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"Partners in Health"

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Good morning.

My name is Chuck Grim. I have worked with the Indian Health Service for almost 20 years now and I have been served in the Oklahoma, Phoenix, and Albuquerque areas of Indian Country. This gave me an opportunity to work with many of the urban programs in those regions and learn about their programs and meet their staff. I look forward to learning even more about urban programs in all the regions of the Indian Health Service.

It was a great honor when President Bush and Secretary Thompson asked me to serve the American Indian and Alaska Native people as the Interim Director of the Indian Health Service. Before my appointment on August 12th, I served as the Director of the Oklahoma City Area of the Indian Health Service. That job had a lot of challenges and opportunities. I thought I understood a little bit about being the Director of the Indian Health Service just because of being an Area Director and working with the Director, Dr. Michael Trujillo. But I did not fully appreciate how many challenges and how complex the job of being Director of the entire agency is. It is an exciting time to be Director of the Indian Health Service and I cannot think of any other position I would rather be serving in right now.

In two short years, this administration has raised the visibility of American Indian and Alaska Native issues to unprecedented levels. Both Secretary Thompson and the Deputy Secretary Claude Allen have traveled throughout Indian Country. I want to add my confirmation of what my colleague Chris McCabe, Director of the Health and Human Services Office of Intergovernmental Affairs, just mentioned – senior Department officials of this Administration are open to meeting with you and to attend meetings like this. The Office of the Secretary where Mr. McCabe works has an open door policy and they are more than happy to schedule an appointment to meet with you. His office also keeps us informed of when meetings are scheduled so that we can also attend to help advocate for the concerns of American Indian and Alaska Native people.

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I consider it an honor to be part of the Department team working for and on behalf of Indian people. Together, the Department, the Indian Health Service, and the National Council of Urban Indian Health, we can accomplish great things.

I know a lot of people have questions about what I consider to be important for the agency to achieve over the next several years. What issues require immediate attention and those that are going to need more long-term attention? Maybe how I view the relationship between the Indian Health Service and NCUIH and urban Indian health issues in particular is an immediate interest of yours.

First off let me begin my complementing the former director, Mike Trujillo on his vision for developing and promoting the Indian health system concept of Indian Health Service, Tribal, and Urban Indian (I/T/U) health programs. I think we have made tremendous progress over the last several years by partnering our health system like that. He welcomed urban programs to the table. That is part of his legacy that has had a remarkable impact on the agency. I plan to build on that legacy. I can assure you, as long as I am Director of Indian Health Service, urban Indians will have a place at the table. As NCUIH has emerged as an entity representing 33 of the 34 urban Indian health programs receiving Title V federal funds via the Indian Health Service, so too has it strengthened the Urban Indian Health Program office on my staff. In the past, when there were opportunities for including urban Indian representation on various workgroups or teams – it was left up to individual headquarters programs to identify and contact members of the urban Indian community. Now, headquarters programs can contact Jim Cussen, the Director of the Urban Indian Health Program, and his staff can quickly notify the NCUIH leadership of a request for participation or consultation on issues that will affect urban Indian health programs. You can then determine who will represent NCUIH or the 33 urban programs on a national level. I also assure you that all headquarters programs will understand that process to ensure that there is urban Indian leadership at the table when we discuss policy and budget issues.

As I said earlier, I greatly appreciate the many Tribes across the nation that placed my name before the President for his consideration of me as Director of the Indian health service. Until the final determination is reached, I consider it a privilege to serve you as Director of the agency. I have the full authority from the President and the Secretary to ensure the agency aggressively represents the health concerns of American Indians and Alaska Natives across the nation. There is no other agency that I consider to be as important or as honorable with a workforce whose dedication is unparalleled. A distinction that is collectively shared by the I/T/U.

During my past 20 years with the Indian health service, I have had the privilege of meeting many tribal leaders and other urban Indian health leaders. As I said I have worked in three regions of the Indian Health Service and had an opportunity to meet with Indian leaders in those states. During my tenure as the Interim Director, I invite urban Indian leaders to meet with me and discuss health issues so that we can improve the health of Indian people regardless of where they live. I would also like to personally visit your programs so I can see some of the challenges faced on a daily basis and I can personally meet and thank your staff for the remarkable work they are doing.

I think the Indian Health Service has an enviable history of meeting challenges head on and triumphing over them. The track record will be invaluable as we continue to maintain the services and also make changes in the health care environments that we are facing today. I think we are going to have multiple opportunities to employ our talents, administration and health delivery meet the challenges that we face ahead for health care reform, Department reorganization and the President's Management agenda.

And the urban Indian health program faces similar challenges and also has a history of success. From the first urban Indian clinic in 1972 that received funds from the Indian Health Service, through the expansion made possible with Title V of the 1976 Indian Health Care Improvement Act, to the 34 Title V urban programs funded today – urban Indians have received services that they would likely not have received over these years were it not for the dedication and passion of your leadership and your clinic staff. In a phrase, you are the Indian health system for urban Indians. We help you where we can, but you are there every day giving the best care possible with the resources you have. In that, the Indian Health Service employees and the urban Indian health program employees share a common bond.

The urban Indian health programs experience every day the reality that the Indian Health Service is not the sole source for assistance and support in meeting urban Indian health needs. Your collaboration and partnerships with others is what extends the effectiveness of your programs. Your partnerships with state, local, and private providers of grants and contracts is what it takes to meet our shared health objective of eliminating health disparities between the general population and American Indians and Alaska Natives.

I realize there is a great deal of curiosity as to what my focus will be for the agency. Personally, one focus will be to learn from you. We can learn from your success with exceptionally innovative programs, such as the Physician Residency Program in Seattle through your collaboration with the Office of Minority Health, the San Francisco/Oakland health services collaboration to provide health services in the Bay area, the Phoenix program and its focus on Treatment and Prevention of HIV/AIDs and its collaboration with the Phoenix Indian Medical Center. And most recently the Albuquerque program's new dental facility and the collaboration with the Southwest Polytechnic Institute.

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We will rely on your consultation and insight for how Indian Health Service programs can help support your efforts in meeting the health needs of Indian people in urban areas. I expect you to be at the table as an active participant.

One of the things I plan to do is actively engage other Department of Health and Human Services programs to look for ways to increase access to their programs by Tribal and urban Indian programs and organizations. I am privileged to serve as the Vice-Chair of the Secretary's Interdepartmental Council on Native American Affairs. The Secretary elevated that Council to his immediate office. The Council will be composed of the Directors of all the Operating Divisions of the Department. All of those agency leaders will be sitting down with me at the Council to discuss American Indian and Alaska Native issues. A recent study done by the Department indicated that Tribes currently access 46 to the more than 90 programs for which they are eligible. The 90 programs are specifically targeted to address American Indian and Alaska Native health issues. However, there are more than 320 programs in the HHS that also are accessible by minority population organizations and programs, such as urban Indian health organizations. In HHS alone, it is obvious that the Indian Health Service is not the only program that can assist Indian people. This Interdepartmental Council will offer us a venue to discuss Department resources in a systematic way to assist Indian people.

The breakout session this afternoon titled, "Funding Connections – Working With Private Resources" is an example of NCUIH understanding that to meet the health needs of Indian people takes a network and not a single agency or program. In addition to private resources, there are still many government programs across all of the executive departments, that are open to Indian tribes and organizations that are not being accessed. One of my goals is to increase awareness of the possibilities.

I applaud NCUIH for such an ambitious and relevant agenda. In addition to the funding topic, the topic on "Data Solutions" I consider an absolutely critical topic. All of us are aware that September 11, 2001, shifted the priorities of this nation from a peacetime agenda to a wartime agenda. This shift in priorities naturally shifted funding priorities. To respond to that shift and continue our advocacy for Indian people it is critical that we have data that supports our efforts. Our advocacy efforts should continue to put a face on the data, because it is the quality of people's lives we are advocating for, but without the data there may be less justification to fund a health program.

The computer connectivity of the urban programs and the Indian Health Service demonstrates the value of investing in data systems – those programs that now are connected to the Indian Health Service network achieved 100 percent compliance in the standardized urban Indian health program reporting system. This validates that the urban Indian health program is making a positive difference in health status and quality of life by, among other quality measures, providing more than half-a-million patient services on an annual basis.

While the Title V funding level for urban programs steadily increases, from $31 million for fiscal year 2002 to the president's proposal of $31.6 million for 2003, we all realize that it contributes approximately 22% of the funding need identified by the urban programs. Title V funding was never intended to provide full coverage of the cost of providing health services.

When the Indian Health Care Improvement Act was initially put together we had a different demographic makeup of Indian people; they were dying at an earlier age (around 40 or 50 years of age compared to now), they were living more on reservations than in urban areas but through government policies and programs many Indian people were shifted, some estimate as high as 50 percent of the Indian population, were shifted to urban areas and many of them and their families remain today.

That is why partnerships to help meet the health needs of our people are so important; your partnerships with the Indian Health Service and private and public programs and organizations. It is to the credit of the urban program leadership that you almost double, through partnerships and leveraging of the funds you have, the Title V funding you receive. It is recognized that, like the Indian Health Service and the nation, the cost of providing medical services continues to increase at a pace that appropriations have yet to match.

Another of my management priorities for the Indian Health Service is to explore how we can increase our capacity to recruit new health professionals and what we can do to extend the length of time that they serve with us. I feel we have a vacancy crisis in some health positions. We in the Indian Health Service as well as tribal and urban Indian health programs are facing, along with the rest of the nation, what has been described in newspapers and media reports of studies as a retirement crisis. Staffing urban Indian health programs is also a challenge and in some of your programs you have particular needs in the area of nurses and nurse practitioners. Together we may be able to help one another fill our vacancies. I plan to emphasize recruitment and retention of health professionals and I have established a group that is working on initiatives that the agency might be able to adopt and also to work with the Department's efforts at recruitment and retention, such as the development of one application system for all Department vacancies. We will continue to provide the urban programs the opportunity to post your vacancy announcement on the Indian Health Service Job Vacancies database on our website. And we will continue to suggest to applicants who decide they do not want to work in one of the IHS or tribal programs that they consider working for one of the urban Indian health programs.

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Even with the challenges of our vacancies, the quality of our care is not in doubt. Our JCAHO scores are consistently among the top in the nation. And 14 of the urban programs are formally designated as Federally Qualified Health Centers – a designation that reflects a record of achievement as well as high quality of health care delivery services.

Preventing disease and injury I consider a worthwhile financial and resource investment that will result in long-term savings by reducing the need for providing acute care and expensive treatment processes. Many of the chronic diseases we face now are lifestyle diseases where prevention activities begun at any time, and certainly early in life, can help. Much of our focus will be focused on the ten leading health indicators that are outlined in *Healthy People 2010.* Programs that are developed as a result can be exported to urban Indian health programs. I also feel that you are doing a lot of things already because many of you focus heavily on those health indicators now, and we can learn from you. And savings can be redirected to strengthening prevention efforts and also for developing programs to care for our elderly. That is another demographic shift we have seen over the past 30 or 40 years. As I mentioned, Indian people used to die at an early age and now the Indian population is not far behind the average age of death for the general population.

When I spoke to an audience of elders in Albuquerque last week I said that elder health care issues are everyone's issues. And they applauded. The urban health priorities have also indicated that elder care needs are among their 14 priority areas for emphasis. I hope we can work together on the elder care issue.

Our successes at improving health includes the benefit of having our elders with us and healthy throughout their lifetime, and we need to have programs of care that will sustain their quality of life with their families and within their communities for as long as possible. One of our chief advocates for elder health, Dr. Bruce Finke, from Zuni, New Mexico, said that there is no elder so sick that they can't be cared for in their home with the right resources.

I encourage you all to review the Indian Health Service Roundtable Report on Elder Long-Term Care; it is available on our website. The roundtable was with elder care experts inside and outside the Indian Health Service. They looked at the challenges that we face as a nation regarding long-term care. One thing the report demonstrates is that we are not facing it alone.

My commitment to the agency is to follow the lead of the Administration by assisting the agency to have a results-oriented and market-based business plan so that the Indian Health Service can most effectively fill its role in the Indian health system of IHS, Tribal, and Urban Indian health programs. And this effort is being assisted and influenced with the involvement and leadership of urban Indian people like Kay Culbertson. Her participation in the Indian Health Service budget formulation process has been invaluable. Over the years I know many of you have made substantial contributions to the development of Indian Health Service policy, I had the privilege of working with many of you, and I look forward to your continued contributions to the Indian Health Service.

I consider the foundation of the effectiveness of our health programs to be the consultation between us to establish the health priorities, policies, and programs to meet the health needs of American Indians and Alaska Natives, no matter where they reside. Effective and meaningful consultation will continue. It is through consultation that the Indian Health Service has achieved the status it has today with Indian country, with the Federal Government, and on the international stage.

On your agenda there are also sessions focusing on strategic planning. I believe that is another reason our advocacy efforts are successful – because we are continuing looking ahead. We are not ignoring the past, we are benefiting from it. What the past has taught us we apply in our strategic planning for the future. I am sure NCUIH is developing strategies that might address legislative changes necessary to expand the opportunities urban Indian organizations have to meet the needs of their communities, particularly now that the Indian Health Care Improvement Act is up for reauthorization. If you have not already reviewed the proposed changes in that document, I urge you to do so. And that you propose changes if you feel that it will not effectively meet the urban Indian health care needs of the future. It is available from the Indian Health Service website.

Thank you for inviting me and I look forward to meeting and listening to you over the course of my tenure and working with you as we plan the future of the Indian Health Service as we begin this journey of health leadership together.

I want to close with a quote of Secretary Thompson: "If you are not pushing the envelope you are merely taking up space."

Together I feel that we can truly push the envelope for our Indian people. They deserve no less from any of us.

Thank you.

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