				Yr 1 BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 4 BBA Amt	Yr 4 Supple- ment	TOTAL BBA/ Suppl	Yr 5 BBA Amt	Yr 5 CAA Amt	TOTAL BBA/ CAA	Yr 6 CAA Amt		
	H1D9400081	41HD00001	Cabazon Band	1,500	1,586	1,500	1,500	3,500	5,000	1,500	4,500	6,000	6,000	21,586	
	H1D9400353	41HD00002	CRIBB, Inc.(5)	263,813	387,187	272,788	272,504	662,134	934,638	272,524	727,808	1,000,332	1,000,332	3,859,090	
			Shingle Springs	48,009						14,577	33,432	48,009			
			Sonoma	357,567						87,541	270,026	357,567			
			Tuolumne	122,677						37,400	85,277	122,677			
			United Indian	454,487						131,034	323,453	454,487			
			Warner Mt.	17,592						1,972	15,620	17,592			
	H1D9400120	41HD00003	Chapa-De Indian	56,817	83,403	82,708	82,622	158,804	241,426	82,622	174,655	257,277	257,277	978,908	
	H1D9400016	41HD00004	Colusa Indian Health	1,524	2,237	2,218	2,716	13,850	16,566	2,216	14,684	16,900	16,900	56,345	
	H1D9400348	41HD00005	Consolidated Tribal	39,585	58,107	57,623	57,563	115,144	172,707	57,563	126,638	184,201	184,201	696,424	
	H1D9400121	41HD00006	Feather River Tribal Hlth	46,243	67,881	67,315	67,245	150,257	217,502	67,245	165,655	232,900	232,500	864,341	
	H1D9400320	41HD00007	Greenville Rancheria	24,334	24,131		24,106	58,127	82,233	24,106	63,930	88,036	88,036	306,770	
	H1D9400122	41HD00008	Hoopa Health Assoc.	42,617	62,558	62,037	61,972	140,454	202,426	61,972	158,874	220,846	220,846	811,330	
	H1D9400156	41HD00009	Indian Health Council, Inc.	64,588	94,810	94,020	93,922	208,049	301,971	93,922	228,815	322,737	322,737	1,200,863	
	H1D9400231	41HD00010	Karuk Tribal Health	30,031	44,083	43,716	43,671	79,196	122,867	43,671	87,100	130,771	130,771	502,239	
	H1D9400157	41HD00011	Lake County Tribal Health	17,461	25,631	25,418	25,391	72,374	97,765	25,391	79,599	104,990	104,990	376,255	
	H1D9400017	41HD00012	Susanville (Lassen)	11,367	16,686	16,546	16,529	42,756	59,285	16,529	47,024	63,553	63,553	230,990	
	H1D9400123	41HD00013	Modoc Indian Health	3,200	4,697	4,658	5,153	16,849	22,002	4,653	17,683	22,336	22,336	79,229	
	H1D9400170	41HD00014	Northern Valley Indian	18,863	27,689	27,458	27,430	91,843	119,273	27,430	101,011	128,441	128,441	450,165	
	H1D9400018	41HD00015	Pit River Health Services	12,738	18,698	18,542	18,523	43,611	62,134	18,523	47,966	66,489	66,489	245,090	
	H1D9400019	41HD00016	Redding Rancheria	66,066	96,979	96,171	96,071	189,975	286,046	96,071	208,939	305,010	305,010	1,155,282	
	H1D9400233	41HD00017	Riverside San Bernadino	139,128	204,227	202,523	202,311	498,876	701,187	202,311	542,671	744,982	744,982	2,737,029	
	H1D9400158	41HD00018	Round Valley Indian Health	15,633	22,948	22,756	22,733	67,583	90,316	22,733	74,329	97,062	97,062	345,777	
	H1D9400020	41HD00019	Santa Ynez Band	7,771	11,407	11,312	11,300	21,956	33,256	11,300	24,149	35,449	35,449	134,644	
	H1D9400021	41HD00020	Southern Indian Health	47,386	69,558	68,979	68,907	117,966	186,873	68,907	129,740	198,647	198,647	770,090	
	H1D9400333	41HD00021	Sycuan Band of Mission	2,249	2,329		2,826	13,242	16,068	2,326	14,074	16,400	16,400	53,446	
	H1D9400372	41HD00022	Table Mt. Rancheria				Did not apply			Awarded to Colusa		6,000	6,000	12,000	
	H1D9400234	41HD00023	Toiyabe Indian Health	43,516	63,878	63,345	63,279	141,042	204,321	63,279	155,121	218,400	218,400	811,860	
	H1D9400196	41HD00024	Tule River Indian	42,053	61,730	61,216	61,152	114,409	175,561	61,152	125,829	186,981	186,981	714,522	
	H1D9400182	41HD00025	CAO-Data Improvement	135,829	118,028	82,905	82,903	100,002	182,905	82,903	100,000	182,903	182,903	885,473	
	H1D9400367	41	Central Valley Indian Health			111,031	110,916	263,874	374,790	110,916	290,212	401,128	401,128	1,288,077	
			CA Diabetes Control								150,000	150,000	150,000	300,000	
<b>TOTAL</b>				<b>1,107,729</b>	<b>1,570,591</b>	<b>1,523,245</b>	<b>1,523,245</b>					<b>5,388,771</b>	<b>5,388,371</b>	<b>19,887,825</b>	

Greenville Rancheria applied YR 02 as YR 01  
 Sycuan Band of Miss applied YR 02 as YR 01  
 31 awarded in California

## SDPI GRANT SITES Nashville Area

- <\$10,000
- \$10,000 - 14,999
- \$15,000 - 24,999
- ◆ \$25,000 - 49,999
- ▲ \$50,000 - 99,999
- ☆ > \$100,000
- ★ State Capitol







## SUMMARY OF YR 1-6

## GRANTS FOR SPECIAL DIABETES PROGRAM FOR INDIANS - NASHVILLE AREA

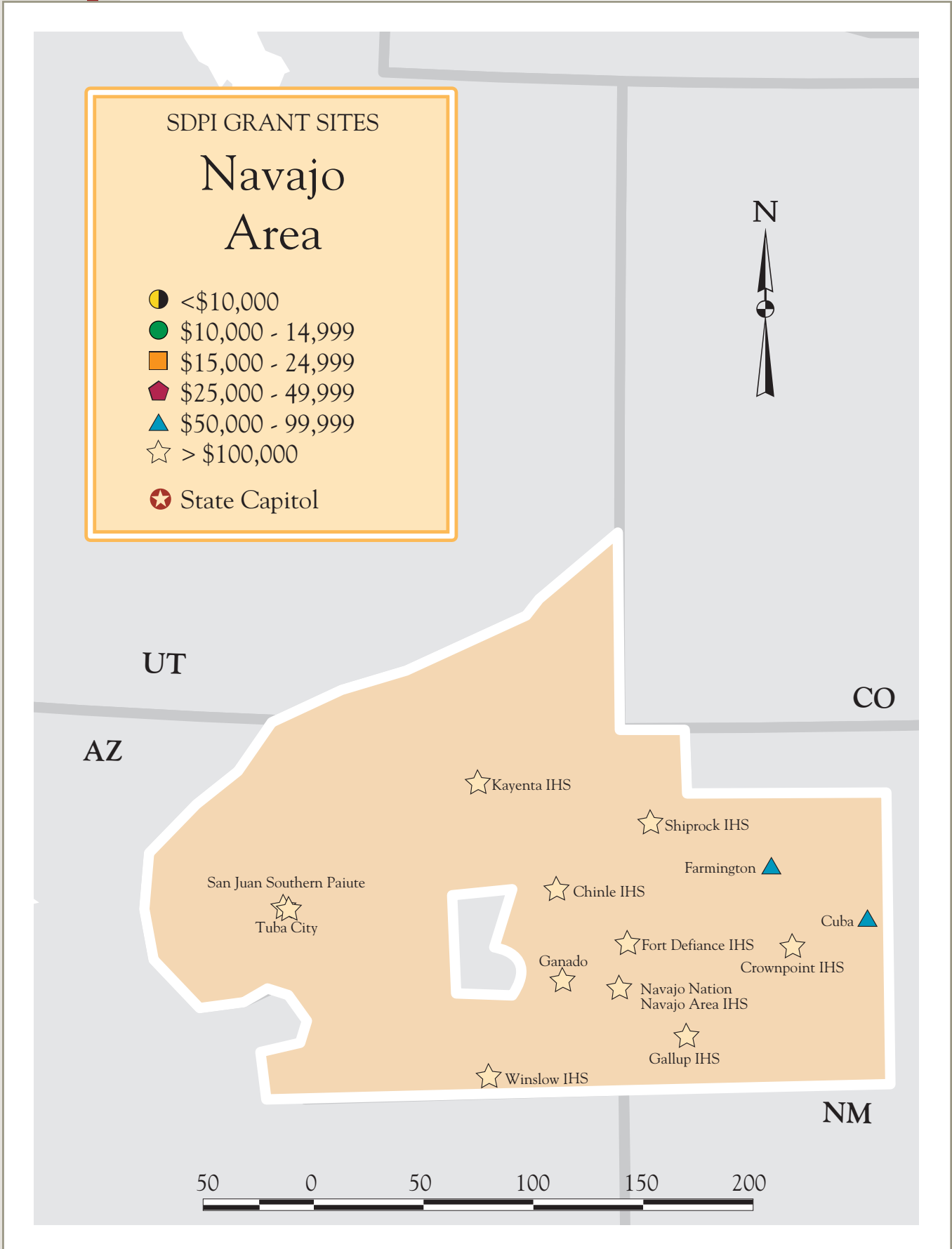
Tribe IHS Urban	NEW GRANT NUMBER	FORMER GRANT NUMBER	GRANTEE	AWARDED			AWARDED			AWARDED			AWARDED		GRAND TOTAL
				1997-1998	1998-1999	1999-2000	2000-2001		TOTAL	2001-2002		TOTAL	2002-2003		
				Yr 1 BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 4 BBA Amt	Yr 4 Supple- ment	TOTAL BBA/ Suppl	Yr 5 BBA Amt	Yr 5 CAA Amt	TOTAL BBA/ CAA	Yr 6 CAA Amt	Yr 6 CAA Amt	
T	51/31	Coushatta - Alabama		32,883	36,203	35,107	34,680	67,295	101,975	34,680	67,854	102,534	102,534	411,236	
T	51/32	Catawba Tribe of SC		79,220	85,256	13,666	34,125	69,681	103,806	34,125	61,561	95,686	95,686	473,320	
T	51/34	Chitimacha		26,034	28,751	25,315	27,797	48,249	76,046	27,797	38,646	66,443	66,443	289,032	
T	51/35	Choctaw Tribe of Mississippi		186,404	204,928	225,570	222,540	500,654	723,194	222,540	587,484	810,024	810,024	2,960,144	
T	51/36	Coushatta		22,841	24,151	25,989	27,207	46,777	73,984	27,207	44,530	71,737	73,879	292,581	
T	51/37	Houlton Band of Maliseet		24,770	25,805	23,354	23,729	43,631	67,360	23,729	33,317	57,046	57,046	255,381	
T	51/38	Jena of Choctaw		16,774	18,195	14,636	23,159	36,040	59,199	23,159	31,299	54,458	54,458	217,720	
T	51/39	Micosukee		29,411	31,830	30,669	31,797	59,894	91,691	31,797	60,857	92,654	92,654	368,909	
T	51/40	Micmac		26,015	28,390	24,312	25,495	44,871	70,366	25,495	27,435	52,930	52,930	254,943	
T	51/41	Mohegan Tribe of Conn		40,053	43,231	35,152	35,495	67,434	102,929	35,530	71,278	106,808	106,808	434,981	
T	51/42	Narragansett		28,770	31,143	29,856	28,771	54,976	83,747	28,771	60,185	88,956	88,956	351,428	
T	51/43	Oneida Indian Nation		41,582	46,631	49,782	43,497	98,100	141,597	43,497	94,794	138,291	138,291	556,174	
T	51/44	Passamaquoddy - Indian Township		31,902	36,374	33,016	34,505	67,134	101,639	34,505	40,824	75,329	75,329	353,589	
T	51/45	Passamaquoddy - Pleasant Pt.		35,412	40,020	33,410	31,486	64,605	96,091	31,486	47,058	78,544	78,544	362,021	
T	51/46	Penobscot		42,865	45,675	35,735	32,691	68,673	101,364	32,691	41,671	74,362	74,362	374,363	
T	51/47	Pequot		29,770	33,464	31,927	33,603	67,220	100,823	33,603	45,723	79,326	54,458	329,768	
T	51/48	Poarch Band Creek		53,903	62,502	49,742	43,955	105,181	149,136	43,955	98,554	142,509	142,509	600,301	
T	51/49	Seminole Tribe of FL		63,054	68,385	75,176	83,771	191,064	274,835	83,771	197,710	281,481	281,481	1,044,412	
T	51/50	Seneca Nation of Indians		128,970	138,513	132,898	114,429	252,588	367,017	114,429	387,299	501,728	501,728	1,770,854	
T	51/51	St. Regis Mohawk		102,880	103,700	95,236	93,362	220,152	313,514	93,362	161,440	254,802	254,802	1,124,934	
T	51/52	Tunica-Biloxi		16,060	17,194	15,782	23,065	38,965	62,030	23,065	32,815	55,880	55,880	222,826	
T	51/53	Wampanoag-Gayhead		23,823	26,836	20,444	23,340	38,595	61,935	23,340	28,350	51,690	51,690	236,418	
Tribe	HID5100241	51HD00001	USET Total	1,083,396	1,177,177	1,056,774			3,324,278			3,333,218	3,310,492	13,285,335	
Tribe	HID5100280	51HD00002	East Band Cherokee, NC	244,313	266,682	264,783	253,143	601,551	854,694	253,143	811,254	1,064,397	1,064,379	3,759,248	
IHS	HID5100167	51HD00003	ADSA-Area, Nashville, TN	116,155		82,905	82,905		82,905					281,965	
			<b>TOTAL</b>	<b>1,443,864</b>	<b>1,443,859</b>	<b>1,404,462</b>			<b>4,261,877</b>			<b>4,397,615</b>	<b>4,374,871</b>	<b>17,326,548</b>	

2 awarded in Alabama  
3 awarded in Connecticut  
2 awarded in Florida  
4 awarded in Louisiana  
5 awarded in Maine  
1 awarded in Mississippi

3 awarded in New York  
2 awarded in North Carolina  
1 awarded in Rhode Island  
1 awarded in South Carolina  
2 awarded in Tennessee

## APPENDIX

Grant Programs by  
Area—Nashville





## SUMMARY OF YR 1-6

## GRANTS FOR SPECIAL DIABETES PROGRAM FOR INDIANS - NAVAJO AREA

Tribe IHS Urban	NEW GRANT NUMBER	FORMER GRANT NUMBER	GRANTEE	AWARDED			AWARDED			AWARDED			AWARDED		GRAND TOTAL
				1997-1998 Yr 1 BBA Amt	1998-1999 Yr 2 BBA Amt	1999-2000 Yr 3 BBA Amt	2000-2001 Yr 4 BBA Amt	2000-2001 Yr 4 Supple- ment	TOTAL BBA/ Suppl	2001-2002 Yr 5 BBA Amt	2001-2002 Yr 5 CAA Amt	TOTAL BBA/ CAA	2002-2003 Yr 6 CAA Amt		
Tribe	HID5400242	54HD00001	Navajo Nation	1,344,873	1,444,873	1,264,701	1,444,701	5,838,437	7,283,138	1,623,296	3,787,692	5,410,988	6,443,988	23,192,561	
Tribe	HID5400243	54HD00002	San Juan	55,000	55,000	85,000	55,000	75,000	130,000	39,000	91,000	130,000	130,000	585,000	
IHS	HID5400132	54HD00003	Navajo Area IHS	2,920,874	2,820,874	2,937,797	2,787,797	2,744,053	5,531,850	2,211,982	5,161,293	7,373,275	5,601,275	27,185,945	
Tribe	H1D9400411		Winslow Indian Health Ctr										284,500	284,500	
Tribe	H1D9400409		Tuba City Health Care										454,500	454,500	
		<b>TOTAL</b>		<b>4,320,747</b>	<b>4,320,747</b>	<b>4,287,498</b>			<b>12,944,988</b>			<b>12,914,263</b>	<b>12,914,263</b>	<b>51,702,506</b>	

5 awarded in Arizona

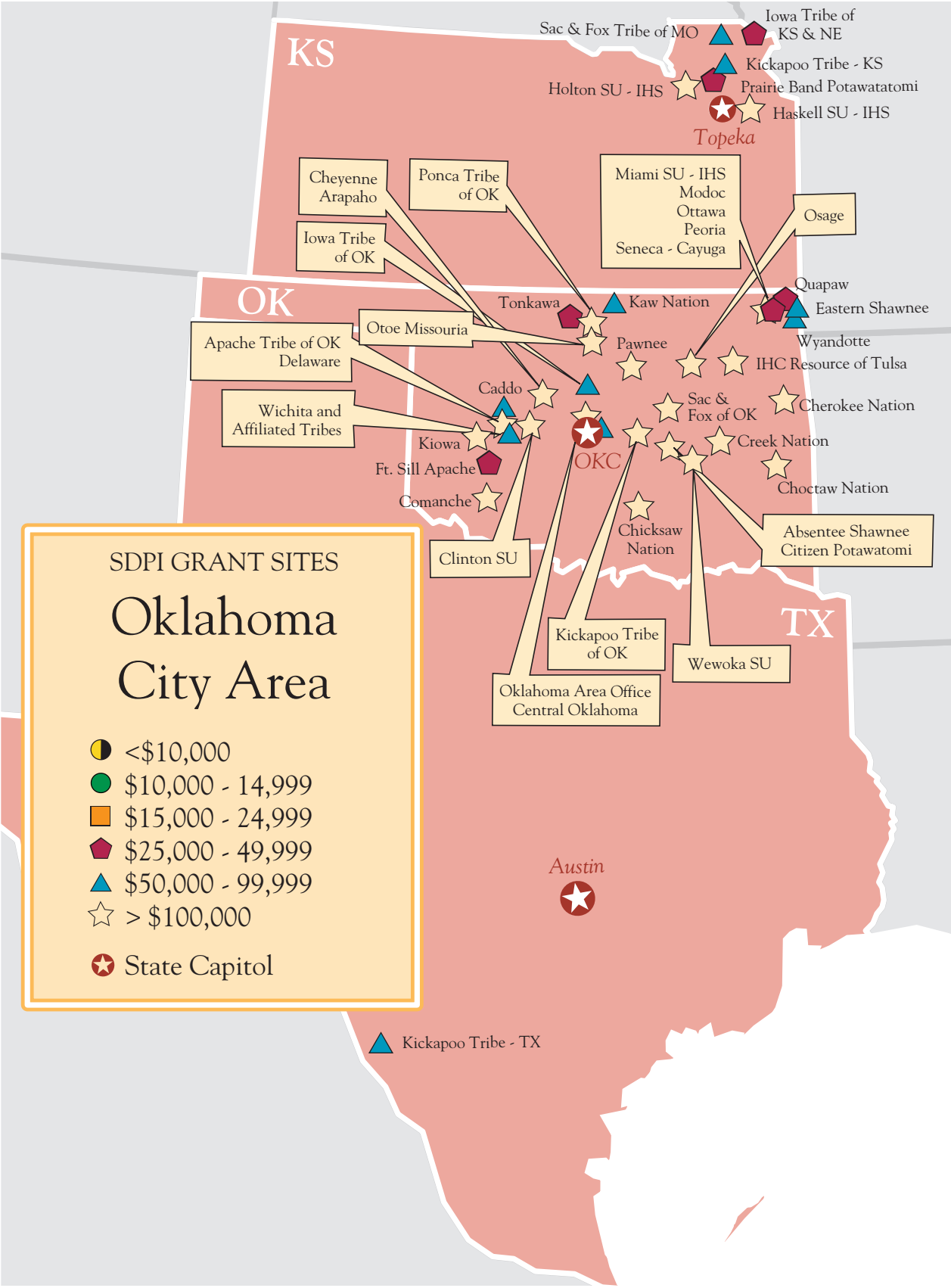
## APPENDIX

Grant Programs  
by Area—Navajo

**SDPI GRANT SITES**

# Oklahoma City Area

- <\$10,000
- \$10,000 - 14,999
- \$15,000 - 24,999
- ◆ \$25,000 - 49,999
- ▲ \$50,000 - 99,999
- ☆ > \$100,000
- ★ State Capitol



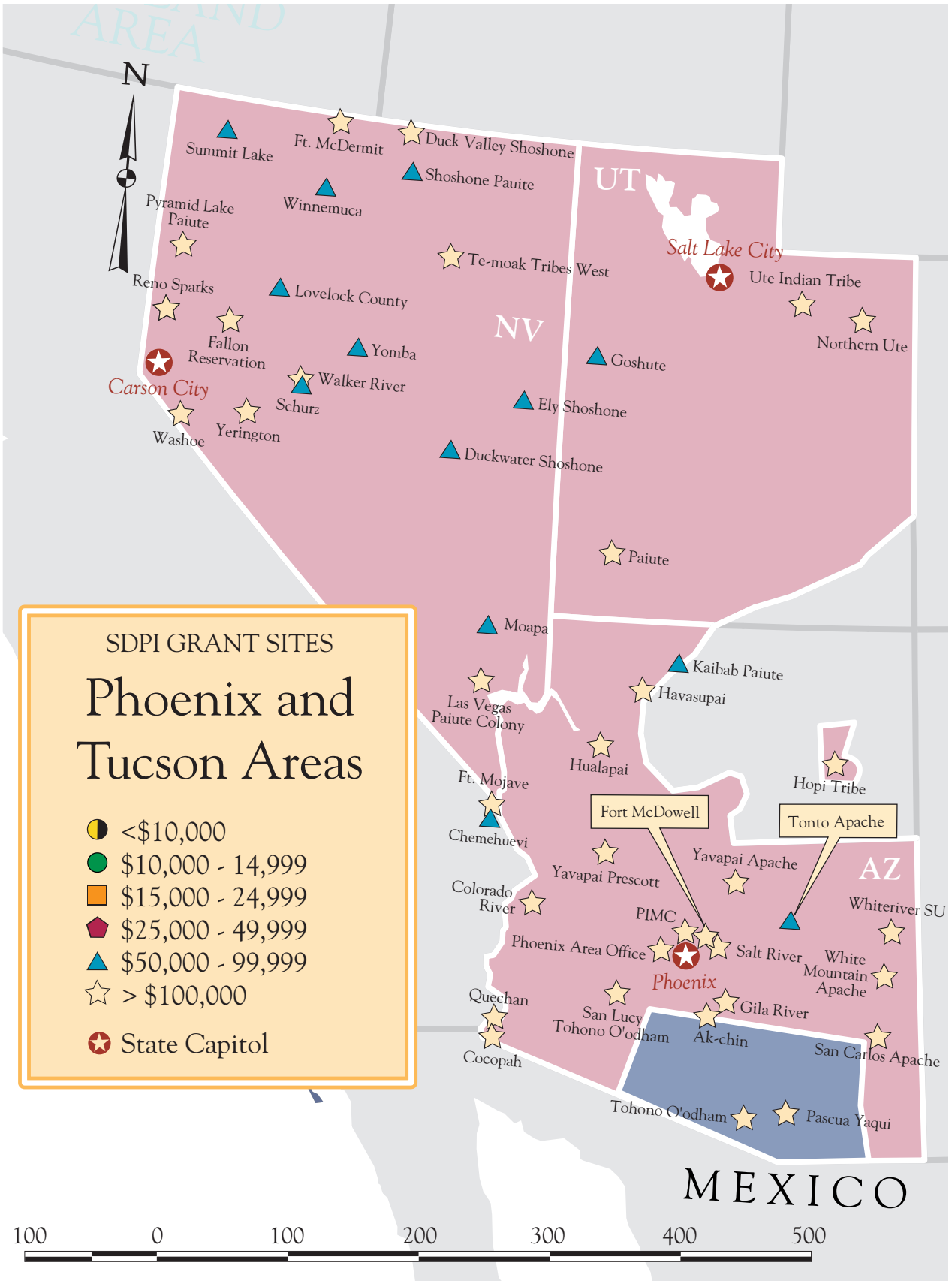


SUMMARY OF YR 1-6

GRANTS FOR SPECIAL DIABETES PROGRAM FOR INDIANS - OKLAHOMA AREA

Tribe	NEW IHS GRANT NUMBER	FORMER GRANT NUMBER	GRANTEE	AWARDED 1997-1998			AWARDED 1998-1999			AWARDED 1999-2000			AWARDED 2000-2001			AWARDED 2001-2002			AWARDED 2002-2003	
				Yr 1 BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 4 BBA Amt	Yr 5 CAA Amt	TOTAL BBA/ Suppl	Yr 1 BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 4 BBA Amt	Yr 5 CAA Amt	TOTAL BBA/ CAA	Yr 6 CAA Amt	GRAND TOTAL			
Tribe	H1D5000183	50HD00001	Absentee Shawnee	109,268	109,268	108,260	108,260	153,635	261,895	108,260	153,635	261,895	1,112,481							
Tribe	H1D9400039	50HD00004	Cherokee Nation	1,381,059	1,381,059	1,380,051	1,380,051	4,020,083	5,400,134	1,380,051	4,020,083	5,400,134	5,400,131	20,342,568						
Tribe	H1D9400115	50HD00005	Citizen Potawatomi	146,524	146,524	145,516	145,516	409,034	554,550	145,516	409,034	554,550	554,550	2,102,214						
Tribe	H1D9400169	50HD00006	Comanche Tribe	124,823	124,823	123,815	123,815	258,335	382,150	123,815	258,335	382,150	382,150	1,519,911						
Tribe	H1D9400040	50HD00007	Muscogee Creek	382,262	382,262	381,254	381,254	1,066,144	1,447,398	381,254	1,066,144	1,447,398	1,447,398	5,487,972						
Tribe	H1D9400041	50HD00009	Iowa Tribe of OK	36,902	36,902	35,894	35,894	44,527	80,421	35,894	44,527	80,421	80,421	350,961						
Tribe	H1D9400042	50HD00010	Kaw Tribe	37,545	37,545	36,537	36,537	35,485	72,022	36,537	35,485	72,022	72,022	327,693						
Tribe	H1D9400116	50HD00011	Kickapoo Tribe/KS	35,681	35,681	34,673	34,673	20,484	55,157	34,673	20,484	55,157	55,157	271,506						
Tribe	H1D9400043	50HD00012	Kickapoo Tribe/OK	91,115	91,115	90,107	90,107	198,050	288,157	90,107	198,050	288,157	288,157	1,136,808						
Tribe	H1D9400044	50HD00013	Chickasaw Nation	203,090	203,090	202,082	202,082	543,465	745,547	202,082	543,465	745,547	745,547	2,844,903						
Tribe	H1D9400117	50HD00014	Choctaw Nation	547,434	547,434	546,426	546,426	1,535,577	2,082,003	546,426	1,535,577	2,182,003	2,182,003	8,087,303						
Tribe	H1D9400045	50HD00015	Wichita & Affiliated	44,706	44,706	43,698	43,698	47,296	90,994	43,698	47,296	90,994	90,994	406,092						
Tribe	H1D9400046	50HD00016	Otoe-Missouria	51,995	51,995	50,987	50,987	68,365	119,352	50,987	68,365	119,352	119,352	513,033						
Tribe	H1D9400159	50HD00019	Osage Tribe	93,622	93,622	92,614	92,614	190,941	283,555	92,614	190,941	283,555	312,832	1,159,800						
			<i>DE Eastern OK</i>								29,277	29,277								
Tribe	H1D9400048	50HD00020	Tonkawa Tribe	33,097	33,097	32,089	32,089	13,436	45,525	32,089	13,436	45,525	45,525	234,858						
Tribe	H1D9400114	50HD00021	Kickapoo Tribe/TX	35,539	35,539	34,532	34,532	18,440	52,972	34,532	18,440	52,972	52,972	264,526						
Tribe	H1D9400113	50HD00023	Wyandotte Tribe	34,344	34,344	33,336	33,336	11,378	44,714	33,336	11,378	44,714	96,699	288,151						
	H1D9400047	50HD00017	Eastern Shawnee	35,539	35,539	34,532	34,532	17,453	51,985					157,595						
														Sub-grant of Wyandotte Tribe after Year 4						
Tribe	H1D9400238	50HD00024	Sac & Fox Nation	111,505	111,505	110,497	110,497	303,843	414,340	110,497	303,843	414,340	414,340	1,576,527						
Tribe	H1D9400050	50HD00025	Pawnee Tribe	58,937	58,937	57,929	57,929	85,109	143,038	57,929	85,109	143,038	143,038	604,917						
Tribe	H1D9400141	50HD00026	Wewoka SU	99,227	99,227	98,222			319,443	98,222	225,904	324,126	324,126	1,264,371						
Tribe	H1D9400142	50HD00027	Ponca Tribe of OK	78,786	78,786	77,779	77,779	143,081	220,860	77,779	143,081	220,860	220,860	897,931						
Tribe	H1D9400239	50HD00028	IHC Resource of Tulsa	105,711	105,711	104,703	104,703	246,288	350,991	104,703	246,288	350,991	350,991	1,369,098						
IHS	H1D9400143	50HD00029	Central Oklahoma	105,711	105,711	104,703	104,703	246,991	351,694	104,703	246,288	350,991	350,991	1,369,801						
IHS	H1D9400112	50HD00030	Haskell Health Center, KS	53,388	53,388	52,380	52,380	134,269	186,649	52,380	134,269	186,649	186,649	719,103						
Tribe	H1D9400287	50HD00031	Cheyenne/Arapaho Tribe	159,830	159,830	158,822	158,822	391,601	550,423	158,822	391,601	550,423	400,423	1,979,751						
IHS	H1D9400111	50HD00032	Holton SU, KS	99,320	99,320	98,312		2,512	136,451				133,939	165,460	732,802					
			<i>Iowa KS/NE</i>				30,695	20,355		30,695	20,355									
			<i>PB Potawatomi</i>				39,167	43,722		39,167	43,722									
Tribe	H1D9400413		Sac & Fox MO				25,938	5,583	31,521	25,938	5,583	31,521	31,521	94,563						
IHS	H1D9400394		Oklahoma City IHS									88,010	88,010	176,020						
IHS	H1D9400379	50HD00033	Northeastern	187,965	187,965	186,965	184,453	118,218	302,671			302,671	302,671	1,470,908						
			<i>Miami</i>				27,995	13,373		27,995	13,373									
			<i>Modoc</i>				25,347	3,873		25,347	3,873									
			<i>Ottawa</i>				29,898	16,191		29,898	16,191									
			<i>Peoria</i>				30,412	17,799		30,412	17,799									
			<i>Quapaw</i>				34,115	30,614		34,115	30,614									
			<i>Seneca Cayuga</i>				36,686	36,368		36,686	36,368									
IHS	H1D9400383		Lawton SU										633,637	633,637						
Tribe	H1D9400130	50HD00002	Apache Tribe of OK	49,205	49,205	48,197	48,197	59,307	107,504	48,197	59,307	107,504	107,504	372,365						
Tribe	H1D9400301	50HD00003	Caddo Tribe	47,482	47,482	46,475	46,475	52,272	98,747	46,475	52,272	98,747	98,747	348,808						
Tribe	H1D9400131	50HD00008	Delaware Western OK	34,717	34,717	33,709	33,709	17,509	51,218	33,709	17,509	51,218	51,218	210,701						
Tribe	H1D9400187	50HD00018	Ft. Sill Apache	31,053	31,053	30,045	30,045	6,770	36,815	30,045	6,770	36,815	36,815	202,596						
Tribe	H1D9400327	50HD00022	Kiowa Tribe	140,353	140,353	139,345	139,345	307,227	446,572	139,345	307,227	446,572	446,572	1,759,767						
IHS	H1D9400417		Clinton SU									150,000	150,000	150,000						
			<b>TOTAL</b>	<b>4,787,735</b>	<b>4,787,735</b>	<b>4,754,486</b>			<b>15,807,468</b>			<b>15,974,238</b>	<b>16,459,656</b>	<b>62,571,318</b>						

39 awarded in Oklahoma  
 6 awarded in Kansas  
 1 awarded in Texas





**SUMMARY OF YR 1-6 GRANTS FOR SPECIAL DIABETES PROGRAM FOR INDIANS - PHOENIX AREA**

Tribe IHS Urban	NEW GRANT NUMBER	FORMER GRANT NUMBER	GRANTEE	AWARDED			AWARDED			AWARDED			AWARDED		GRAND TOTAL
				1997-1998	1998-1999	1999-2000	2000-2001		2001-2002		2002-2003				
				Yr 1 BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 4 BBA Amt	Yr 4 Supple- ment	TOTAL BBA/ Suppl	Yr 5 BBA Amt	Yr 5 CAA Amt	TOTAL BBA/ CAA	Yr 6 CAA Amt		
Tribe	H1D9400307	40HD00002	Chemehuevi, CA	21,312	21,312	21,312	21,312	69,859	91,171	21,202	69,498	90,700	90,699	336,506	
Tribe	H1D9400007	40HD00003	Cocopah	33,785	33,785	33,785	33,785	91,718	125,503	33,610	91,244	124,854	124,854	476,566	
Tribe	H1D9400247	40HD00004	Colorado River Indian	123,774	123,774	123,774	123,774	264,582	388,356	123,134	263,214	386,348	386,348	1,532,374	
Tribe	H1D9400008	40HD00005	Duckvalley Shoshone	59,217	59,217	59,217	59,217	138,126	197,343	58,911	137,412	196,323	196,322	767,639	
Tribe	H1D9400110	40HD00006	Duckwater Shoshone	19,422	19,422	19,422	19,422	67,636	87,058	19,322	67,286	86,608	86,608	318,540	
Tribe	H1D9400246	40HD00007	Ely Shoshone	23,051	23,051	23,051	23,051	77,249	100,300	22,932	76,849	99,781	99,781	369,015	
Tribe	H1D9400150	40HD00008	Fallon Paiute	53,728	53,728	53,728	53,728	133,216	186,944	53,450	132,527	185,977	185,977	720,082	
Tribe	H1D9400164	40HD00009	Fort McDowell	35,126	35,126	35,126	35,126	107,067	142,193	34,944	106,513	141,457	141,458	530,486	
Tribe	H1D9400358	40HD00010	Fort Mohave, CA	37,993	37,993	37,993	37,993	110,116	148,109	37,797	109,547	147,344	147,343	556,775	
Tribe	H1D9400009	40HD00011	Gila River Res./West En	585,365	585,365	585,365	585,365	1,133,334	1,718,699	549,791	1,040,856	1,590,647	1,590,647	6,656,088	
Tribe	H1D9400402	40HD00012	Ak-Chin (GRIC)									119,165	119,165	238,330	
Tribe	H1D9400096	40HD00012	Goshute Res., UT	18,263	18,263	18,263	18,263	71,306	89,569	18,169	70,937	89,106	89,106	322,570	
Tribe	H1D9400151	40HD00013	Havasupai Tribe	28,966	28,966	28,966	28,966	85,569	114,535	28,816	85,126	113,942	113,943	429,318	
Tribe	H1D9400309	40HD00014	Hopi Tribe	204,127	204,127	204,127	204,127	404,165	608,292	203,071	402,075	605,146	605,146	2,430,965	
Tribe	H1D9400010	40HD00015	Hualapai Tribe	68,152	68,152	68,152	68,152	156,833	224,985	67,800	156,022	223,822	223,821	877,084	
Tribe	H1D9400152	40HD00016	Kaibab Res./Paiute	16,860	16,860	16,860	16,860	66,241	83,101	16,773	65,898	82,671	82,671	299,023	
Tribe	H1D9400011	40HD00017	Las Vegas Paiutes	58,451	58,451	58,451	58,451	175,736	234,187	34,854	102,914	232,976	232,976	875,492	
Tribe	H1D9400203	40HD00018	Lovelock Paiute	21,526	21,526	21,526	21,526	70,789	92,315	21,415	70,423	91,838	91,838	340,569	
Tribe	H1D9400355	40HD00021	Paiute Tribe of Utah	30,339	30,339	30,339	30,339	80,143	110,482	30,182	79,729	109,911	109,911	421,321	
IHS	H1D9400171	40HD00022	PIMC	492,524	492,524	492,524	492,524	508,186	1,000,710	489,977	505,558	995,535	959,109	4,432,926	
Tribe	H1D9400252	40HD00023	Pyramid Lake	57,723	57,723	57,723	57,723	146,859	204,582	57,424	146,099	203,523	203,524	784,798	
Tribe	H1D9400359	40HD00024	Quechan Tribe, CA	99,836	99,836	99,836	99,836	219,519	319,355	99,320	218,384	317,704	317,703	1,254,270	
Tribe	H1D9400012	40HD00025	Reno/Sparks	109,289	109,289	109,289	109,289	230,991	340,280	108,724	229,796	338,520	338,520	1,345,187	
Tribe	H1D9400311	40HD00026	Salt River	150,705	150,705	150,705	150,705	335,222	485,927	149,922	333,492	483,414	483,414	1,904,870	
Tribe	H1D9400013	40HD00027	San Carlos Apache	337,601	337,601	337,601	337,601	666,691	1,004,292	335,856	663,242	999,098	999,098	4,015,291	
Tribe	H1D9400095	40HD00028	San Lucy Tohono O'odh	16,863	16,863	16,863	16,863	28,010	44,873	16,776	27,865	44,641	117,493	257,596	
Tribe	H1D9400177	40HD00031	Te Moak Tribes West	71,628	71,628	71,628	71,628	157,970	229,598	71,258	157,153	228,411	228,411	901,304	
Tribe	H1D9400176	40HD00032	Tonto Apache	18,812	18,812	18,812	18,812	61,830	80,642	18,715	62,505	81,220	81,220	299,518	
IHS	H1D9400147	40HD00033	Uintah-Urday, UT	152,740	152,740	152,740	136,886	326,741	463,627	136,179	265,733	401,912	75,090	1,398,849	
Tribe	H1D9400376	40HD00029	Skull Valley Res.(U&O, UT)				15,854		15,854	15,772	59,318	75,090		90,944	
Tribe	H1D9400094	40HD00034	Walker River	44,915	44,915	44,915	44,915	111,873	156,788	44,683	111,294	155,977	155,977	603,487	
Tribe	H1D9400175	40HD00035	Washoe Tribes of CA&N	79,587	79,587	79,587	79,587	174,352	253,939	79,175	173,450	252,625	252,626	997,951	
Tribe	H1D9400014	40HD00036	White Mountain Apache	436,647	436,647	436,647	436,647	830,563	1,267,210	434,390	826,267	1,260,657	1,260,656	5,098,464	
IHS	H1D9400405		Whiteriver SU												
Tribe	H1D9400200	40HD00038	Yavapai-Apache	31,589	31,589	31,589	31,589	91,150	122,739	31,426	90,679	122,105	122,104	461,715	
Tribe	H1D9400092	40HD00039	Yavapai-Presc	25,917	25,917	25,917	25,917	77,300	103,217	25,783	76,900	102,683	102,683	386,334	
Tribe	H1D9400199	40HD00040	Yerington Res & Clny	31,254	31,254	31,254	31,254	91,925	123,179	31,092	91,450	122,542	122,542	462,025	
Tribe	H1D9400015	40HD00041	Yomba Shoshone	18,019	18,019	18,019	18,019	64,071	82,090	17,926	63,740	81,666	81,665	299,478	
IHS	H1D9400186	40HD00042	Phx IHS - Data	116,152	116,152	82,903			254,905	82,474	171,112	253,586	217,160	1,040,858	
IHS	H1D9400093	40HD00043	Schurz Service Unit	67,535	67,535	67,535	67,535	218,310	285,845	67,185	217,180	284,365	284,365	1,057,180	
Tribe		40HD00019	McDermitt Res.				31,741	90,272		31,577	89,804				
Tribe		40HD00030	Summit Lake				15,000	58,231		14,922	57,930				
Tribe		40HD00037	Winnemucca Colony				20,794	69,807		20,686	69,446				
Tribe	H1D9400419		Ute Indian Tribe										401,912	401,912	
<b>TOTAL</b>				<b>3,798,793</b>	<b>3,798,793</b>	<b>3,765,544</b>			<b>11,582,794</b>			<b>11,523,890</b>	<b>11,523,886</b>	<b>45,993,700</b>	

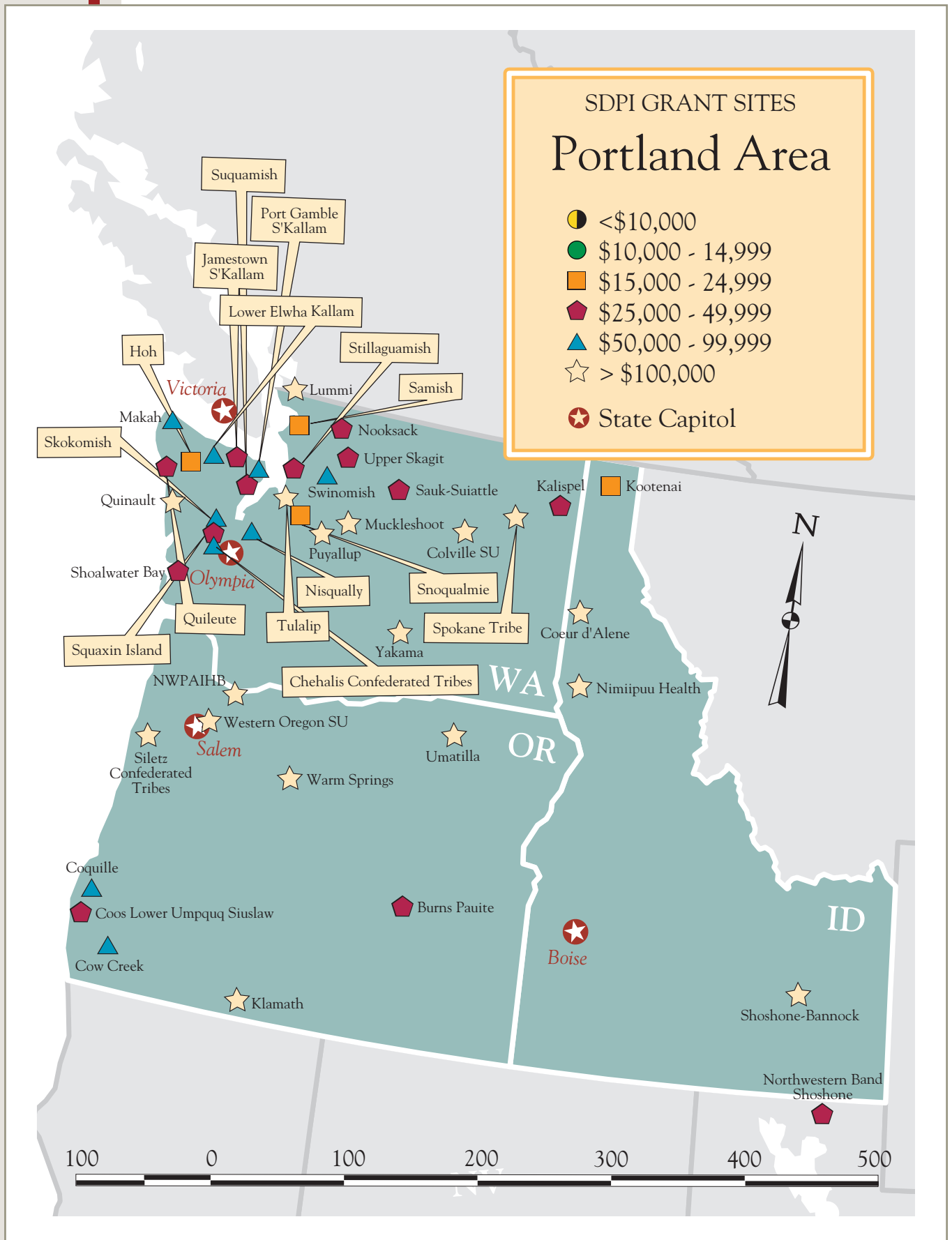
20 awarded in Arizona  
2 awarded in California

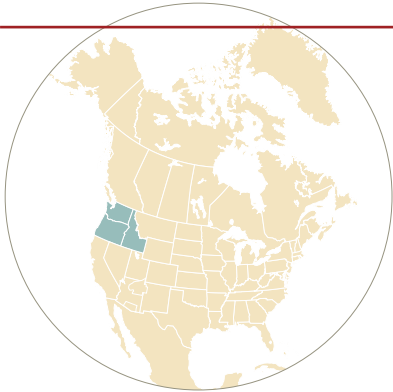
17 awarded in Nevada  
6 awards in Utah

**SUMMARY OF YR 1-6 GRANTS FOR SPECIAL DIABETES PROGRAM FOR INDIANS - TUCSON AREA**

Tribe IHS Urban	NEW GRANT NUMBER	FORMER GRANT NUMBER	GRANTEE	AWARDED			AWARDED			AWARDED			AWARDED		GRAND TOTAL
				1997-1998	1998-1999	1999-2000	2000-2001		2001-2002		2002-2003				
				Yr 1 BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 4 BBA Amt	Yr 4 Supple- ment	TOTAL BBA/ Suppl	Yr 5 BBA Amt	Yr 5 CAA Amt	TOTAL BBA/ CAA	Yr 6 CAA Amt		
Tribe	H1D9400022	42HD00001	Tohono O'odham	536,566	536,566	583,880	583,880	1,225,475	1,809,355	583,880	1,266,055	1,849,935	1,852,268	7,168,570	
Tribe	H1D9400023	42HD00002	Pascua Yaqui	116,822	137,590	152,413	152,413	319,892	472,305	152,413	330,483	482,896	480,563	1,842,589	
IHS	H1D9400029	42HD00003	Tohono O'o Nation	116,154										116,154	
<b>TOTAL</b>				<b>769,542</b>	<b>674,156</b>	<b>736,293</b>			<b>2,281,660</b>			<b>2,332,831</b>	<b>2,332,831</b>	<b>9,127,313</b>	



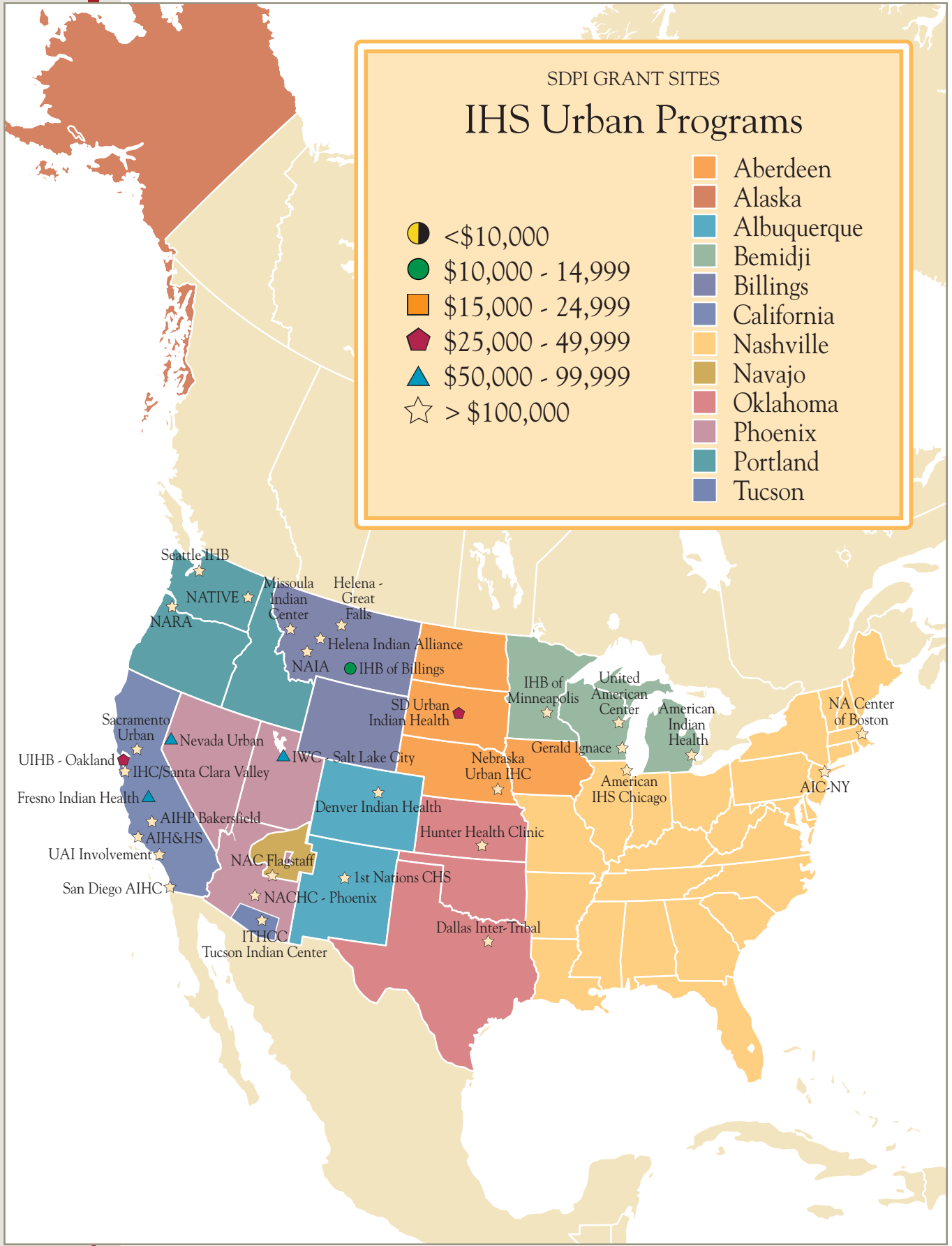




**SUMMARY OF YEAR 1-6 GRANTS FOR SPECIAL DIABETES PROGRAM FOR INDIANS - PORTLAND AREA**

Tribe	NEW GRANT NUMBER	FORMER GRANT NUMBER	GRANTEE	AWARDED 1997-1998			AWARDED 1998-1999			AWARDED 1999-2000			AWARDED 2000-2001			AWARDED 2001-2002			AWARDED 2002-2003	
				Yr 1 BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 4 BBA Amt	Yr 5 BBA Amt	Yr 6 BBA Amt	Yr 1 BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 4 BBA Amt	Yr 5 BBA Amt	Yr 6 BBA Amt	Supplement	TOTAL BBA/Suppl	Yr 5 CAA Amt	Yr 6 CAA Amt	TOTAL BBA/CAA
Tribe	HID9400184	64HD00001	Burns	13,295	13,295	13,295	13,295	13,295	13,295	13,295	13,295	13,295	13,295	26,590	13,295	13,451	26,746	26,746	119,967	
Tribe	HID9400356	64HD00002	Chehalis	20,046	20,046	20,046	20,046	20,046	20,046	20,046	20,046	20,046	36,641	56,687	20,046	37,367	57,413	57,413	231,651	
Tribe	HID9400173	64HD00003	Coeur d-Alene SG	48,986	48,986	48,986	48,986	48,986	116,893	165,879	48,986	119,208	168,194	168,194	168,194	168,194	168,194	649,225		
IHS	HID9400198	64HD00004	Colville	95,140	95,140	95,140	95,140	275,461	370,601	95,140	280,916	376,056	376,056	1,408,133						
Tribe	HID9400339	64HD00005	Coos	17,377	17,377	17,377	17,377	17,377	34,754	17,377	17,663	35,040	156,965							
Tribe	HID9400072	64HD00006	Coquille	17,716	17,716	17,716	17,716	31,678	49,394	17,716	32,305	50,021	202,584							
Tribe	HID9400180	64HD00007	Cow Creek	20,296	20,296	20,296	20,296	35,233	55,529	20,296	35,931	56,227	228,871							
Tribe	HID9400073	64HD00008	Grand Ronde	61,026	61,026	61,026	61,026	98,872	159,898	61,026	100,830	161,856	666,688							
Tribe	HID9400236	64HD00010	Jamestown	14,809	14,809	14,809	14,809	14,809	29,618	14,809	14,969	29,778	133,601							
Tribe	HID9400153	64HD00011	Kalispel	12,942	12,942	12,942	12,942	12,942	25,884	12,942	13,099	26,041	116,792							
Tribe	HID9400273	64HD00012	Klamath	36,069	36,069	36,069	36,069	77,225	113,294	36,069	78,754	114,823	451,147							
Tribe	HID9400090	64HD00013	Kootenai	12,116	12,116	12,116	12,116	12,116	24,232	12,116	12,228	24,344	109,268							
Tribe	HID9400285	64HD00014	L Elwha	22,589	22,589	22,589	22,589	29,461	52,050	22,589	30,044	52,633	225,083							
Tribe	HID9400335	64HD00015	Lummi	59,998	59,998	59,998	59,998	162,862	222,860	59,998	166,087	226,085	855,024							
Tribe	HID9400237	64HD00016	Makah	29,542	29,542	29,542	29,542	65,821	95,363	29,542	67,125	96,667	377,323							
Tribe	HID9400149	64HD00017	Muckleshoot	42,384	42,384	42,384	42,384	103,800	146,184	42,384	105,856	148,240	569,816							
Tribe	HID9400097	64HD00018	Nimipuu Health	50,715	50,715	50,715	50,715	126,256	176,971	50,715	128,756	179,471	688,058							
Tribe	HID9400352	64HD00019	Nisqually	24,193	24,193	24,193	24,193	28,616	52,809	24,193	29,183	53,376	232,140							
Tribe	HID9400074	64HD00020	Nooksack	21,812	21,812	21,812	21,812	26,891	48,703	21,812	27,424	49,236	212,611							
Tribe	HID9400160	64HD00021	NW Shoshoni	13,231	13,231	13,231	13,231	13,231	26,462	13,231	13,265	26,496	119,147							
Tribe	HID9400328	64HD00022	Pt. Gamble	20,960	20,960	20,960	20,960	36,817	57,777	20,960	37,546	58,506	237,669							
Tribe	HID9400251	64HD00023	Puyallup	92,509	92,509	92,509	92,509	255,574	348,083	92,509	260,636	353,145	1,331,900							
Tribe	HID9400321	64HD00024	Quileute	17,515	17,515	17,515	17,515	18,057	35,572	28,679	29,624	58,303	182,350							
Tribe	HID9400098	64HD00009	Hoh	11,614		11,614	11,614	Did not apply	11,614				33,942							
Tribe	HID9400340	64HD00025	Quinalt	42,108	42,108	42,108	42,108	86,200	128,308	42,108	87,907	130,015	514,662							
Tribe	HID9400371	64HD00026	Samish	12,304	12,304	12,304	12,304	12,304	24,608	12,353	12,353	24,706	110,932							
Tribe	HID9400357	64HD00027	Sauk-Suiattle	12,992	12,992	12,992	12,992	12,992	25,984	12,992	13,097	26,089	117,138							
Tribe	HID9400341	64HD00028	Shoalwater Bay	14,045	14,045	14,045	14,045	14,045	28,090	14,045	14,288	28,333	126,891							
Tribe	HID9400179	64HD00029	Shoshone-Bannock	79,655	79,655	79,655	79,655	206,578	286,233	79,655	210,669	290,324	1,105,846							
Tribe	HID9400174	64HD00030	Siletz-SG	78,490	78,490	78,490	78,490	171,803	250,293	78,490	175,205	253,695	993,153							
Tribe	HID9400313	64HD00031	Skokomish	21,800	21,800	21,800	21,800	35,128	56,928	21,800	35,824	57,624	237,576							
Tribe	HID9400315	64HD00032	Spokane	42,484	42,484	42,484	42,484	73,811	116,295	42,484	75,273	117,757	479,261							
Tribe	HID9400178	64HD00033	Squaxin Island	20,447	20,447	20,447		24,639	24,639	20,447	25,127	45,574	177,128							
Tribe	HID9400075	64HD00034	Stillaquamish	12,667	12,667	12,667	12,667	12,667	25,334	12,667	12,780	25,447	114,229							
Tribe	HID9400334	64HD00035	Suquamish	16,300	16,300	16,300	16,300	16,300	32,600	16,300	16,493	32,793	147,086							
Tribe	HID9400076	64HD00036	Swinomish SG	20,535	20,535	20,535	20,535	32,734	53,269	20,535	33,382	53,917	222,708							
Tribe	HID9400324	64HD00037	Tulalip	48,685	48,685	48,685	48,685	117,421	166,106	48,685	119,746	168,431	649,023							
Tribe	HID9400316	64HD00038	Umatilla (Yellowhawk)	44,639	44,639	44,639	44,639	98,731	143,370	44,639	100,686	145,325	567,937							
Tribe	HID9400077	64HD00039	Upper Skagit	15,586	15,586	15,586	15,586	15,586	15,586	15,586	17,697	33,283	128,910							
Tribe	HID9400197	64HD00040	Warm Springs	64,684	64,684	64,684	64,684	174,444	239,128	64,684	177,899	242,583	918,346							
Tribe	HID9400286	64HD00041	Yakama SU	151,717	151,717	151,717	151,717	411,819	563,536	151,717	419,975	571,692	2,162,071							
IHS	HID9400399		Yakama SU									20,000	20,000							
IHS	HID9400084	64HD00042	Portland I.H.S.	116,154	127,768	82,905	114,966		114,966				441,793							
IHS	HID9400387		Western Oregon SU					40,000	40,000		41,927	41,927	123,854							
Tribe	HID9400389		NWPAIHB						167,371	82,905	148,893	231,798	630,967							
Tribe	HID9400400		Snoqualmie									22,398	44,796							
<b>TOTAL</b>				<b>1,592,172</b>	<b>1,592,172</b>	<b>1,558,473</b>			<b>4,889,002</b>			<b>4,992,408</b>	<b>4,950,035</b>	<b>19,574,262</b>						

4 awarded in Idaho  
12 awarded in Oregon  
1 awarded in Utah  
29 awarded in Washington



SUMMARY OF YR 1-6

GRANTS FOR SPECIAL DIABETES PROGRAM FOR INDIANS - URBAN PROGRAMS

Tribe IHS Urban	NEW GRANT NUMBER	FORMER GRANT NUMBER	GRANTEE	AWARDED			AWARDED			AWARDED			AWARDED		GRAND TOTAL
				1997-1998	1998-1999	1999-2000	2000-2001		2001-2002		2002-2003				
				Yr 1 BBA Amt	Yr 2 BBA Amt	Yr 3 BBA Amt	Yr 4 BBA Amt	Yr 4 Supple- ment	TOTAL BBA/ Suppl	Yr 5 BBA Amt	Yr 5 CAA Amt	TOTAL BBA/ CAA	Yr 6 CAA Amt		
Urban	H1D9400318	ISHD02180	SD Urban Indian Health	46,875	45,455	44,953	43,631	123,570	167,201	43,631	91,638	135,269	132,837	572,590	
Urban	H1D9400083	ISHD02181	Nebraska Urban IHC	46,875	45,455	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,869	
Urban	H1D9400319	ISHD02182	1st Nations CHS	46,875	45,455	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,869	
Urban	H1D9400089	ISHD02183	Denver Indian Health	46,875	45,455	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,869	
Urban	H1D9400288	ISHD02184	American IHS Chicago	46,875	45,455	44,953	43,631	123,570	167,201	43,631	91,638	135,269	132,837	572,590	
Urban	H1D9400281	ISHD02185	Utd Amer Ctr-Green Bay	46,875	45,455	44,953	43,631	50,181	93,812	43,631	61,092	104,723	103,103	438,921	
Urban	H1D9400360	ISHD02186	Milwaukee-Gerald Ignace	46,875	45,454	44,973	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,888	
Urban	H1D9400230	ISHD02187	IHB of Minneapolis - MN	46,875	45,455	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,869	
Urban	H1D9400289	ISHD02188	AIH, Detroit, MI	46,875	45,455	44,953	43,631	123,570	167,201	43,631	91,638	135,269	132,837	572,590	
Urban	H1D9400282	ISHD02189	IHB of Billings	46,875	45,455	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,869	
Urban	H1D9400295	ISHD02190	NAIA, Butte, MT	46,875	45,455	44,953	43,631	50,181	93,812	43,631	61,092	104,723	103,103	438,921	
Urban	H1D9400397	ISHD02191	Helena-Great Falls	46,875	45,455					43,631	91,638	135,269	162,570	390,169	
Urban	H1D9400317	ISHD02192	Helena Indian Alliance	46,875	45,455	44,953	43,631	123,570	167,201	43,631	91,638	135,269	162,570	602,323	
Urban	H1D9400284	ISHD02193	Missoula Indian Center	46,875	45,455	44,953	43,631	50,181	93,812	43,631	61,092	104,723	103,103	438,921	
Urban	H1D9400262	ISHD02194	San Diego AIHC - CA	46,875	45,455	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,869	
Urban	H1D9400082	ISHD02195	Sacramento Urban - CA	46,875	45,455	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,869	
Urban	H1D9400304	ISHD02196	UIHB - Oakland, CA	46,875	45,455	44,953	43,631	123,570	167,201	87,262	183,276	270,538	265,673	840,695	
Urban	H1D9400303	ISHD02197	Fresno Indian Health - CA	46,875	45,455	44,953	43,631		43,631	funds to UIHB-Oakland				180,914	
Urban	H1D9400398	ISHD02198	AIHP - Bakersfield	46,875	45,454				93,812	43,631	61,092	104,723	103,103	393,967	
Urban	H1D9400312	ISHD02199	IHC/Santa Clara Valley	46,875	45,454	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,868	
Urban	H1D9400308	ISHD02200	UAI Involvement - LA	46,875	45,455	44,953	43,631	50,181	93,812	43,631	61,092	104,723	103,103	438,921	
Urban	H1D9400310	ISHD02201	AIH&HS-Santa Barb	46,875	45,454	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,868	
Urban	H1D9400322	ISHD02202	AIC-NY	46,875	45,454	44,953	43,631	50,181	93,812	43,631	61,092	104,723	103,103	438,920	
Urban	H1D9400330	ISHD02203	NA Center of Boston	46,875	45,454	44,953	43,631	50,181	93,812	43,631	61,092	104,723	103,103	438,920	
Urban	H1D9400331	ISHD02204	NAC Flagstaff, AZ	46,875	45,454	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,868	
Urban	H1D9400264	ISHD02205	Dallas Inter-Tribal	46,875	45,454	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,868	
Urban	H1D9400244	ISHD02206	Hunter Health Clinic	46,875	45,454	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,868	
Urban	H1D9400351	ISHD02207	Nevada Urban - Reno	46,875	45,454	44,953	43,631	50,181	93,812	43,631	91,638	135,269	132,837	499,200	
Urban	H1D9400229	ISHD02208	NACHC-Phx	46,875	45,454	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,868	
Urban	H1D9400323	ISHD02209	NARA - Portland, OR	46,875	45,454	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,868	
Urban	H1D9400305	ISHD02210	Seattle IH Board	46,875	45,454	44,953	43,631	123,570	167,201	43,631	122,184	165,815	162,570	632,868	
Urban	H1D9400314	ISHD02211	ITHCC - Tucson	46,875	45,454	44,953	43,631	50,181	93,812	Changed name & ID#		104,723	103,103	438,920	
Urban	H1D9400245	ISHD02392-01	IWC- Salt Lake City		45,454	44,953	43,631	50,181	93,812	43,631	61,092	104,723	132,837	421,779	
Urban	H1D9400406		Tucson Indian Center						93,812	43,631	61,092	104,723	103,103	301,638	
Urban	H1D9400370		N.A.T.I.V.E.-Spokane			44,953	43,646	123,570	167,216	43,646	122,184	165,830	162,570	540,569	
Urban	H1D9400396		Seattle IHB					125,000	125,000		125,000	125,000	125,000	375,000	
Urban	H1D9400395		IHB of Billings					31,000	31,000		14,940	14,940	14,957	60,897	
	<b>TOTAL</b>			<b>1,500,000</b>	<b>1,500,000</b>	<b>1,438,516</b>			<b>4,910,000</b>			<b>5,088,192</b>	<b>5,086,572</b>	<b>19,523,280</b>	

4 awarded in Arizona  
8 awarded in California  
1 awarded in Colorado  
1 awarded in Illinois  
1 awarded in Kansas

1 awarded in Massachusetts  
1 awarded in Michigan  
1 awarded in Minnesota  
1 awarded in Montana  
1 awarded in Nebraska

1 awarded in Nevada  
1 awarded in New Mexico  
1 awarded in New York  
1 awarded in Oregon  
1 awarded in South Dakota

1 awarded in Utah  
3 awarded in Washington  
2 awarded in Wisconsin

APPENDIX

Grant Programs  
by Area - H&S Areas