



AUG 28 2003

Dear Tribal Leader:

I am providing you with my decisions for allocating the Special Diabetes Program for Indians (SDPI) funds. The table "SDPI Allocations FY 2004" is attached at Tab A, and the fiscal year (FY) 2004 list of diabetes program activities with due dates is attached at Tab B.

I have decided to allocate \$104.8 million to Indian Health Service (IHS) Areas for distribution to local diabetes grant programs; \$7.5 million to Urban Indian programs; \$4.1 million for program support, evaluation, and administration; \$5.2 million for data improvement; \$1 million to support the National Diabetes Prevention Center (NDPC); and \$27.4 million for a new competitive grants program.

Congress has extended the SDPI through FY 2008, with a \$150 million annual appropriation starting in FY 2004. The \$150 million, which provides a \$50 million increase over the FY 2003 funding, opened new discussions about how to make the best use of the new funds.

As we enter the 7th year of the SDPI, we can all be proud of the successful contributions we have made individually and through partnerships toward treating and preventing diabetes in the American Indian and Alaska Native population. I extend my gratitude to members of the Tribal Leaders Diabetes Committee (TLDC) and participants of the Area consultations for their willingness to listen to all viewpoints, openly and respectfully discuss their differences, and formulate the input that influences Agency decisionmaking.

Revisions to the Formula

The national allocation formula recommended by the TLDC and used since 1998 to allocate SDPI funds is retained for FYs 2004-2008. The three formula components remain the same as used in the FY 2003 formula: user population weighted at 30 percent, Tribal size adjustment at 12.5 percent, and disease burden at 57.5 percent. In past years, the disease burden component was determined using a combination of diabetes mortality rates and diabetes prevalence rates. This year we have improved the precision of disease burden component by removing diabetes mortality rates and using more accurate diabetes prevalence as the only measure. This improvement is possible after years of investing in data improvements to more completely measure the degree of diabetes disease in the Indian population.

Because the extent of diabetes disease among Indian people has continued to expand in recent years, I have decided to protect funding for existing prevention and treatment programs by adding two important formula components: a hold-harmless component and an inflationary-cost component. When we used the new, more accurate diabetes prevalence data to define disease burden, the new allocation lowered funding for seven Areas below their FY 2003 funding levels. Since Congress has directed that no grant program be dismantled or funded at less than its

FY 2003 level, the best approach for complying with this direction is to avoid reducing the FY 2003 amounts by adding the hold harmless component to the FY 2004 formula. I have allocated \$6.1 million to ensure that programs within these seven Areas continue to be funded at their current levels.

I have also added an inflationary-cost component to SDPI formula that applies to allocations to all Areas. The inflation component allocates \$8.9 million to help compensate for higher costs that accumulated during previous years when there were no funding increases for the SDPI and to help restore buying power to the prevention and treatment programs. The inflation component will also apply to the administrative costs of running and evaluating the program, increasing the total from \$3.8 million to \$4.1 million.

In summary, the total of \$108.9 million is allocated for the existing SDPI diabetes prevention and treatment grant programs and their administration -- \$93.9 million is allocated using the same SDPI formula with more accurate diabetes disease data, \$6.1 million is allocated to prevent funding reductions, and \$8.9 million is allocated to restore lost buying power

Revisions to Set-Asides

The SDPI non-formula components, commonly called “set-asides,” generally remain at the same percentages used in FY 2003 and are applied to the total \$150 million. The set-asides and their amounts are: \$7.5 million for Urban Indian diabetes programs, \$5.2 million for data improvement, and \$1 million for the NDPC. The TLDC unanimously supported continued funding for the Urban Indian health programs. The Urban programs will continue to determine their own distribution methodology.

Congress has directed the IHS to strengthen the diabetes data infrastructure. The data improvement set-aside directs \$5.2 million for improvement at the national and Area levels. Data improvement funds will provide benefits at the national and regional levels to strengthen the infrastructure for the IHS electronic data system; enhance laboratory and pharmacy data collection; provide Diabetes Management System training and use; and expand resource and patient management system packages, tools, and services for better management of chronic diseases.

A \$1 million set-aside for the NDPC will continue and be added to the \$2 million yearly contribution of the Centers for Disease Control and Prevention, Division of Diabetes.

I have decided to add a set-aside of \$27.4 million for conducting a new competitive grant program to address the prevention of diabetes and cardiovascular disease in persons with diabetes. This decision was influenced by the instruction from the House and Senate Appropriations Committees and the Chair of the Congressional Diabetes Caucus to conduct a competitive grant program with the new funding that addresses these compelling diabetes issues. I believe it is important to heed the congressional direction, and I personally greatly appreciate that the TLDC proposed various approaches for implementing a competitive grant program for

my consideration even though establishing this grant program was not the committee's preference. The IHS National Diabetes Program will provide leadership and direction for the competitive grant program.

There will be no set-aside for newly recognized Tribes; I agree that new users will be captured in the user population data, and individual Areas may decide internally to address this issue with their allocation.

Decisions Apply Through FY 2008

All of my allocation decisions are a result of careful consideration of the TLDC and the Area-level recommendations as well as the directions provided by congressional leaders in both the House and Senate. I believe that applying these decisions to the entire 5-year funding period will ensure that diabetes grant programs experience the least disruption to their program activities and staffing considerations.

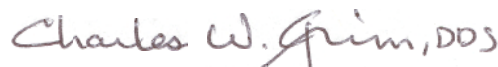
Grant Eligibility

The Public Health Service Act states that the following groups are eligible to apply for diabetes grants: 1) IHS entities; 2) Indian Tribes or Tribal organizations that operate an Indian health program that includes programs under a contract, grant cooperative agreement, or compact with the IHS under the Indian Self-Determination and Education Assistance Act; and 3) Urban Indian organizations that operate an Urban Indian health program that includes programs under a grant or contract with the IHS under Title V of the Indian Health Care Improvement Act.

The Office of Grants Management will mail the FY 2004 Application Kit, "Grants for Special Diabetes Program for Indians," directly to grantees. The kits will also be mailed to the Area Diabetes Consultants and can also be accessed on the IHS National Diabetes Program Web site at www.ihs.gov/medicalprograms/diabetes.

If you have questions, please contact Kelly Acton, M.D., M.P.H., Director, IHS National Diabetes Program, at (505) 248-4182 or Ms. Crystal Ferguson, Grants Management Officer, IHS Office of Grants Management, at (301) 443-5204.

Sincerely yours,



Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Director

Enclosures

Tab A – SDPI Allocations FY 2004

Tab B – FY 2004 SDPI Grant Program Activities and Dates