Tribal Leaders Diabetes Committee

Summary of Meeting Minutes

(Approved August 11, 2005)

February 10–11, 2005
Denver, Colorado

TLDC Members Present: Dr. Kelly Acton (Federal co-chair), Christine Arzate (California), Jerry Freddie (Navajo), David Garcia (Albuquerque), Linda Holt (Portland), Sandra Ortega (Tucson), Dr. Judy Goforth Parker (Oklahoma), Buford Rolin (Tribal alternate co-chair; Nashville), H. Sally Smith (Alaska)

Others in Attendance: AnnaMarie Bosma, Michael Bitrick, Elaine Dado, Dr. Lemyra DeBruyn, Dr. Brenda Farris, Martia Glass, Lois Hodge, Dr. Spero Manson, Dr. Kelly Moore, Robert Nakai, Anthia Nickerson, Marie Osceola-Branch, J.T. Petherick, Dawn Phillips, Madan Poudel, Charles Rhodes, Dianna Richter, Jim Robertson, Dr. Yvette Roubideaux, P. Ben Smith, Tina Tah, Dr. Bernadine Tolbert, Althea Tortalita, Mary Tso

Frequently Used Abbreviations:

AI/AN	American Indian and Alaska Native
ATNI	Affiliated Tribes of Northwest Indians
BBA	Balanced Budget Act of 1997
BIA	Bureau of Indian Affairs
CDC	Centers for Disease Control and Prevention
DETS	Diabetes-based Science Education in Tribal Schools
DDTP	Division of Diabetes Treatment and Prevention
DGO	Division of Grants Operations
DMS	Diabetes Management System
DPP	Diabetes Prevention Program
DUNS	Data Universal Numbering System
GPRA	Government Performance and Results Act
IHCIA	Indian Health Care Improvement Act
IHS	Indian Health Service
IRB	Institutional Review Board
IT	information technology
MOU	Memorandum of Understanding
NARCH	Native American Research Centers for Health
NDPC	National Diabetes Prevention Center
NDWP	Native Diabetes Wellness Program
NIDDK	National Institute of Diabetes and Digestive and Kidney Diseases

Frequently Used Abbreviations (continued)

NIH ..... National Institutes of Health
NIHB ..... National Indian Health Board
NPAIHB ..... Northwest Portland Area Indian Health Board
PART ..... Performance Accountability Report
RFA ..... Request for Application
RPMS ..... Resource and Patient Management System
SDPI ..... Special Diabetes Program for Indians
TLDC ..... Tribal Leaders Diabetes Committee
VA ..... Department of Veterans Affairs

Summary of Motions:

- TLDC meeting agenda for February 10–11, 2005, was approved
- TLDC meeting minutes from January 7–8, 2004, were approved
- NIHB will begin managing travel and meeting expenses for the TLDC
- Buford Rolin elected as the Tribal co-chair
- Judy GoForth Parker elected as the Tribal alternate co-chair

Summary of Meeting Action Items:

- The IHS DDTP will work with the IHS public relations office to develop a protocol for distributing the Report to Congress
- The IHS DDTP will bring reports on data infrastructure activities from the national IT department to the next TLDC meeting
- The competitive grant program coordinating center discussed posting the contact information for each EpiCenter on the competitive grant program website
- The IHS DGO will inform IHS Headquarters about the concern expressed by a TLDC member that the carryover policy should be developed with Tribal consultation
- The TLDC representative from the Albuquerque Area would like a copy of the department alert list for his Area
- The IHS DGO will work with the IHS DDTP to provide grantees with training on the application process, budgets, payment management, and grant requirements
- The IHS DDTP and the NIHB will hold a training for IHS DGO staff
- The IHS DGO will examine the possibility of assigning each Area to a particular staff member

Summary of Meeting Action Items (continued)

- The Federal co-chair recommended that the Area diabetes consultants be preserved in the new version of the IHCIA
- The NIHB will manage TLDC travel and meeting funds and will provide the TLDC with quarterly expenditure reports
- Mr. Rolin and Dr. Acton will write a letter to Dr. Grim with the TLDC response to Dr. Grim's TLDC letter. A draft of the response letter will be sent to TLDC members for comment before the letter is sent to Dr. Grim
- The NPAIHB volunteered to host the next quarterly meeting in Portland, Oregon, May 12–13, 2005
- The NIHB, with input from Lorraine Valdez and Dr. Yvette Roubideaux, will develop a draft charter for the TLDC, which will be reviewed at the next TLDC meeting
- Linda Holt from the Portland Area has volunteered to serve as the TLDC representative to the Chronic Disease Workgroup. Dr. Acton and Ms. Holt will update the TLDC on the progress of the workgroup at future TLDC meetings
- H. Sally Smith from the Alaska Area requested that support for Tribal epidemiology centers be added to the next meeting agenda. The NPAIHB will prepare an information packet on all of the Tribal epidemiology centers for the TLDC prior to the next meeting
- Co-chair Buford Rolin requested that the next meeting agenda include developing a calendar of TLDC activities for the rest of 2005
- IHS Areas and organizations without TLDC representation need to appoint their representatives

Tribal Leaders Diabetes Committee Meeting

Day 1: February 10, 2005

Subject	Discussion	Action
Welcome, Prayer, and Introductions	**Day One—Thursday, February 10, 2005** **Mr. Buford Rolin, acting co-chair, called the meeting to order at 9:20 a.m.** Mr. Rolin:	
Changes to TLDC leadership	– Informed the committee that: ▪ Mr. Alvin Windy Boy will no longer serve as the Tribal co-chair. ▪ Dr. Kermit Smith will no longer serve as the Federal co-chair. ▪ The IHS deputy director, Mr. Robert McSwain, has appointed Dr. Kelly Acton as the new Federal co-chair.	
Discontinuation of the Member-at-large position	▪ IHS director Dr. Charles Grim has discontinued the member-at-large position.	
	– Delivered the opening prayer. – Asked committee members and guests to introduce themselves. – Reviewed meeting agenda.	
Motion carried to adopt the meeting agenda	**Ms. Smith moved to approve the meeting agenda. Dr. GoForth Parker seconded the motion. All in favor. Motion carried.**	
Reorganization of the IHS	Mr. Rolin notified the committee about the reorganization of the IHS: – Dr. Grim has named a new deputy director, Mr. McSwain. – Dr. Grim expects to fill several other positions, including the chief medical officer. – The National Diabetes Program has been elevated to the status of division. It is now called the Division of Diabetes Treatment and Prevention. The division will remain in Albuquerque.	
Concerns of the TLDC members	Mr. Rolin opened the floor for committee members to voice concerns: – Mr. Garcia noted that Tribal leaders from the Albuquerque Area have voiced concern about the SDPI competitive grant program, reorganization of the IHS, facility closures, and need for data improvement. – Mr. Freddie voiced concern about the TLDC's need to regroup, provide feedback on the IHS reorganization process, and develop methods for distributing information on various Indian health initiatives. – Ms. Arzate noted that the California Area is concerned about the evaluation process, how information is gathered, and the status of current programs. The California Area also has concerns about carryover and programs that may not have met their goals.	

Subject	Discussion	Action
Concerns of the TLDC members (continued)	– Ms. Holt voiced concern about small Tribes, the evaluation process, how information is used, and the role of EpiCenters in providing information to Tribes in their regions. – Mr. Rolin mentioned the Federal government's interest in health promotion and disease prevention, and notified the committee that the IHS received excellent scores for GPRA and PART and received an overall increase in its budget (though some budget line items, such as construction and housing, received cuts). Mr. Rolin also emphasized the importance of obtaining the support of partner organizations as the IHS nears the final year of the SDPI.	
Review of TLDC meeting minutes	**Ms. Smith moved to approve the TLDC meeting minutes of January 7–8, 2004. Ms. Arzate seconded the motion. All in favor. Motion carried.**	
Update on the SDPI Diabetes prevalence Non-competitive SDPI History of the SDPI Purpose of the SDPI Best practices	Dr. Acton from the IHS DDTP provided an update on the SDPI: – Dr. Acton opened the presentation by showing the latest data from the CDC on diabetes prevalence among adults by age, race and ethnicity, and sex in the U.S. For every age group compared to other races (i.e., white men and women, black men and women, and Hispanic men and women), AI/ANs have the highest prevalence of diabetes. – Dr. Acton's presentation focused on the non-competitive grants. She proposed that the IHS change the name of the non-competitive program. The SDPI currently has 318 grantees. 81% of programs are Tribally run, 9% are IHS, and the rest are urban programs. – The SDPI started in 1997 when the BBA gave the IHS $30 million for five years (1998–2002). In 2001, Congress increased the amount from $30 million per year to $70 million a year for 2001 and 2002. When the $30 million per year ran out in 2002, Congress brought the amount up to $100 million for 2003. Since 2001, the SDPI has received $100 million per year. In 2003, the SDPI received an additional $50 million per year through 2008. Because the funds came to the IHS at the end of the fiscal year, they will extend through 2009. – The purpose of the original legislation was the prevention and treatment of diabetes. Congress instructed the IHS to distribute the funds through a grants process and evaluate the program; in 2000, the IHS submitted a report on the SDPI to Congress. – In 2001, Congress required the SDPI to follow a best practices approach. The IHS DDTP pulled together experts from the IHS and CDC to develop 14 best practices. They covered foot care, eye care, heart disease, basic diabetes care, school health, exercise, nutrition, etc. The grantees receive the best practices each year, and the IHS DDTP assesses their use. The best practices will be updated in August 2005, and the IHS DDTP plans to add five or six new best practices, such as prediabetes and metabolic syndrome.	

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Building on lessons learned and working with partners	– Congress also required the SDPI to build on lessons learned and to work with partners, such as the NIH, CDC, and ADA. To fulfill this requirement, the IHS DDTP has held large regional meetings where grantees share and gather information, has worked closely with its partners, and will distribute the SDPI Report to Congress.	
Report to Congress and ideas to distribute the report	– Dr. Acton asked the TLDC for input on how to use the Report to Congress for maximum effect. Ideas included an ADA event in Washington D.C., Tribes and Tribal organizations distributing the reports in Washington D.C., distributing an Executive Summary of the report, and making the report available on the web. Dr. Acton will work with the IHS public relations office to ensure that protocols are followed.	The IHS DDTP will work with the IHS public relations office to determine the protocol for distributing the Report to Congress
Data infrastructure and competitive grant program	– In 2004, Congress directed the IHS to maintain current grant programs, strengthen the data infrastructure, and develop a competitive grant program with a focus on two areas: (1) primary prevention of diabetes, and (2) the most compelling complication of diabetes, which is cardiovascular disease.	
2004 funding allocation	– For the $150 million in funding for 2004, $108.9 million was distributed to the Areas by formula, and $5.2 million was allocated to strengthen the data infrastructure for the Indian health system. Dr. Acton has asked for reports from the national IT department to track how the data improvement funds are being spent and will bring these reports to the next TLDC meeting. $27.4 million went to the competitive grant program, $7.5 million went to the urban allocation, and $1 went to the NDPC.	The IHS DDTP will bring reports on data infrastructure activities from the national IT department to the next TLDC meeting
Concerns about the IT budget cuts	Mr. Roberts from NPAIHB raised concern that funds intended for diabetes treatment and prevention may be used to offset the budget cuts for IT.	
Office of Inspector General review	Dr. Acton informed that committee that the Office of Inspector General will conduct a review of the SDPI in late 2005. The review will focus on the SDPI grants and financial processes, policies and procedures, and application and monitoring guidelines. The goal of the review is to help the SDPI and provide guidance about how to improve processes. Dr. Tolbert noted that the Office of Inspector General will ask about the processes and will look at what the processes should be. She further noted they will probably review work plans (i.e., what programs said they were going to do) and progress reports (i.e., do the reports reflect the process and outcomes measures that programs said that they were going to carry out).	
Technical assistance for non-competitive grantees	Dr. Acton reviewed the technical assistance that the IHS DDTP has provided grantees: – Successful regional meetings around the country in 2004 to provide technical assistance. – Summer institute in conjunction with the Oregon Health Sciences University in Portland and the University of New Mexico in Albuquerque will take place in summer 2005. – Upcoming newsletters to showcase grantees' successes and help other grantees learn about and contact the showcase grantees.	

Subject	Discussion	Action
Reporting requirements and budget justifications	– Plans to expand and refine evaluation activities. Dr. Acton summarized policy changes regarding reporting requirements and budget justifications. The IHS DDTP is considering requiring grantees to report every six months, rather than every year. In addition, grantees will be required to provide more detailed budget justifications. **Break at 11:00 a.m.**	
Update on the Competitive Grant Program Background on the competitive grant program Tribal and Area consultation Funding Description of the demonstration projects Collaborative evaluation process	**Mr. Rolin called the meeting back to order at 11:21 a.m.** Dr. Acton provided an update on the new Competitive Grant Program: – Congress directed the IHS DDTP to implement a competitive grant program for the primary prevention of type 2 diabetes and the most compelling complication of diabetes, which is cardiovascular disease, and to evaluate the program in 2008. – Dr. Acton described the Tribal and Area consultation process for this initiative. The TLDC and Dr. Grim reviewed recommendations from each Area. The TLDC also provided a set of recommendations for Dr. Grim, which stated that the eligible entities for the competitive grant program should be SDPI grantees and that the selection of the grantees must take into consideration diversity by Area, region, program size, and type of program. The TLDC also wanted strong coordination and evaluation of this program. – The competitive grant program is a $27.4 million program ($23.3 million to the grantees and $4.1 million for the administration, coordination, and evaluation of the program). Grantees had to compete for available funding, and grantees could not be awarded grants in both diabetes prevention and cardiovascular disease risk reduction. – The competitive grant program is set up as a demonstration project. The goal is to take existing information from the scientific literature and figure out how to use it in AI/AN communities. For the primary prevention of type 2 diabetes demonstration projects, the grantees will implement the standardized DPP curriculum for individuals at risk for diabetes. The second demonstration project will be a cardiovascular disease risk reduction project for people who already have type 2 diabetes. The grantees are pulling from a number of different studies and curricula to design the project. It will use a clinical, case-management, team approach to treating the risk factors for cardiovascular disease to specific target levels in people with diabetes. Both demonstration projects will include community prevention activities that the grantees will design for their individual communities. – The evaluation will be comprehensive, multi-component, and designed through a collaborative process with the grantees. Congress has notified the IHS that future funding might be affected by the evaluation of this project.	

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Grantee selection process Project timeline Structure of the program	The IHS DDTP office and the coordinating center will analyze and report the data. There will not be a release of the data before it is brought to the TLDC and has received clearance from the IHS DDTP. – The RFA went out in May 2004, the applications were due on July 1, and the notice of grant awards went out in September 2004. The IHS DDTP received 128 applications; 36 DPP applications were approved for funding, and 30 cardiovascular disease applications were approved for funding. It was a very competitive selection process, using an NIH style review process with some outside reviewers. – 2005 is the planning year. 2006–2008 will be for the demonstration project activities. 2009 will be a dissemination and training year so that all of Indian Country to benefit from what was learned. – The IHS DDTP is responsible for general oversight, coordination, and leadership of the project. The Area diabetes consultants provide general oversight in their Areas, attend the planning meetings, and offer their expertise and guidance; they are not coordinating the day-to-day management of the competitive grant programs. The IHS DGO provides general oversight of the grants administration, financial audits, monitoring, and reports. The coordinating center at the University of Colorado Health Sciences Center is responsible for the day-to-day coordination and evaluation of this project. The resource core, which is a group of science and content experts who can provide technical assistance and expertise over the phone or through on-site visits, is still being developed.	
Description of the coordinating center Purpose of the coordinating center University of Colorado Health Sciences Center experience Six cores of the coordinating center	Dr. Spero Manson is the director of the coordinating center, which is a joint effort between the University of Colorado Health Sciences Center and the University of Arizona. He provided an overview of the coordinating center: – The purpose of the coordinating center is to organize, support, and manage multiple sites committed toward a common goal; ensure effective, timely, and accurate communication; oversee implementation of a core set of activities while accommodating local variation; identify and address highly variable and considerable technical assistance needs; comprehensively evaluate the processes and outcomes of the efforts; and disseminate information and results in a timely, appropriate manner. – The University of Colorado Health Sciences Center has considerable experience in working with Tribes, non-reservation based communities, urban Indian organizations, Alaska Native villages, and rural communities. It has been the coordinating center for previous multi-site intervention projects in Indian communities, such as the Healthy Nations Initiative and the Circles of Care Initiative. – Six cores represent the basic functions of the coordinating center: (1) Administration Core responsible for administrative details, logistics, and communication; (2) Data Core responsible for the processes for identifying areas of measurement and evaluation; (3) Resource Core responsible for providing technical assistance to each grantee; (4) Information Technology	

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	Core responsible for IT support; (5) Human Participant Protection Core responsible for helping acquire approvals required for evaluation and data collection; (6) Dissemination Core responsible for developing mechanisms to share successes with other SDPI grantees and other stakeholders.	
Coordinating center planning groups and committees	– The coordinating center has a Planning Group, which includes the IHS DDTP and coordinating center staff who meet on a weekly basis. The Executive Committee, which includes the coordinating center staff, handles day-to-day operations. The Steering Committee includes IHS DDTP staff, coordinating center staff, grantee representatives, and technical experts to serve in an advisory capacity. The Core Committees include with grantee representatives, coordinating center staff, and IHS DDTP representatives who have advisory roles on specific components of the projects. The Dissemination Committee will develop procedures for dissemination and publication, develop oversight processes, identify key audiences, determine the form that communication should take, and identify feedback procedures.	
Challenges	– The challenges of the competitive grant program include ensuring the mandatory participation of all grantees, balancing the needs of the more versus less experienced programs, providing adequate and timely training and technical assistance, providing clear communication about the details and required elements of the projects, project leadership, timely staffing, turnover in grant programs, coordination among multi-site programs, on-site training for IT support and data collection procedures, and balancing the need for uniformity in the evaluation approach with local variation.	
Importance of the success of the competitive grant program	Dr. Roubideaux, who is the co-director of the initiative and the head of the resource core, noted that future funding may depend on the success of the competitive grant program, and that grantees need to show that they can successfully prevent diabetes and cardiovascular disease risk in AI/AN communities.	
Role for the EpiCenters and NARCH programs	Mr. Roberts asked if there is a role for the EpiCenters in the competitive grant program. Tribal leaders at the recent ATNI meeting voiced concern about developing capacity at the EpiCenters. – Dr. Acton stated that there is a role for the EpiCenters, particularly during the dissemination year. She is currently reviewing a draft scope of work for the EpiCenters focusing on training and technical assistance that use similar models to those developed at the Portland Area EpiCenter. – Dr. Acton felt that the EpiCenters' role should not be limited to the competitive grant program; it should include the data system as a whole. – Dr. Roubideaux noted that her survey of technical assistance needs among the competitive grantees showed that their needs were more than the coordinating center can handle. The resource core will help connect grantees to technical assistance and could provide the contact information for the EpiCenters on its website. – Dr. Manson also suggested a role for the NARCH programs.	Post the contact information for each EpiCenter on the competitive grant program website

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Concerns about the non-competitive versus competitive grant programs	Mr. Poudel voiced concern about the need to avoid giving the impression to Congress that only the competitive programs work and the non-competitive programs don't work. Dr. Acton agreed: – The way that we talk about our work—the "spin"—is as important as the work we do. It is important to point out that a process like this could not possibly take place on a scale as large as the non-competitive program. – If Congress is interested in seeing change, then funding small, intense projects in a competitive way, getting the best of the best to figure out how to do things, and then disseminating the "how" information to the rest of the programs, will be extremely important. **Break for lunch at 12:30 p.m.**	
Update on the IHS DGO Budget justifications and negotiations Carryover policy Annual reporting changing to semi-annual reporting Indirect cost rates	**Mr. Rolin called the meeting back to order at 1:33 p.m.** Ms. Hodge provided an update from the IHS DGO. Changes in grants policy include: – The requirement of detailed budget justifications from grantees. This will help the IHS DGO understand how costs relate to diabetes treatment and prevention as allowed under the Office of Management and Budget cost principles. – A new carryover policy. ▪ Michelle Bulls from the NIH has joined the IHS DGO to write the carryover policy for the IHS. The policy proposes that 25% of funds can be carried over. Grantees with carryover greater than 25% will need to provide a justification to ensure that money is being spent on diabetes as originally planned. For grantees with a large carryover balance of 50% or more, they will be monitored more to ensure that money is being spent. The IHS DGO is considering putting a restriction on awards pending the spending of the carryover. ▪ Once the policy is approved by Dr. Grim, it will go to the DHHS. ▪ The SDPI legislation specifies that funds are available until spent. Although the department has a carryover policy, legislation takes priority over department policy. That is why the IHS DGO is developing a new policy. ▪ Mr. Garcia and Mr. Nakai felt that Tribal consultation was a necessary step in the development of the carryover policy. Ms. Hodge will inform Dr. Grim's office of their concerns. – The requirement of semi-annual reporting. This will help the IHS DGO track expenditures and inform grantees on spending status. – The requirement that grantees provide current indirect cost rates. The rate must be current for the time of the active grant. If a grantee has an expired rate, the IHS DGO will put a restriction on the indirect costs until they	The IHS DGO will inform IHS Headquarters about the concern expressed by a TLDC member that the carryover policy should be developed with Tribal consultation

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The need for up-to-date financial audits Training and technical assistance Website FY 2006 continuation application kit Requests from the Albuquerque Area	receive the current rate. To avoid restrictions, grantees can submit a letter from whoever negotiates the rate (e.g., Department of Interior) extending the current rate until the new rate is approved. Grantees usually need to apply for a new rate six months before the current rate expires. – Indirect cost rates are also based on the financial audits. Audits that are not current will hold up indirect cost rate proposals. In addition, the Office of Inspector General is preparing to implement a plan to implement sanctions if programs do not have up-to-date audits. Ms. Hodge noted that she will work with the IHS DDTP to provide grantees with training on the applications process, budgets, payment management, submitting applications electronically, and grant requirements. Ms. Hodge, Dr. Acton, and Mr. Petherick from the NIHB discussed the possibility of the IHS DDTP and NIHB conducting a training session for IHS DGO staff. The IHS DGO is also developing a website for grants and policy, where they will post policies, policy changes, application kits, and information that is helpful to grantees. In addition, the IHS DGO will work with the IHS DDTP on the FY 2006 continuation application kit with the goal of minimizing what is asked of grantees. Mr. Garcia made a request and several recommendations: – Requested a copy of the department alert list for his Area. – Recommended that the IHS DGO trainings include financial status reports and that finance department personnel be invited to participate. – Recommended that the new application kits include the identification of the organization's DUNS number and that the continuation application simply be a summary of what the grantees are doing and the budget justification. – Recommended that the IHS DGO assign one staff person to specific IHS Areas. Ms. Hodge said the IHS DGO assigns grants based on levels of complexity and grade level, but she will see if assigning one staff to specific Areas would be possible.	The IHS DGO and DDTP will provide grantees with training and technical assistance The IHS DDTP and NIHB will hold a training for IHS DGO staff A TLDC member would like a copy of the department alert list for his Area The IHS DGO will examine the possibility of assigning each Area to a particular staff member
DETS Project Update Purpose of DETS	Dr. Moore from the IHS DDTP provided an update on the DETS Project, which is a grant project that stands for the Diabetes-based Science Education in Tribal Schools. – NIDDK is the leader of this initiative with two Federal partners: CDC Native Diabetes Wellness Program (formerly the NDPC) and IHS DDTP. – Many Tribal colleges received this grant award, and a diverse group of AI/AN communities are represented in this initiative. – The purposes of the initiative are to: ▪ Develop and implement a school-based diabetes curriculum that supports the integration of AI/AN culture and community	

Subject	Discussion	Action
Purpose of DETS (continued)	knowledge with diabetes-related science. ▪ Use diabetes as a model to engage AI/AN students in considering a career in health or biomedical research. ▪ Increase K–12 AI/AN students' understanding and appreciation of the process of developing scientific and community knowledge in relation to health, diabetes, and maintaining healthy balances.	
Steering committee	– The steering committee is divided into three subcommittees based on school grades: (1) K–Grade 4; (2) Grades 5–8; and (3) Grades 9–12. There are also evaluation, scientific review, curriculum development, and external advisory subcommittees.	
National standards	– The project aims to design the curriculum so that it meets national scientific education benchmarks and standards across the country so that it can be disseminated nationwide.	
Teaching materials	– The teaching materials are culturally-sensitive, are appropriate to a diverse range of AI/AN communities, and provide hands-on, science-based materials that reflect traditional learning styles, such as emphasizing visual, spatial, and perceptual modes of learning.	
Evaluation	– The project includes a very strong evaluation component, which includes pre-and post-testing for determining students' progress, attitude change, and knowledge increase.	
Progress	– Tribal colleges have already formed partnerships with local school districts, and the pilot tests of the lesson plans are complete. The project expects to conduct more extensive, systematic field tests of the lesson plans from September 2005 through June 2006. **Break at 3:07 p.m.**	
IHS Diabetes Care and Outcomes Audit Results, GPRA, and PART	**Mr. Rolin called the meeting back to order at 3:30 p.m.** Dr. Moore from the IHS DDTP provided a presentation on the IHS diabetes audit, GRPA, and PART.	
IHS Diabetes Care and Outcomes Audit	– The diabetes audit, GPRA and PART are important because they demonstrate the quality of care in the Indian health system. – The annual diabetes audit is a chart audit that looks at the medical records of people with diabetes. It is based on the standards of care for diabetes that were developed in 1986, and looks at more than 85 different process and outcome measures related to the care of diabetes. Sites voluntarily participate. – The audit allows the IHS DDTP to construct rates over time and provide local reports down to the facility level, regional reports by Area, and a national report, which is used to present data to Congress and other outside agencies and funders.	

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Improvements in diabetes care	– Dr. Moore shared data on glycemic control, blood pressure control, proportion of patients with diabetes who had their LDL cholesterol (i.e., bad cholesterol) examined, proportion of patients screened for kidney disease, use of ACE inhibitors, and annual dental exam rates—all of which have improved over time.	
Challenges associated with retinopathy assessments	– Dr. Moore reported that the Indian health system did not meet its performance targets with retinopathy assessments due to staff vacancies. Dr. Horton, the Chief Ophthalmologist and Optometrist for the IHS, is examining how to mitigate staffing problems.	
Prevalence	– The IHS DDTP also collects data on prevalence and reports it, even though GRPA no longer requires it. The age-adjusted prevalence for all of the IHS is 15%. The highest increase in prevalence between 1997 and 2002 was in the Alaska Area between 1997 and 2002. The most alarming increase in prevalence is among the younger age groups. The adolescent population has experienced a 106% increase, and young adults (25–34 years of age) experienced a 132% increase from 1990 to 2002. This trend is being replicated in other minority groups worldwide.	
Main accomplishments of the Indian health system	– Dr. Moore summarized the main accomplishments of the diabetes programs as: clinical care of diabetes, consistency through standards and guidelines, increased provider awareness, improved data quality, enhanced and measured delivery and quality of care, clinical and public health approach, and development of a diabetes network for rapid translation.	
IHCIA Update	Mr. Rolin and Ms. Smith provided an update on the IHCIA reauthorization efforts. – Last year, Secretary Thompson testified before Senate Indian Affairs Committee that the IHS would receive reauthorization of the IHCIA in the 2004 session of Congress. However, the reauthorization did not occur. – The administration said after the election that they wanted the reauthorization to be a priority. Deputy Secretary Claude Allen has made several visits to Indian Country and has made assurances to Tribal leaders that the reauthorization is still a priority with him and the administration. – The NIHB and members of the reauthorization steering committee will meet with Mr. Allen, Senator McCain, and Congressman Pombo in March. The goal is to achieve passage of the reauthorization of the IHCIA this year.	
Key people involved with the IHCIA reauthorization efforts	– Key people in the reauthorization effort include Mr. Allen; Senator McCain, chairman of the Senate Committee on Indian Affairs; John Tahsuda from the Senate Committee on Indian Affairs staff; Michael Enzi, who is the new chairman of the Senate Health, Education, and Labor (HELP) Committee; Richard Pombo, who is chairman of the House Resources Committee; Joe Barton, who is chairman of the House Energy and Commerce Committee; and Ted Kennedy, who is the ranking democrat in the Senate. The Senate Finance Committee is also important because leadership on this committee remains the same, but it has jurisdiction over Medicare and Medicaid. The	

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	House Ways and Means Committee, which has jurisdiction over Medicare, is also important. The new DHHS secretary is an unknown factor, and the steering committee has not been able to meet with him. In addition, Jennifer Farley will be the White House representative on AI/AN issues. She has stated that it is the administration's goal to see this legislation reauthorized.	
Concerns about the role of the Area diabetes consultants in the IHCIA	Dr. Acton noted the issue of the Area diabetes consultants and model diabetes programs. They were both a part of the original IHCIA. In the current version of the reauthorization legislation, the model diabetes programs are preserved, but the Area diabetes consultants are not. Dr. Acton reminded the TLDC that the Area diabetes consultants play a critical role in the SDPI by serving as project officers on the grants. Without them, the IHS DDTP will be forced to hire people to fulfill their role. Dr. Acton also reminded the TLDC that they wrote a letter in 2001 asking the steering committee to change the language and make Area diabetes consultants a part of the legislation, but the request was not acted on by the steering committee. Dr. Acton requested that the TLDC consider making the request again.	The Federal co-chair would like the TLDC to recommend that the Area diabetes consultants be preserved in the new version of the IHCIA
Management of Travel Funds for the TLDC Motion carried to have the NIHB manage travel and meeting expenses for the TLDC	Mr. Rolin explained that Alvin Windy Boy's Tribe had administered the travel funds for the TLDC. Since Mr. Windy Boy is no longer a member of the committee, a new entity needs to take over the responsibility. The NIHB expressed an interest, and Mr. Rolin and Ms. Smith explained that the NIHB has a finance officer who can manage the funds and provide the TLDC with quarterly financial reports. **Dr. Goforth Parker moved to have the NIHB administer the TLDC's travel funds. Ms. Arzate seconded the motion. All in favor. Motion carried.** **Meeting recess at 4:45 p.m. until 8:30 a.m. on February 11, 2005**	The NIHB will administer TLDC's travel funds and provide the TLDC with quarterly financial reports.

Tribal Leaders Diabetes Committee Meeting

Day 2: February 11, 2005

Subject	Discussion	Action
Welcome and Prayer	**Day Two—Friday, February 11, 2005** **Mr. Rolin called the meeting to order at 8:40 a.m.** – Welcome and review of meeting agenda by Buford Rolin, TLDC Alternate Chairperson – Prayer by Mr. Garcia, delegate from Albuquerque Area – Mr. Rolin noted that the TLDC received a letter from Margo Kerrigan, Director of the California Area IHS, officially appointing Ms. Arzate as the delegate from California.	Christine Arzate is the official delegate from the California Area
Response to TLDC Letter from Dr. Grim Vision statement Objectives Membership composition	Mr. Rolin described the TLDC letter from Dr. Grim. This letter outlined Dr. Grim's recommendations for the TLDC, specifically its: (1) vision; (2) mission; (3) objectives; (4) membership composition and rotation; (5) leadership; (6) meetings; (7) support of activities; and (8) budget. Mr. Rolin led a discussion among TLDC members about the letter and asked for responses to Dr. Grim's letter. Mr. Rolin notified the TLDC that he and Dr. Acton will send a letter to Dr. Grim that outlines the TLDC's response. The following is a summary of the recommended changes to Dr. Grim's proposal made by TLDC members: – Change *Vision Statement* to read, "…while preserving culture, traditions, and values through Tribal leadership…" – Change second bullet of the *Objectives* to read, "…appropriate culture, traditions, and values in program development…" – Under *Objectives*, the TLDC recommends that all organizations and agencies take into consideration culture, traditions, and values when new funding becomes available. – Change third bullet of the *Objectives* to read, "Provide broad-based guidance and assistance in defining how other Federal agencies and organizations, States, Tribal epidemiology centers, institutions of higher learning, and private health organizations…" – Change fourth bullet of the *Objectives* to read, "…committee for the Center for Disease Control's Native Diabetes Wellness Program" – Change first bullet of *Membership Composition* to read, "One Tribal elected or appointed representative and one alternate from each IHS Area…" – Change second bullet of *Membership Composition* to read, "One representative and one alternate will be selected by each of the following national organizations with Tribal membership: National Congress of American Indians and National Indian Health Board." – Add a bullet after the second bullet of *Membership Composition* that reads, "One	Mr. Rolin and Dr. Acton will write a response letter to Dr. Grim that outlines the recommended changes. A draft of the letter will be sent to TLDC members for comment.

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Membership composition (continued)	representative and one alternate will be selected by the Tribal Self-Governance Advisory Committee." – Change the fourth bullet (previously the third bullet) of *Membership Composition* to read, "One representative and one alternate will be selected by the National Council of Urban Indian Health." – Change the fifth bullet (previously the fourth bullet) of *Membership Composition* to read, "One representative and one alternate will be selected by the Direct Service Tribes." – Change the sixth bullet (previously the fifth bullet) of *Membership Composition* to read, "One IHS representative and one alternate will be appointed by the IHS Director…"	
Membership rotation	– Under *Membership Rotation*, the TLDC strongly recommends that any membership restrictions be removed and that the Areas should determine who their representatives and alternates are and how long their terms last. The response to Dr. Grim should indicate that the TLDC was unanimous in their recommendation.	
Leadership	– Change the first bullet under *Leadership* to read, "One TLDC elected or appointed Tribal representative from one of the 12 IHS Areas will be voted co-chairperson, and one elected or appointed Tribal representative from one of the 12 IHS Areas will be voted as this person's alternate." – Under *Leadership*, the TLDC recommends that it re-evaluate its leadership every four years, or as necessary, through an elections process or other process to be determined by the TLDC. – Under *Leadership*, the TLDC recommends that each delegate seated at the table be allowed one vote. If the alternate represents the Area or organization at the table, he or she will vote on behalf of that Area or organization. – Under *Leadership*, one member of the TLDC recommended that the Federal co-chair be a non-voting, ex-officio position.	
Meetings	– Under *Meetings*, the TLDC recommends that the committee meet on a quarterly basis. Quarterly meetings are necessary because of the expanded scope of the TLDC to make recommendations on chronic disease.	
Support of TLDC activities	– Under *Support of TLDC Activities*, the TLDC recommends that technical services to the committee be provided by the NIHB executive staff and that an MOU of understanding be developed with the NIHB for these services.	
Budget	The TLDC discussed Dr. Grim's proposed budget of $150,000 to cover travel expenses. The TLDC decided to accept the proposed budget, track expenses through the quarterly financial reports from the NIHB, and ask Headquarters for more funds if necessary.	The NIHB, with input from Lorraine Valdez and Yvette Roubideaux, will develop a draft charter for the TLDC. The charter will be an agenda item for the next TLDC meeting
Technical workgroup	With respect to the technical workgroup, the TLDC discussed how the NPAIHB could collaborate with the NIHB on the workgroup activities and provide support on the regional level. Mr. Freddie expressed concern that the technical workgroup should be evaluated.	
TLDC charter	Mr. Rolin noted that the IHS Headquarters has recommended that all advisory groups to the IHS have a charter in place. The NIHB offered to help develop the draft of the TLDC	

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	charter. Dr. Acton asked that Ms. Valdez from the IHS DDTP and Dr. Roubideaux be involved in the charter development. The TLDC recommended that the charter be on the agenda for the next TLDC meeting.	
Update on the "Just Move It" Campaign	Mr. Petherick from the NIHB provided an update on the "Just Move It" program. – "Just Move It" is an incentive program developed by the IHS and Nike to encourage Tribal members to engage in healthy activities and supplement existing Tribal physical activity programs. – Shelley Frazier, who is an IHS employee, is the national coordinator for the program. Elaine Dado at the NIHB also provides support for the program. – If a community wants to start a program, they can contact Shelley or Elaine, who will put together an incentive package to get them started. They can also visit the program website at www.justmoveit.org to sign up as a participant. The website also provides contact information for Shelley and Elaine.	
Native Diabetes Wellness Program (formerly the NDPC) Program objectives Eagle Books DETS Program and garden projects RFA on community indicators of change Clearinghouse for diabetes education materials	Dr. DeBruyn provided the TLDC with an update on the NDWP: – This CDC program has changed its name from the National Diabetes Prevention Center to the Native Diabetes Wellness Program. The NDWP has moved its office from Gallup, New Mexico. A team leaders is now located in Atlanta, and a field office is located in Albuquerque. – The objectives of the program are to find, design, adapt, and share information from communities on a wide basis. The NDWP has a team of external evaluators who can provide technical assistance to communities. – Dr. DeBruyn updated the TLDC on the *Eagle Books*, which will be released in the summer of 2005. The books are by Georgia Perez and designed to be read to young children. They cover topics, such as exercise and physical activity and nutrition. The NDWP has received clearance for the books from the DHHS. – The NDWP is participating in the DETS Program by attending meetings and providing evaluation assistance. The program is also helping fund community garden projects, such as the Dakota Plains Project. – The NDWP will release an RFA in the summer of 2005. Grants will be awarded to 6–8 Tribes, Tribal organizations, or urban programs around the country for between $75–100,000 per community to look at community indicators of change. The criteria, besides scoring well on the RFA application, are that the applicants be culturally diverse communities from throughout the country. The first year will be a planning year, followed by two years of implementation through 2008. Mr. Freddie expressed the need for a resource library that would house diabetes education materials and provide materials to AI/AN communities, who could then modify the materials for local needs. He suggested that the NDWP could serve as a clearinghouse. **Break 12:05 p.m.**	A TLDC member recommended that the NDWP serve as a clearinghouse for diabetes education materials

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Chronic Disease Initiative Performance objectives Chronic Care Model Chronic Care Report Five-Year Strategic Plan for Chronic Disease Tribal leader involvement	**Mr. Rolin called the meeting back to order at 1:29 p.m.** Dr. Acton described the IHS Chronic Disease Initiative: – One of Dr. Grim's top three performance objectives for this year is a new approach to chronic disease. Dr. Acton supports this objective because she feels that the Indian health system has been thinking in terms of "silos". By focusing separately on a diabetes program, cardiovascular disease program, chronic kidney disease program, and asthma program, for example, the Indian health system wastes resources by duplicating effort. – Dr. Ed Wagner from the McColl Institute at Group Health Cooperative has developed the Chronic Care Model. Managed care and other organizations, such as the VA and Kaiser Permanente, use the model to redirect resources and services in a way that maximizes care of chronic diseases in an integrated way. Dr. Wagner based much of the model on what he learned from Indian health. Dr. Grim and Dr. Acton both believe that the Indian health system needs to use the semantics of the Chronic Care Model to describe itself. – At the next TLDC meeting, Dr. Acton will present a report that she and Dr. Roubideaux wrote that examined the diabetes program and how it fits into the Chronic Care Model using their terminology. – Dr. Acton and Dr. Nat Cobb will lead the development of a five-year strategic plan to address chronic care within the IHS. The goals of the plan are to: (1) immediately implement parts of the plan that will not require resources; and (2) be ready to present the plan to Congress or other funders when they believe it is the right time to take on chronic disease as an integrated whole. Using the principles used to design the diabetes approach, the IHS would like to show Congress its approach to chronic disease as a whole, complete with details on what the IHS is already doing, what the gaps are, and what the price tag is. Dr. Acton asked the TLDC for input on when Tribal leaders should get involved with the initiative. The TLDC recommended that Tribal leaders be involved in the initiative and development of the strategic plan as soon as possible. Ms. Smith also recommended that Dr. Acton's team look into the national groups that are working on chronic care, such as the State policy academy teams and the National Governors Association. Ms. Holt from the Portland Area volunteered to be the TLDC representative for the Chronic Disease Workgroup. The next workgroup meeting will be held in May in Seattle.	Linda Holt from the Portland Area will serve as the TLDC representative for the Chronic Disease Workgroup. She will attend the next Chronic Disease Workgroup meeting in Seattle in May 2005.
Tribal co-chair and alternate co-chair Motion carried to elect Mr. Rolin as Tribal co-chair	Mr. Rolin recused himself from the discussion of the Tribal co-chair; Dr. Acton led the discussion. **Dr. Goforth Parker moved to nominate Mr. Rolin as Tribal co-chair. Ms. Smith seconded the motion. Mr. Rolin accepted the nomination. Ms. Smith moved to close the nominations and ask for unanimous consent. Ms. Arzate seconded the motion. All in favor. Motion carried.** Mr. Rolin thanked the TLDC and led the discussion of the Tribal alternate co-chair.	

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Motion carried to elect Dr. Goforth Parker as Tribal alternate co-chair	**Ms. Smith moved to nominate Dr. Goforth Parker as the Tribal alternate co-chair. Mr. Freddie seconded the motion. Dr. Goforth Parker accepted the nomination. Ms. Smith moved to close nominations and ask for unanimous consent. Ms. Arzate seconded the motion. All in favor. Motion carried.**	
EpiCenters Role of the EpiCenters The "Portland Model" and Diabetes Screening Toolkit Training and technical assistance for EpiCenters	Mr. Roberts described the projects coordinated by Portland Area EpiCenter at the NPAIHB. Mr. Roberts expressed his hope that the EpiCenters would be included in the evaluation of the SDPI, and noted that this would help build capacity at the EpiCenters. The TLDC discussed how the EpiCenters have cooperated with one another, and Mr. Rolin described projects at the Nashville Area EpiCenter. Dr. Acton described the "Portland Model", which is a unique diabetes model that the Portland Area EpiCenter developed to provide hands-on training on DMS at the community level. She also described Portland Area EpiCenter's Diabetes Screening Toolkit, which many sites around the country are using. Dr. Roubideaux noted that the EpiCenters provide a great opportunity for regional and local data capacity in Indian health. She also expressed concern that they are massively under-funded and under-supported. She noted that EpiCenters need more training and support to bring them all to the same level, and she felt that they have been given too much responsibility too soon without adequate training. Ms. Smith noted that the EpiCenters warrant time on the agenda at the next TLDC meeting and requested that an information packet be developed to bring all TLDC members up to speed. The NPAIHB volunteered to develop the EpiCenter information packet.	Request from Alaska that the subject of EpiCenters be added to the agenda for the next TLDC meeting The NPAIHB will develop an information packet on all EpiCenters for the TLDC prior to their next meeting
Future Directions for the TLDC Date and location for next quarterly meeting Diabetes and Cardiovascular Disease Conference Meeting wrap-up	The TLDC discussed the date of the next meeting: – The NPAIHB offered to host the next meeting in Portland, Oregon. The TLDC will meet May 12–13, 2005, in Portland. – Mr. Rolin noted that the TLDC will probably review Dr. Grim's response to the TLDC's recommendation letter during the May meeting. The agenda for the May meeting should also include finalizing the TLDC meeting calendar. – Mr. Rolin noted that Areas without representation need to appoint representatives. Dr. Acton reminded the TLDC about the diabetes and cardiovascular disease conference, which will take place in Denver, May 16–20. The conference is a TLDC-sponsored event, and Dr. Goforth Parker and Kelly Short-Slagley are the two TLDC representatives for the steering committee. TLDC members who plan to attend will likely be invited to moderate or sit on panels and participate in the powwow, which will be sponsored by the ADA Awakening the Spirit Campaign. Dr. Tolbert noted that the conference is critically important to all the health professionals in AI/AN communities, and expressed concern that many of them might be unable to attend because of scheduling conflicts. **Meeting adjourned at 2:36 p.m.**	The NPAIHB in Portland, Oregon, will host the next TLDC meeting (May 12–13, 2005) Include finalizing the 2005 TLDC calendar on the May agenda IHS Areas and organizations without representation need to appoint representatives