



Board Represented Tribes

Jicarilla Apache Nation
Mescalero Apache Tribe
Ramah Band of Navajo

Southern Ute Indian Tribe
To'Hajiilee Band of Navajo
Ute Mountain Ute Tribe

August 12, 2026

The Honorable Robert F. Kennedy Jr.
Secretary of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Sent via email to: consultation@ihs.gov

RE: SDPI Funding

Dear Secretary Kennedy,

On behalf of the Albuquerque Area Indian Health Board ("AAIHB"), thank you for the opportunity to provide comments regarding the Indian Health Service's (IHS) Tribal Consultation on the use of approximately \$70 million in Special Diabetes Program for Indians (SDPI) funding, including the additional one-time unobligated funding available through Calendar Year 2026 administrative grant supplements.

AAIHB was established in 1980 and is a consortium of federally recognized Tribes in New Mexico and Southern Colorado.¹ AAIHB provides direct health care and public health services to citizens of Tribes throughout New Mexico, Southern Colorado, and West Texas. AAIHB's purpose is to research and implement evidence-based and culturally relevant healthcare programs within 27 Tribal communities which collectively serve more than 80,000 Tribal members.² AAIHB greatly values the federal government's commitment to meaningful Tribal consultation and appreciates the opportunity to provide recommendations regarding future SDPI investments.

The Special Diabetes Program for Indians remains one of the most successful federal public health investments serving Tribal Nations. For nearly three decades, SDPI has demonstrated measurable improvements in diabetes prevention, treatment, and care coordination while allowing Tribes to develop culturally relevant approaches that reflect local priorities and community values. Continued investment in SDPI has contributed to substantial reductions in

¹ Member Tribes include the To'Hajiilee Band of Navajos, the Ramah Band of Navajos, the Jicarilla Apache Nation, the Mescalero Apache Tribe, the Ute Mountain Ute Tribe and the Southern Ute Indian Tribe. For financial purposes the AAIHB is considered a government because the AAIHB board of directors is appointed by members of Tribal governments.

² AAIHB serves all 27 American Indian communities in the IHS Albuquerque Area, which, in addition to its member Tribes includes: the Alamo band of Navajos and the Pueblos of Taos, Picuris, Santa Clara, Pojoaque, Nambe, Tesuque, Ohkay Owingeh, San Ildefonso, Cochiti, Jemez, Zia, Santa Ana, Sandia, San Felipe, Santo Domingo, Laguna, Isleta, Zuni, Acoma, and Ysleta del Sur.

diabetes-related mortality, end-stage renal disease, and other preventable complications while strengthening Tribal health systems and expanding access to quality diabetes care. The additional funding now available presents an important opportunity to further strengthen these successes through Tribal-driven solutions that honor Tribal sovereignty and local decision-making.

AAIHB respectfully offers the following recommendations.

1. Recommendations Regarding the CY 2026 Administrative Grant Supplement

AAIHB recommends that additional SDPI funds be distributed directly to current SDPI grantees as an administrative supplement, in equal measure and as quickly as possible, to maximize the time available for Tribes to plan and implement expanded activities. Utilizing the existing SDPI funding structure rather than creating a new competitive funding process will minimize administrative burden, promote equity among current grantees, and allow programs to immediately build upon successful diabetes prevention and treatment efforts.

AAIHB supports providing current SDPI grantees with maximum administrative flexibility to fully utilize supplemental funding during the grant period and strengthen successful existing programs.

To maximize expenditure of supplemental funds, IHS should streamline budget revision and grant modification approvals, provide greater authority for Tribes to rebudget funds within existing approved scopes of work, allow flexibility to address procurement and contracting delays, issue awards as early as possible to support local planning and provide reasonable expenditure flexibility when delays occur outside Tribal control. These flexibilities recognize the workforce shortages, lengthy hiring processes, and procurement challenges that many Tribal programs continue to experience.

AAIHB further recommends that IHS provide clear, practical flexibility for one-time purchases and community-based supports that can directly strengthen diabetes services, including appropriate equipment and infrastructure, mobile health and screening capacity, community kitchen and gardening equipment, fitness and physical activity resources, and other locally identified capital needs. Where allowable under federal requirements, Tribes should also have flexibility to provide direct patient support that address barriers to diabetes care, such as transportation assistance, diabetes technology and supplies, and other costs that may otherwise prevent patients from accessing or adhering to recommended care. IHS should also consider establishing a reasonable threshold for budget-line reallocations that may be made without prior approval, while maintaining appropriate accountability and reporting.

AAIHB also recommends expanding practical technical assistance that focuses on successful implementation rather than compliance alone. Priority assistance should include individualized grants management support, training on allowable costs and budget modifications, guidance on Required Key Measures and The SDPI Outcomes System, technical

assistance for implementing Diabetes Best Practices, workforce recruitment and retention strategies, procurement guidance, and opportunities for Tribal peer-to-peer learning and sharing of successful practices. Technical assistance should remain responsive to differences in Tribal size, staffing capacity, and geographic circumstances.

Technical assistance should also include culturally tailored youth and family curriculum development, training for Tribal staff and Community Health Representatives on continuous glucose monitoring and tele-nutrition, grant management and program evaluation support, third-party billing and sustainability strategies, and training or certification opportunities for Tribal youth and community members to serve as peer wellness educators. IHS should provide flexibility for reasonable participant incentives and engagement supports—such as healthy food resources, physical activity equipment, traditional craft or educational materials, or other locally appropriate supports—when these tools are part of an approved prevention or wellness activity.

Additional supplemental funding should remain flexible so Tribes can strengthen existing diabetes treatment, prevention, and care coordination efforts based on locally identified priorities. Appropriate uses include expanding Diabetes Self-Management Education and Support services, hiring and retaining multidisciplinary diabetes care teams, expanding diabetes screening and early intervention, increasing access to diabetes technology and telehealth services, improving care coordination for individuals living with diabetes and related chronic diseases, strengthening transportation and outreach services, and expanding culturally appropriate nutrition education and physical activity programming.

Tribes should also be able to allocate supplemental funds across prevention, care coordination, and clinical treatment according to community need rather than being required to follow a uniform national percentage. For example, a Tribal program may determine that a balanced investment in youth and family prevention, care coordination and medical-cost barriers, and clinical treatment enhancements are necessary to achieve the greatest local impact. Eligible activities could include family cooking and nutrition programs, youth and weekend physical activity initiatives, traditional outdoor recreation, diabetes educators or medical navigators, continuous glucose monitoring and other diabetes technologies, and mobile screening services for remote communities.

2. Prioritizing the Use of the Additional \$70 Million

To achieve the greatest impact, AAIHB recommends that IHS prioritize direct investment in existing Tribal SDPI programs before establishing any new competitive funding opportunities. AAIHB further recommends that current SDPI grantees be provided maximum authority to determine how supplemental funding are utilized in accordance with locally identified Tribal priorities. Tribes are best positioned to identify community health needs, implement culturally appropriate interventions, and respond quickly to changing local conditions.

In distributing additional funds, IHS should also account for the substantially different operating environments of Tribal programs, including geographic isolation, transportation barriers, limited local healthcare infrastructure, and workforce shortages. An equity-based approach should ensure that rural and geographically isolated Tribes have sufficient resources to overcome these barriers while preserving Tribal authority to determine how funds are used. AAIHB supports consideration of adjustments or supplemental resources that recognize these documented differences in access and cost of delivering services.

Priority investments should include:

- Increasing base funding for existing SDPI grantees,
- Strengthening workforce recruitment and retention
- Expanding prevention activities for individuals at high risk for developing Type 2 diabetes
- Improving diabetes treatment and care coordination,
- Supporting youth and family wellness initiatives,
- Investing in telehealth and diabetes technology,
- Strengthening data infrastructure; and
- Maintaining sufficient program flexibility to allow Tribes to respond to community-defined priorities.

3. Diabetes Risk Factors Affecting Tribal Communities

These investments are particularly important because Tribal communities continue to experience diabetes risk that is shaped by social, economic, environmental, and geographic factors that extend beyond clinical care alone. Significant contributors include food insecurity, limited access to affordable healthy foods, transportation barriers, geographic isolation, shortages of healthcare professionals, poverty, housing instability, limited opportunities for safe physical activity, historical trauma, chronic stress and disproportionately high rates of obesity, hypertension, and prediabetes.

Effective prevention initiatives should address these underlying social determinants of health while supporting culturally relevant wellness activities that promote healthy lifestyles across the lifespan.

For some Tribal communities, these risks are intensified by food-desert conditions and dietary shifts away from traditional, nutrient-dense foods; long distances to specialty care; and the erosion of traditional forms of physical activity. Prevention investments should therefore support food sovereignty, traditional food access and preparation, community gardens, produce-prescription or other healthy-food initiatives, transportation supports, and culturally grounded opportunities for movement and outdoor recreation. Programs should also be able to address diabetes distress, behavioral health needs, and historical trauma as components of comprehensive diabetes prevention and management.

4. Supporting Tribal Sovereignty Through Prevention and Wellness

AAIHB strongly supports prevention and wellness programs that reinforce Tribal sovereignty and respect each Tribe's authority to determine its own health priorities. IHS should avoid prescribing a single national prevention model and instead allow Tribes to determine the prevention strategies that best reflect their cultural values, governance structures, and community practices.

For many Pueblos and Tribal communities throughout the Albuquerque Area, successful diabetes prevention is achieved by reconnecting individuals and families with traditional ways of living. SDPI should continue supporting programs that incorporate traditional foods, farming, hunting, fishing, gathering, language revitalization, cultural teachings, intergenerational learning, and community events that reinforce healthy lifestyles. These culturally grounded approaches strengthen community engagement, improve participation, and promote long-term wellness while respecting Tribal sovereignty and local decision-making. Tribes should retain the flexibility to implement prevention strategies that best reflect their own cultural values and community priorities rather than standardized national models.

AAIHB also supports community-defined governance structures that bring together Tribal patients, youth, elders, families, and program staff to guide prevention priorities and supplemental investments. Such structures can strengthen accountability to the community while preserving Tribal decision-making authority. Culturally grounded models may include seasonal traditional food gathering, land-based activities, elder-youth knowledge sharing through gardens and cooking programs, and integration of behavioral health supports into diabetes services where identified by the Tribe.

5. Supporting Children, Youth, and Families

Long-term reductions in diabetes prevalence depend upon sustained investments in prevention efforts that begin early in life.

AAIHB recommends continued support for school-based nutrition and physical activity programs, family-centered diabetes prevention education, youth leadership and peer wellness initiatives, traditional food and cooking programs, community recreation opportunities, healthy pregnancy and maternal wellness initiatives, and early screening for diabetes risk factors among children and adolescents. Investments in children and families produce lasting improvements in community health while reducing future healthcare costs associated with diabetes complications.

Tribes should have the flexibility to develop innovative youth and family initiatives tailored to local circumstances, including culturally relevant movement challenges, youth-led wellness activities, mobile or community-based healthy cooking programs, home or community

garden projects, school movement breaks, youth sports and recreation opportunities, and family-based transportation or medical-cost supports where allowable. These approaches can connect diabetes prevention with food sovereignty, physical activity, family engagement, and practical reduction of barriers to care.

6. Future Direction of the Special Diabetes Program for Indians

AAIHB believes SDPI should continue as a permanent, adequately funded federal program that provides tribes with the flexibility necessary to respond to changing community needs while strengthening Tribal self-determination.

Future program improvements should include establishing permanent mandatory funding with adjustments that reflect inflation and rising healthcare costs; increasing base funding for existing Tribal SDPI programs; preserving Tribal flexibility in selecting Diabetes Best Practices and implementing community-defined activities; reducing administrative burden through streamlined reporting and grant administration; continuing investments in workforce recruitment, retention, certification, and professional development; expanding support for telehealth, diabetes technology, and modern data systems; ensuring routine data sharing and interoperability between Indian Health Service facilities and tribally managed SDPI programs; strengthening multidisciplinary care coordination; and continuing meaningful Tribal consultation as the program evolves.

One of the greatest challenges facing Tribal SDPI programs remains the recruitment and retention of qualified healthcare professionals. Future investments should support competitive salaries, workforce retention incentives, certification and continuing education, career advancement opportunities, and succession planning to ensure continuity of diabetes services. Stable staffing is essential to maintaining successful Diabetes Best Practices, improving Required Key Measures, and providing consistent, high-quality patient care. Workforce investments should also support training and certification of Tribal members, including Community Health Representatives, diabetes educators, and other community-based staff, so that Tribes can build a sustainable local workforce. Building local capacity is particularly important for rural and geographically isolated communities where recruitment of outside professionals can be difficult.

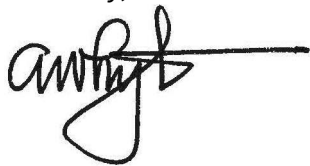
As IHS continues to modernize its health information technology systems and implements a new Electronic Health Record, AAIHB encourages the agency to prioritize interoperability between IHS facilities and Tribal SDPI programs. Many SDPI programs do not have direct access to the Electronic Health Record used by IHS facilities, resulting in fragmented communication and missed opportunities for coordinated, multidisciplinary care. Improved data sharing would enable clinical providers and SDPI staff to develop shared care plans, better coordinate services, reduce duplication, and improve patient outcomes. Enhanced interoperability would also allow IHS to better recognize and evaluate the significant contributions SDPI programs make toward improving community health and wellness.

The Albuquerque Area has demonstrated that community-driven, culturally grounded diabetes programs improve health outcomes while strengthening Tribal self-determination. Continued investment in flexible, sustainable SDPI funding will allow Pueblos and Tribes throughout the Albuquerque Area to expand prevention efforts, strengthen diabetes treatment, and care coordination, address social determinants of health, and improve the health of future generations. AAIHB looks forward to continued partnership with IHS to ensure SDPI remains a Tribal-driven program that reflects the priorities, values, and health needs of Tribal Nations.

AAIHB's member Tribes have developed diverse approaches to prevention of diabetes and wellness that reflect their own communities, including programs centered on traditional foods, youth engagement, family wellness, physical activity, community-based education, and care coordination. These locally developed models demonstrate why SDPI funding should remain flexible enough to support innovative approaches identified by individual Tribes.

Thank you for the opportunity to provide these comments. AAIHB appreciates IHS's commitment to meaningful Tribal consultation and looks forward to continued collaboration to strengthen the Special Diabetes Program for Indians.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ayn Whyte', followed by a long horizontal line extending to the right.

Ayn Whyte, M.S.
Executive Director
Albuquerque Area Indian Health Board