2003 Spring Tribal Self-Governance
HHS & DOI Joint Conference

"Protecting our Way of Life
Through Sovereignty, Self-Sufficiency, and Self-Governance"
April 27 – May 1, 2003
Phoenix, Arizona

"Partnerships for Protecting Health"

by

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April 28, 2003

I appreciate the honor to speak before a large group of tribal leaders and to those of you who are involved with health programs back in your communities. I have attended many of these conferences during my 20 years of service with the Indian Health Service, and this is the second one I have attended as the Interim Director of the IHS.

A lot has happened since the last time I spoke with you, and part of my comments today will be to update you on some of those things. I will close my comments by speaking to you more directly about the Intergovernmental Council on Native American Affairs that the Secretary has re-established.

Hopefully the next time I speak to you, it will be as the permanent Director of the Indian Health Service. My nomination has been sent forward to the Senate, and they have been in contact with us regarding a date in June for a confirmation hearing. I have enjoyed the time as Interim Director; it has been very rewarding. One of the things that I learned about the directorship of the IHS is that there have only been six directors since the time that the IHS has been an agency within the Department of Health and Human Services. It would be an honor and a privilege to serve you as the seventh Director of the Indian Health Service.

Many jobs in my career have required a large commitment on my part to improving the health of Indian country; a commitment I was always willing to make. But none of those jobs have had the scope of responsibilities and level of accountability that this position holds, and none has had the potential to do so much good for future generations of Indian people across the country. I welcome the responsibility and accountability and I am committed to improving the health in Indian country. I take this responsibility seriously. Every day that I am in D.C. reminds me of why I am there; to serve American Indian and Alaska Native people. I know I will go home one day, but while I am there, I will do the best that I can to advocate on your behalf, and I want you to know that you have every opportunity to approach me if you think that I am not doing something on your behalf.

The other reason that I am in D.C. is spelled out in the theme of this joint conference. I and all of our staff in Washington are there to do all that we can to protect our way of life through sovereignty, self-sufficiency, and self-governance.

The text is the basis of Dr. Grim's oral remarks at the 2003 Spring Tribal Self-Governance HHS & DOI Joint Conference in Phoenix, Arizona, on Monday, April 28, 2003. It should be used with the understanding that some material may have been added or omitted during presentation.

It is an honor to lead an organization that has done so much for the health and welfare of Indian people across the nation. Along with that leadership comes responsibility to make decisions. I rely on you, my staff, the people that are on workgroups, and tribal leaders to come speak to us to help me make the best decisions. I am committed to tribal consultation, to use tribal consultation, and to strengthen it over the years. I believe that the IHS does well and has improved through consultation with you on how to continue to enhance our programs. Through tribal consultation, we end up with decisions that are much better and stronger, whether it is policy, funding, or operational. Sometimes the decisions that need to be made are not easy, may not be popular, but usually after reaching that level of dialogue with Indian country in our consultation efforts, I feel that everyone has an awareness of the decision and justification of what it was made.

Our history as a people attests to our ability to respond to challenges, overcome the adversities that we sometimes face, and maximize our opportunities. Part of our success lies in our strength and intelligence as a people; in having the wisdom to know when it is in our best interests to adapt to the changes that are coming while conserving our energies in order to better ensure future victories. Strengthening our health programs and the IHS will help us remain a priority through these difficult times and continue to give life to the treaties our ancestors entered into with the Federal government.

This nation is currently engaged in a struggle against tyranny and terror. We all watched as the conflict in Iraq unfolded and watched as the monuments raised to tyranny were toppled. The price of freedom is often high. There are more than 128 families and communities experiencing the grief of losing a loved one so that our freedom can be preserved. Native people continue to answer our nations call and enter military service in higher proportions that any other group of people and I think we can all be proud of that. PFC Lori Piestewa answered that call and died in defense of our nation. She is the first Native American woman to die in combat. Not far from here her family and tribe mourn her loss. I was pleased to see that a honor song was done for her today, even more pleased to see how many people walked up to make a donation to help the children she left behind. I have been in meetings over the last few weeks where tribal leaders and others have acknowledged the sacrifice she made for us. We must also acknowledge the sacrifice that all of our communities are making to the war effort in this country. We also need to acknowledge the responsibility that we have here in this country to help ensure that those sacrifices have not been in vain.

The war in Iraq is not over. The war on terrorism still continues. Protecting our homeland is still a priority. The Federal government is involved in a war on global terrorism, protecting our homeland, dealing with diseases without cures such as AIDS, and now SARS, while also modernizing Medicare for future generations who will be entering Medicare so that they will have a health system that is sound. We are also trying to increase the accessibility to health services and health benefits to many in our population who do not have it, and making changes to improve the country's education, employment, and economic programs – and all this amid efforts to try to restructure the government to provide American citizens with a government that is more accountable and responsive.

We have to consider where we fit within all of this and consider what we need to do to *"protect our way of life through sovereignty, self-sufficiency, and self-governance."*

Where is the Indian Health Service among these national priorities and focus? We remain a priority with the Administration and within the Department of Health and Human Services. The commitment of the Administration and the Department to ensuring that Indian health programs are strengthened and Indian health priorities are addressed is demonstrated in the decisions that have been made. For example:

- The Secretary has revitalized the Intradepartmental Council on Native American Affairs, which I will speak more about later.
- The Secretary and Deputy Secretary both heard Indian country's concerns about the CMS Outpatient Prospective Payment System when they visited your homes. The final decision to exempt the IHS and Tribes from implementing the OPPS, and avoiding a loss of revenue to our programs is directly attributable to the work of the leadership of the Intragovernmental Council and the intervention of the Secretary and Deputy Secretary.

The recognition of the importance of Indian health programs is also shared by the Congress. The first week of April, I testified before the Senate Committee on Indian Affairs regarding the President's fiscal year 2004 budget proposal for the agency. I mentioned some of the highlights of his proposal. I also recognized the Committee for raising the 2003 budget appropriation to a higher level than had originally submitted by the President for that year. In this era of war and economic challenges that we face, there are austere budgets for many Federal government programs and the fact that we received the kind of increase that we did is a success. We have proven to the Department, the Congress, and Office of Management and Budget that our programs have been effective.

Two very positive program increases in the President's Request for FY 2004 are a $25 million

increase in Contract Health Services and a $20 million increase in Sanitation Facilities Construction. These increases, coupled with $150 million in the special diabetes funding represent a significant amount of support by the Administration and the Congress for IHS programs. The effectiveness of the Indian health system of IHS, tribal, and urban Indian health programs has been demonstrated through many measurement tools and has been reported to the Department, Congress, and OMB over the course of the last several years. I want to thank you all for your willingness to contribute data to those systems.

The following week I testified again before the Senate Committee on Indian Affairs regarding the Department's position on the proposed reauthorization language for the Indian Health Care Improvement Act. I believe the concerns of the Department are valid and deserve further consideration. The Department's concerns are just that, *concerns*. They are not a rejection of the proposed provisions in that bill. The Department, along with the Indian Health Service, wants an effective Indian Health Care Improvement Act that is not only visionary but also practical when it comes to implementation.

During the hearing there were also questions raised regarding the effects of the "One Department" initiative of the Department of Health and Human Services and questions regarding the restructuring of the Agency and the reorganization of the headquarters of the Agency.

I would like to speak more about the Secretary's One Department Initiative in a moment but let me first mention another piece of legislation you may have heard about. Senator Campbell has recently a bill into the Senate that would establish an IHS Health and Wellness Foundation, similar to those at the Centers for Disease Control and Prevention and the National Institutes of Health. The Foundation would create a mechanism for the many external organizations, groups, and individuals who would like to contribute to the national effort to eliminate health disparities in Indian County. We are mindful of the potential benefit this can bring to our efforts in providing health services for our people and eliminating health disparities - and we are mindful that many foundation currently support tribal and community efforts directly, and we do not wish to disrupt those supportive relationships. We will keep you informed about the bill's progress as it makes its way through Congress.

Let me return to the topic of One Department – and three distinct activities that affect one another but are not all part of a "One Department" initiative. There is the "One Department" initiative, which is being spearheaded by the HHS. There is the joint IHS/Tribal/Urban workgroup on restructuring recommendations for the IHS Area and field functions; that is an IHS initiative. And there is the management priority that I have taken upon myself, that was started by the previous Director, Dr. Michael H. Trujillo, in response to a request to all agencies from President Bush and the OMB, to look at reorganizing our operations. I have made it a priority to reorganize our Headquarters operations so that we can be more responsive to Tribes, the Department, and also follow very closely the recommendations of the restructuring initiative workgroup.

Regarding the "One Department" Initiative – the purpose of the initiative is to ensure that all offices and agencies within the Department communicate and work together to improve the delivery of health and social services. The goal is not to consolidate or eliminate agencies, but to improve similar functions found in each of the agencies. As Secretary Thompson stated, his goal is "that every agency, every office, every branch of HHS work as units of a common Department." With that in mind, here are a few examples of what the "one Department" initiative has meant for the Indian Health Service.

- The "One Department" formalizes the responsibility of the entire Department to address Indian health status and disparities and take action to eliminate health disparities.
- One benefit I have already mentioned -- the decision to exempt the IHS and tribal programs from the OPPS rate, saving the agency and Tribes $30 million in first year cost and $17 million each year thereafter.
- Many new grants and contracts are being amended to request information on how the applicant's proposal serves Indian people.
- The Secretary has requested State Governors to include IHS/tribal/urban health programs in their Emergency Preparedness activities;
- there are additional joint meetings among Department programs to increase tribal access to their programs.
- As I mentioned, the Secretary has strengthened the role of the Intragovernmental Council on Native American Affairs and also strengthened the role of the Intergovernmental Affairs Office in the Secretary's office;
- and the Department has made one of its top four research priorities that of identifying the research needs in Indian health – in addition to the $4 million in NIH support for expanding the Native American Research Centers in Health. I recently attended the HHS Research Coordinating Council and presented concerns that Tribes have relevant to research that the different Operating Divisions, that have research budgets, could address in the

development of their Fiscal Year 2005 budget requests.

The "One Department" also benefits the Agency and Indian programs by the budgetary decisions and activities of the Department:

- There is support for IHS and the Centers for Medicare and Medicaid Services to collaborate in rate negotiations for IHS and qualified tribal programs. We have also reinstituted a high-level policy workgroup between the two agencies to work on various issues of concern.
- The Department increased the IHS Sanitation Facilities Construction program by $20 million as a direct result from the Secretary's visit to Alaska.
- The Department is supporting additional funding in support of Tribal Colleges and Universities.
- The Department's support, via CDC, of more than $1 million in 2003 to target the needs of tribal governments and American Indian and Alaska Native communities. In addition, the CDC Agency for Toxic Substances and Disease Registry is supporting tribal governments and Indian communities to improve their environmental health services efforts.
- The Department's Agency for Healthcare Research and Quality is also assisting the Indian health system through inclusion of Indian-specific health questions and oversampling of Indian country in their various surveys. The surveys are very important to the Federal government; OMB and others take a look at these to see what the health needs of the country are, and having statistically significant data about the health of Indian people will aid in making decisions.
- As the Department moves forward in the development of a Unified Financial Management System for the entire Department, other than for Medicare and Medicaid financial accounting, they are including Indian health specific requirements so that the final system will be effective for our complex financial needs and transactions. We at the agency are looking at this as an ideal opportunity to be able to strengthen the financial management of our programs. Many of you know that our accounting systems have not been capable of keeping up with health care accounting workload and technological advancements.
- And the Department is supporting funding to improve the electronic medical record capabilities of the Indian health system to improve patient care quality and safety.

One avenue for achieving the goals of the "One Department" initiative is consolidating similar functions found in each of the agencies. This one particular issue has stirred a lot of interest in Indian country. One of the things that many tribal leaders have talked with me about and have sent letters and resolutions concerning is the consolidation of the human resources functions throughout the Department. You have probably heard of the phrase "40 to four." The 40 refers to the number of personnel systems within the Department when Secretary Thompson was appointed. If someone wanted to apply for a position within the Department, they would have to apply to 40 different places. The Secretary thought that was a little much so one of his initiatives is to consolidate down to just four services human resource centers. Consolidating down from 40- to four.

There has been a lot of discussion in Indian country, in the restructuring initiative workgroup, and at various other tribal meetings, about the initiative. Early on we were unable to tell you a lot about that because it was sin the planning and pre-decisional process, but I can assure you that my high-level staff has been at every HR consolidation meeting to make sure that concerns of Indian country have been raised. Other high level members of the Department – the Deputy Secretary, Chief of Staff, Assistant Secretary for Management and Budget – are all aware of the issues and impact of this initiative in Indian country. We continue to work with the Department on assessing the impact of consolidation on the programs of the Agency and on the affect it will have on employees, services, and the economic impact to our communities. Those negotiations have been positive. The Department recently has determined that the consolidation of the human resource positions will take place on October 1st of this year, but that all IHS human resource employees can remain at their current work sites and continue providing personnel services to our staff. There are probably additional details to work out, but the major joint decision was allowing our employees to remain where they are rather than having to relocate to Baltimore, unless they so choose.

I have let our Area Directors know that I hope some of our employees choose to apply and accept positions in Baltimore because that is the servicing personnel center that will be supporting the Indian Health Service. It will benefit the agency and Indian programs to have staff familiar with the staffing needs, Indian Preference hiring requirements, and diversity of our job series at the Baltimore location.

As far as restructuring the Area Office and our field functions – that is a tribal/urban/IHS initiative, it is not an HHS-directed initiative. The former IHS Director, Dr. Trujillo, put together a Restructuring Initiative Workgroup (RIW) and they turned in an interim report, and within the next few weeks, they will provide a final report to me. The report will provide recommendation

and information about organization changes the agency might consider over the course of the next five years relative to the way our field operations are set up and how we might prepare for the challenges we anticipate may occur.

After the RIW interim report recommendations were shared, I established a Headquarters Restructuring Group (HRG) to consider not only the RIW recommendations but also the 1997 IHS/Tribal/Urban Indian Health Design Team recommendations and make recommendations for how the headquarters of our agency could be structured over the course of the next several years to support the RIW recommendations and also be responsive to the "One Department" initiatives. I assure tribal leaders that whatever the ultimate outcome will be, the headquarters reorganization will be structured along some basic principles – that tribal shares will not be affected and that the long-term consequences to the agency, to Indian country, and to health programs and services, will be positive and beneficial, and most importantly, tribal sovereignty and the government-to-government relationship will be strengthened. I also want tribal leaders to know that my door will always remain open for tribal consultation.

Tribal access to the Director of the Agency will remain a basic principle for how we do business and how decisions are reached. For example, I benefited from consultation with Tribes and from the joint workgroups of your representatives and the IHS, and I accepted the recommendations that came out of that process for the distribution of $30 million of additional funds for Alcohol and Substance Abuse, for the $49 million available for Contract Health Services, and for the $26 million available for the Indian Health Care Improvement Fund.

On March 28th I announced my final decisions on the distribution of the fiscal year 2003 funds, which the agency began to receive earlier that week. For the Alcohol and CHS funding, those funds will now be recurring and will be distributed using a new formula. The recommendations from the workgroups were the formulas that I accepted. For the Indian Health Care Improvement Fund for 2003, the distribution formula was modified slightly to comply with the emphasis of Congress in this year's appropriations committee language and to continue the process to help all programs to reach parity in the percentage of funds to reflect their needs. I believe each of the decisions reflected the priority of creating the least level of per capita disparity between previous amounts and current amounts.

I will conclude my remarks by sharing with you information about the Secretary's Intradepartmental Council on Native American Affairs. I will go into a fair level of detail than I usually have in the past. There have been a couple of meetings where actions have occurred since I last spoke with you. This is another strong example of the Department's and Administration's commitment to the health program in Indian country.

Last November, the first Council was convened by the Deputy Secretary, Claude Allen. As the Interim Director of the Indian Health Service, I serve as the Vice-chair of the Council. The Council Chair is Quanah Stamps, the Commissioner for the Administration for Native Americans in the Department. The members of the Council are the Directors of the other Operating and Staff Divisions and programs of the Department. Not their Deputy and not a representative. The expectation of the Secretary is that the Director of each of the agencies will attend the Council meetings. The Intradepartmental Council will help coordinate the resources and programs of the Department to ensure that the health disparities, social service and economic development interests of American Indians, Alaska Natives, and Native Hawaiians and other Native American Pacific Islanders benefit from the more than 315 programs of the Department.

The meetings can be compared to tribal caucuses. It is a meeting where there is a free exchange of ideas, opinions, and perspectives at the highest levels of the Department with trust among the participants that the recommendations agreed upon are the ones that will be carried out. In much the same way as the Tribal Self-Governance Advisory Committee conducts business and advises the Director of the IHS, the Intradepartmental Council works the same way to advise the Secretary.

I do not think that it is surprising that the Secretary renewed and revitalized that Council and elevated it to his office, before it was in the Administration for Native Americans within the Administration for Children and Families. He has taken it from a level within an OPDIV and raised it to the level of his immediate office. That alone shows a strong commitment.

Secretary Thompson and his senior staff have been out visiting Indian country, speaking with tribal leaders and members of the community, and seeing first hand some of the needs that we have. He has personally seen how a safe and sanitary water system benefits a community, and he has seen how a community copes when that system is not available or is insufficient. The distances that many Indian people have to travel to receive health care are no longer an abstract description that his senior staff has heard – along with the Secretary, they have traveled the same roads or waterways or flown the same routes. They have visited Head Start Centers where we carry out early child care development. They have seen our senior citizen centers and taken meals with our elders. They have seen how

different HHS programs, not only IHS programs, touch the Indian communities.

A number of you have met with the Secretary or the Deputy Secretary during one of their many visits to Indian country. And they do not travel alone – they bring with them senior members of their staff as well as various leaders of the Operating Divisions of the Department. And the Secretary's representatives travel on his behalf. During his debriefing with senior staff following his trip to Alaska last summer, the Secretary said:

> *" I am appalled that **Native Americans continue to live in conditions that I believed no U.S. citizen endured in this day and time**. I was shocked. We came away from that trip knowing there was an expectation left behind that we would do more."*

The Secretary is a man of his word. He has done more. And through the Council, as well as through other avenues, we will all do more.

And I think he has also sent the message that eliminating health disparities involves more than just ensuring access to health care services provided by the IHS, tribal health departments, and urban Indian health programs. It also includes conducting research into the health issues of Indian people and communities, creating jobs, providing adequate family support through social services, improving access to departmental programs.

The Secretary stated,

> *"We must do more with our existing programs to make them work better for Native Americans and consult with our partners to improve our policies and services to their communities."*

The Secretary provided some specific examples of what he expects the Council to achieve:

- Bringing more Native health scholars into HHS hospitals, clinics, and into the workforce in Indian country.
- Involving Native leaders in the planning and emergency response process so that public health emergency preparedness can be fully implemented.
- Promoting Employment Assistance Program TANF grants to ensure Native American parents are employable.
- Establishing Social and Economic Development Strategies grants to revitalize Native government local economies.
- Establishing Language and Cultural Preservation grants in addition to pre-Head Start and Head Start programs on Indian reservations.

Some of these programs and strategies already exist; but the Secretary wants them to be more comprehensive, more effective, and more coordinated – and he wants these issues, and others like them, to be addressed by the "One Department" and not by independent programs.

The charge to the Council consisted of 6 initial goals:

1. Improve the HHS consultation process,
2. Increase the use of web-based and other communication systems for providing information to Tribes, from Tribes, and between regional offices of the agencies and headquarters locations,
3. Improve coordination with and between regions,
4. Assess current grants announcements for inclusion of Native American communities,
5. Inventory the current efforts to expand access to HHS programs,
6. Review public releases for appropriate Native American audiences.

Since the November meeting: The Office of Intergovernmental Affairs is making progress on the second goal, increasing the use of web-based and other communication methods. And the Assistant Secretary for Administration and Management has taken steps to ensure that each of the Department's grants offices include a statement in their grants solicitations that indicate eligibility of Native Americans to apply. Activity on the 5th goal has included completing an inventory of HHS programs and identifying those that are accessed by Native Americans. Their findings are that of the 315 HHS programs, 125 are available to Native Americans, and 85 are being accessed by Tribes. That workgroup is continuing their work to determine why only 125 programs are available to the Native American community and why only 85 of the programs are being accessed. The intent of the Council is to try and identify barriers to expanding access and change policies where needed. My hope is that once we get further down the line on this, we will be able to have a list of those programs to provide to Indian communities. This list would show all the grants and programs in the entire HHS that are available to you.

We also identified 6 pressing policy concerns that supported the goals and required prompt action. These six items were solicited from across the entire HHS programs. We identified ones that were cross-cutting issues and also those we knew were important to Indian country.

1. Completing the Report to Congress on the feasibility of a Tribal Self-Governance Demonstration Project in HHS programs outside of the IHS.
2. Affect of the implementation of the CMS Outpatient Prospective Payment System.

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3. Ensuring that Tribes are included in and have access to Health Promotion and Disease Prevention initiatives.
4. Strengthening Tribal Consultation.
5. Eliminating health disparities.
6. Recruiting Health Professions staff.

Of the policy concerns, since November the first two have been completed.

- On March 12th the Secretary sent the Title VI Study to the Congress. Copies will be available at this conference and the staff of the Assistant Secretary for Planning and Evaluation is in the process of putting it up on their web site. Should the Congress deem a demonstration project to expand Self-Governance within HHS is appropriate and pass legislation to create that authority, the IHS is prepared to assist our sister Agencies should they enter the process.
- As I have mentioned, the HHS, CMS, and IHS have reached agreement that OPPS implementation would be waived for IHS and Tribes.

I believe that the successful resolution of these issues could not have occurred so quickly without the leadership provided by the Secretary and the Deputy Secretary and embodied in the Council.

The 4th item, tribal consultation, includes scheduling 10 regional tribal consultation meetings between May and July. That schedule is well on its way to being completed. Scheduling has taken into consideration other regionally-based meetings taking place to create cost efficiencies, particularly for tribal representative travel expenses. At these meetings we hop to receive comment on HHS programs and any policy issues that are being dealt with. After we have been through half or more of the meetings, through the Council, we will establish a subcommittee to review the comments that the Tribes have provided on how HHS can strengthen their consultation policies.

Tribal consultation on the formulation of the HHS budget request is scheduled to take place, and be opened by the Deputy Secretary, on May 6th. This will be the 5th Annual Tribal Budget Consultation Meeting. These meetings are important and, again, reflect the Secretary's commitment to putting the necessary resources behind addressing health issues in Indian country. The briefings that occur during those meetings provide tribal leaders access to contribute to Operating Divisions' awareness of how things need to be done in our communities and to make them aware of how they can be more helpful to our communities.

I believe we are in a new era of strengthened and expanding partnerships within the Department of Health and Human Services. It includes more than just an IHS partnership with other Operating Divisions or programs within the Department – it is also partnerships directly between tribal and urban Indian health programs and the programs of the Department. This Administration is committed to listening to your concerns, seeing firsthand some of the challenges we face, and taking action on those issues.

Before I close, the Director of the IHS cannot make a speech without talking a little about the health status of our people. I have talked a lot about the partnerships that we are trying to forge to try to address some of those issues, but I want to talk to you about some of the startling statistics we have out there. It is totally unacceptable to me, as an American Indian and also as the Interim Director of the Indian Health Service, that in our prosperous nation, Indian people continue to experience health disparities and death rates that are significantly higher than the rest of the nation:

- Alcoholism - 770% higher
- Diabetes - 420% higher
- Accidents - 280% higher
- Suicide - 190% higher
- Homicide - 210% higher

These statistics are repeated so often that many people in our communities view them as insurmountable facts. But the particular statistics that I picked out are problems influenced by behavior choices and lifestyle. Making significant reductions in health disparity rates, and even eliminating them, can be achieved by implementing best practices, using traditional community values, and building the local capacity to address these health issues and promote healthy choices.

In closing, I am committed to ensuring that the health status of American Indians and Alaska Natives is addressed in a comprehensive manner -- and it is not just about ensuring access to our hospitals and clinics. It is about ensuring that there are educational opportunities for our people; it is about ensuring that we have safe communities; it is about ensuring that we have adequate housing; and it is about ensuring we have adequate economic opportunities. It is about all these things, and more, that are interdependent and that affect health status. One aspect of well-being builds on another. We will do all that we can within the IHS to ensure that all the partners who deal with those health factors are at the table and are aware of the issues that we face.

Thank you again for inviting me to this conference. When I am back in Washington, D.C., and dealing with the issues that we face, I draw strength from knowing where I come from, and knowing that all of you out there are working on a daily basis toward a goal that we share, which is to protect and improve the health of the people we serve.

Thank you.

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