HOUSE COMMITTEE ON NATURAL RESOURCES' SUBCOMMITTEE FOR INDIGENOUS PEOPLES OF THE UNITED STATES
A YEAR IN REVIEW: THE STATE OF COVID-19 IN AMERICAN INDIAN, ALASKA NATIVE, AND NATIVE HAWAIIAN COMMUNITIES—LESSONS LEARNED FOR FUTURE ACTION
MARCH 23, 2021
TESTIMONY OF DR. CHARLES GRIM, SECRETARY OF HEALTH
CHICKASAW NATION

Introduction

Chair Raúl M. Grijalva, Vice Chair Jesús "Chuy" García, Ranking Member Bruce Westerman and Members of the Committee and Subcommittee, thank you for holding this critical hearing on "A Year in Review: The State of COVID-19 In American Indian, Alaska Native, and Native Hawaiian Communities-Lessons Learned For Future Action." On behalf of the Chickasaw Nation and the patients we serve, I submit this testimony for the record.

I am Dr. Charles Grim, Secretary of Health for the Chickasaw Nation. I am a native of Oklahoma and a citizen of Cherokee Nation. I am a retired Assistant Surgeon General and Rear Admiral (upper half) in the Commissioned Corps of the United States Public Health Service (USPHS). I graduated from the University of Oklahoma College of Dentistry in 1983. I am board certified in Dental Public Health and a Fellow in the Academy of General Dentistry. In addition, I hold a master's degree in health services administration from the University of Michigan.

Prior to joining the Chickasaw Nation Department of Health leadership, I served for 10 years in various leadership roles for the Cherokee Nation tribal health system, ultimately serving as their Executive Director. Prior to that I was appointed by President George W. Bush and received unanimous Senate confirmation as the Director of the Indian Health Service (IHS) from 2002-2007. I have served 37 years in Indian Health positions, 26 years for the federal government and now 11 years with self-governance tribes.

As Secretary of Health, I serve as the executive in charge of a tribal health system that includes the 72 bed Chickasaw Nation Medical Center, four outpatient health clinics, an EMS service, revenue cycle, facilities management, and a host of public health, nutrition and community health programs. Quality health care is provided to a patient population in excess of 110,000 in a 13-county tribal service area, however patients receiving care come from communities throughout the United States.

Included in this testimony are sections on:

I. Chickasaw Nation
II. The State of COVID-19 in the Indian Health Care System
III. The State of COVID-19 in the Chickasaw Nation
IV. Chickasaw Nation Efforts to Address COVID-19
V. Importance of Self-Governance in the Chickasaw Nation
VI. Mental Health and Substance Abuse Services

I. Chickasaw Nation

From their ancient history in their ancestral homeland in what is now Mississippi, Kentucky, Alabama and Tennessee to their forced removal to Indian Territory (I.T.) in the mid 1800's to present day, the Chickasaw Nation has proven itself to be resilient, visionary, and indeed, unconquered and unconquerable.

Revered in ancient times as "The Spartans of the Lower Mississippi Valley," the first known contact with Europeans was with Hernando de Soto in 1540. Living in sophisticated town sites, the Chickasaws possessed a highly developed ruling system complete with laws and religion. They conducted a successful trade business with other tribes and with the French and English, and lived largely an agrarian lifestyle, but were quick to go to battle if necessary. They allied with the English during the French and Indian War. Some historians give the Chickasaws credit for the United States being an English-speaking country due to their control of the Lower Mississippi while allied with the Great Britain.

The Chickasaw people moved to Indian Territory during the "Great Removal," on what was called the "Trail of Tears." Other tribes forced to relocate were the Cherokee, Choctaw, Creek and Seminole, called the "Five Civilized Tribes" because of their highly developed ruling systems. While the Chickasaw Nation was the first to sign a removal treaty, they were the last of the five tribes to move to Indian Territory. In 1837, the Treaty of Doaksville called for the resettlement of the Chickasaws among the Choctaw tribe in Indian Territory. In 1856, the Chickasaws, in order to restore direct authority over their governmental affairs, separated from the Choctaws and formed their own government.

Tribal leaders established the capital at Tishomingo, I.T., adopted a constitution and organized executive, legislative and judicial departments of government with the offices filled by popular election. Many Chickasaws became successful farmers and ranchers. Chickasaws built some of the first schools, banks, and businesses in Indian Territory.

After Oklahoma statehood in 1907, the state “abolished” the Chickasaw Reservation and attempted to abolish the government. The President of the United States continued to appoint the principal officers of the Chickasaw Nation. In 1963, President Kennedy appointed Overton James as Governor of the Chickasaw Nation. In 1970, Congress enacted legislation allowing the Five Civilized Tribes to elect their principal officers. In 1983, a new Chickasaw constitution was adopted. The Chickasaw Nations current Governor, Bill Anoatubby, was first elected in 1987, and is currently serving his ninth consecutive four-year term.

Today, under Governor Anoatubby’s leadership, the Chickasaw Nation is economically strong, culturally vibrant and full of energetic people still dedicated to the preservation of family, community and heritage. Since the 1980s, tribal government has focused on building an economically diverse base to generate funds that will support programs and services to Indian people. Business has flourished, programs and services have grown, and the quality of life for all Chickasaws has been greatly enhanced.

The Chickasaw Nation’s current three-department system of government was reestablished with the ratification of the 1983 Chickasaw Nation Constitution. The elected officials provided for in the Constitution believe in a unified commitment, whereby government policy serves the common good of all Chickasaw citizens. This common good extends to future generations as well as today’s citizens.

The structure of the current government encourages and supports infrastructure for strong business ventures and an advanced tribal economy. The Chickasaw Nation uses new technologies and dynamic business strategies in a global market.

As in times past, the Chickasaw work ethic is very much a part of everyday life today. Monies generated in business are divided between investments for further diversification of enterprises and support of tribal government operations, programs and services for Chickasaw people. This unique system is key to

the Chickasaw Nation's efforts to pursue self-sufficiency and self-determination, which helps ensure that Chickasaws stay a united and thriving people.

The mission of the Chickasaw Nation is to enhance the overall quality of life of the Chickasaw people. The vision is to be a nation of successful and united people with a strong cultural identity. The Chickasaw Nation lives its core values that guide all its activities to support the mission and vision. The ten core values are: The Chickasaw people, cultural identity, servant leadership, selflessness, can do attitude, perseverance, stewardship, trust and respect, loyalty, honesty and integrity and teamwork.

Chickasaw Nation Department of Health

The Chickasaw Nation Department of Health (CNDH) is one of nine departments of the Chickasaw Nation. In 1994, the Nation entered into a P.L. 93-638 contract to become a tribally operated health care organization. Direct, primary care health services are provided to all federally recognized First Americans. The majority of these health services are delivered by the Nation from one of their four health care facilities, Chickasaw Nation Medical Center, Ardmore Health Center, Tishomingo Health Center, and Purcell Health Center.

The Chickasaw Nation Medical Center (CNMC) in Ada is a state-of-the-art 405,000 square foot facility that provides the following services:

Inpatient Medicine	Psychiatry	Acute Care & Intensive Care
Optometry	Inpatient and Outpatient Surgery	Dental
Obstetrics & Gynecology	Medical Family Therapy	Primary Care
Physical Therapy	Pediatrics	Laboratory
Imaging Services	Pharmacy	Audiology
Emergency Care	Nutrition & Dietetics	

The CNDH has satellite clinics in Ardmore, Purcell and Tishomingo. The Chickasaw Nation offers a variety of nutrition-focused programs and services in five Nutrition Centers in Ada, Ardmore, Purcell, Tishomingo, and Duncan. WIC services are also available in Pauls Valley, Sulphur and Tishomingo.

The CNDH has 1,640 employees. The medical staff consists of:

- 192 MD/DO (Physicians)
- 20 DDS/DMD (Dentists)
- 2 DPM (Podiatrists)
- 10 OD (Optometrists)
- 44 APRN (Nurse Practitioners)
- 28 PA (Physician Assistants)

During the COVID-19 Public Health Emergency (PHE), direct services provided by the CNDH declined. The CNMC served more than 4,790 inpatient admissions, down from 5,421 the previous year and 873 births down from 930 the previous year. Including pharmacy and ancillary services, the CNDH had the following outpatient visits:

- CNMC – 384,017, down from 405,760
- Ardmore Clinic – 141,138, up from 132,173
- Purcell Clinic – 87,666, up from 84,645
- Tishomingo Clinic – 68,812, down from 70,373

- Total FY20 Outpatient Visits – 681,634, down from 693,131

The emergency department, which includes all service levels, served 36,750 patients, down from 45,005. The pharmacy served 1,365,496 prescriptions. The total number of endoscopy procedures was 1,770, down from 1,884. The total number of operating room procedures was 2,264, down from 3,008. The total workload for FY20 was 988,585, down from 1.1 million in FY19.

The Chickasaw Nation health system is a part of the Oklahoma City Area (OCA) IHS. Forty-three tribes are represented within the Area with 38 in Oklahoma, 4 in Kansas, and one in Texas. The OCAIHS serves the states of Oklahoma, Kansas, a portion of Texas, and Richardson County, Nebraska. In FY 2020, the OCA user population was 391,776--the largest user population in IHS. The OCA is the lowest funded IHS Area per capita. The Indian Health Service/Tribal/Urban (I/T/U) health systems within the Area manage 8 hospitals, 59 health centers (which includes 5 health clinics in urban locations), 1 school health center, and 1 regional youth alcohol and substance abuse treatment center. The large number of tribal health care facilities and programs is a strong reflection of the partnership and cooperation within the OCA to fulfill the existing health care needs of our community.

II. The State of COVID-19 in the Indian Health Care System

Our nation is gripped by the most unprecedented public health crisis in generations. As of March 17, 2021 there are over 29 million COVID-19 cases nationwide and over 534,000 COVID-19 deaths, according to the Centers for Disease Control and Prevention (CDC). Finally, after a year of countless cases and death, public health data has begun to show a downward trend in cases and deaths.

According to an article published in the medical journal, Lancet, earlier this month, as of Feb 7, 2021, "there have been 181,576 cases of COVID-19 among American Indians and Alaska Natives (AI/AN) reported to the Indian Health Service (IHS)".

In a CDC Morbidity and Mortality Weekly Report (MMWR) published December 1, 2021 that included deaths from January 1 to June 30, 2020 from 14 states found that "AI/AN persons had a COVID-19 associated mortality that was 1.8 times higher than that among non-Hispanic Whites. In AI/ANs, mortality was higher among men than among women, and the disparity in mortality compared with non-Hispanic Whites was highest among persons aged 20–49 years". Data utilized for this study pre-dated the most severe surges and periods of peak deaths due to COVID-19 and likely grossly underestimate the true disability and lethality wrecked by the virus in Indian Country.

The Color of Coronavirus project, an independent investigative journalism and public health disparities project sponsored in part by American Public Media (APM) lists indigenous Americans as having a rate of death due to Coronavirus as 1 person in every 390 Indigenous Americans persons or 256 deaths per 100,000. Pacific Islanders have a rate of death of 1 in 565 due to coronavirus or 176.6 deaths per 100,000. By way of comparison, blacks have a rate of death due to coronavirus of 1 in 555 or 179.8 per 100,000 and whites have a rate of date of 1 in 665 or 150.2 per 100,000. This is a 70.4% higher rate of death for Indigenous Americans who live in the United States due to coronavirus as compared to deaths in whites.

In Oklahoma, the rates of death due to Coronavirus as calculated by the Color of Coronavirus for Indigenous Americans is 283.3 per 100,000 and 319.8 per 100,000 for Pacific Islanders as compared to whites which had a rate of death due to Coronavirus of 195.3. This is a 45% higher rate of death for Indigenous Americans who live in Oklahoma due to coronavirus as compared to deaths in whites.

These numbers illustrate the lethal course of the SARS Co-V2 virus in AI/AN peoples and are illustrative of the wide disparity in health outcomes for AI/AN peoples.

According to the CDC on March 10, 2021, Oklahoma has reported 744 AI/AN deaths out of the 7,344 deaths, which constitutes 12.5% of all AI/AN deaths from COVID-19 and 10.1% of AI/AN deaths in Oklahoma.

Similar to every prior public health crisis, there are disparate and disproportionate impacts on underserved and marginalized communities, and Indian Country is at the epicenter. According to the CDC, people with chronic obstructive pulmonary disease (COPD), type 2 diabetes, chronic kidney disease (CKD) and end stage renal disease (ESRD) are at higher risk for a more serious COVID-19 illness. AI/AN populations are disproportionately impacted by all of these underlying health conditions.

The situation that we all feared is not hard to find as we see more deaths in Tribes with some of the nation's highest rates of diabetes. It is important to note that all these underlying conditions not only increase the likelihood of hospitalization and death, but will linger long after the hospital stay of those who do recover. The costs of all this care is an added financial burden to an already overwhelmed and underfunded health care system.

Not only is the health and lives of AI/ANs at risk, but so too is their financial status impacted by the disproportionate incidence of COVID-19. According to the Oklahoma Employment Security Commission in December 2020, the State of Oklahoma lost 145,000 jobs from February through April. From May through October, fewer than 68,000 were recovered. The rate of job recovery is slowing, with Oklahoma averaging a net gain of 2,800 jobs a month over the past four months and even lower rates more recently. Along with a loss of jobs came a loss of health insurance coverage. Even though Oklahoma is expanding Medicaid effective July 1, 2021, it will come too late to provide coverage for these recently unemployed due to COVID-19.

As of March 16, 2021, the IHS reported 188,783 positive cases of COVID-19. However, IHS numbers are highly likely to be underrepresented because case reporting by Tribal health programs, which constitute roughly two-thirds of the Indian health system, is voluntary.

The COVID-19 pandemic has further exposed the vast deficiencies in health care access, quality, and availability that exists across the Indian health system. Prior to COVID-19, the Indian health system was beset by an average 25% clinician vacancy rate, and a hospital system that remains over four times older than the national hospital system. Limited intensive care unit (ICU) capacity to address a surge of COVID-19 cases across many IHS and Tribal facilities has strained limited Purchased/Referred Care (PRC) dollars, creating further challenges that are contributing to rationing of critical health care services.

The CDC has noted that hand-washing is the number one way of protecting against a COVID-19 infection, however, water and sanitation infrastructure in Indian Country is significantly underdeveloped. **Approximately 6% of AI/AN households lack access to running water, compared to less than half of one percent of White households nationwide.**

In a new peer-reviewed study of 287 Tribal reservations and homelands, **COVID-19 cases were found to be 10.83 times more likely in homes without indoor plumbing.**

Despite alarming gaps nationwide in population-specific COVID-19 health disparities data, available information clearly demonstrates that Tribal communities are facing the brunt of this public health crisis. The federal government has treaty and trust obligations to fully fund healthcare in perpetuity for all Tribal Nations and First Americans, and it is imperative that this obligation be met in the face of the COVID-19 pandemic.

To that end, we are grateful that Congress and the Administration recognizes the great need in Indian Country and that each previous COVID-19 relief package has included important Tribal health provisions, such as the $64 million in funding for IHS under the Families First Coronavirus Response Act; $1.032 billion in funding for IHS under the CARES Act; baseline $750 million Tribal set-aside in testing under the Paycheck Protection and Healthcare Enhancement Act, the $1 billion under the Coronavirus Response and Relief Supplemental Appropriations Act, and the $6 billion under the American Rescue Plan Act of 2021.

III. The State of COVID-19 in the Chickasaw Nation

Chickasaw Nation Governor Bill Anoatubby, declared a state of emergency on March 17, 2020. During this pandemic response the CNDH has partnered with local communities, region, state, and nation as well as other health care, business and federal partners to be able to offer services to all persons needing care while continuing to provide robust services to current patients.

The COVID-19 pandemic arrived in Oklahoma at almost the same time as many CNDH employees and patients were returning from spring break 2020. Simultaneously, while many Chickasaw Nation industry businesses were scaling back to essential services only, the CNDH was rapidly converting its operation to be able to serve its patients, employees and the community during the pandemic.

Within the span of less than two weeks, the majority of in person visits were converted to virtual visits using a variety of online electronic platforms. An employee screening process was initiated for all CNDH health employees and then for all Chickasaw Nation employees returning from annual leave and/or who were having symptoms of possible COVID-19 infection, or who had known or possible exposure to persons infected with COVID-19. Many of these employees and family members were directed to self-quarantine or referred for definitive testing.

A daily CNDH employee and patient screening process was introduced at all CNDH facilities to screen employees for temperature and symptoms and exposure to COVID-19. Restrictions on visitors and guests entering CNDH facilities were introduced to reduce unnecessary exposure of patients and health care workers to those potentially infected with COVID-19.

A COVID-19 call center was introduced to triage patients and employees with potential symptoms and/or contacts of COVID-19 to medical care. A COVID-19 clinic was developed to help see persons with symptoms and close contacts. Emergency standards of care and treatment protocols were initiated through the CNDH Medical Executive Committee.

CNDH immediately set up testing tents throughout the Chickasaw Nation at the CNMC, Ardmore, Purcell and Tishomingo Clinics. We stood up testing sites at some of our larger businesses to have massive employee testing before employees returned to work.

CNDH and Chickasaw Nation also stood up their Incident Command teams (ICT) and integrated with local, state, national, IHS, CDC, Federal Emergency Management Agency (FEMA), and Department of

Defense (DoD) emergency operations. The Chickasaw Nation state of emergency declaration was immensely helpful in assuring social distancing, stay at home and quarantine orders and allowed the CNDH health system greater flexibility to defer some elective care and utilize alternative delivery models. The emergency order also allowed the CNDH to provide care to serve broader communities.

CNDH developed a gating criteria and prioritization matrix utilized by the demobilization unit for phased reopening timelines. When the gating criteria established is met it triggers the phased reopening timelines for each CNDH departments. The prioritization matrix helps guide recommendations as to which CNDH departments should be prioritized to open earlier in the phased timeline or those departments that should be delayed to open at a later date. As CNDH continues to progress through the evolution of the COVID-19 pandemic, it is important that a solid, scientifically based public-health strategy is continued to limit viral spread and measurable milestones are utilized as a guide to implementing a phased reopening of operations for the CNDH.

CNDH continues to utilize innovative methods such as virtual visits and work from home options to maintain patient services for the safety of employees, patients, and community members.

Because of the swift action and declaration by Governor Anoatubby to close all non-essential business and offices in the 13-county area in the Chickasaw Nation, very early in the pandemic we were able to initiate COVID-19 safety policy and procedures, screening, testing, contact tracing, case investigation, epidemiological surveillance, environmental controls and use national, state and local data and especially our own data to make evidence-based decisions. Because of this, the Chickasaw Nation workforce experienced significantly lower rates of Coronavirus infection as compared to rates within our local communities and the State of Oklahoma. For this reason, we were able to maintain a seven-day percent positive rate at all times that was 50% or less than rates seen in the community and State. Most importantly, our approach allowed us to find almost all infections outside of the workplace and allowed data driven approach to perfecting our mitigation processes. We tested the integrity of these processes by randomly testing our workplaces for asymptomatic positive employees using a statistically significant sampling approach and found extremely low rates at all times in our workforce. If workplace spread became a concern, suppression testing combined with isolation, quarantine, contact tracing and epidemiological investigation was quickly deployed to extinguish any continuation of spread within our workforce. Epidemiological investigation has consistently shown that infections almost always begin in the community and were usually due to employees not following required safety protocols.

At present our 7 day rolling averages within our employee population is at 0.96 whereas the community rate is still at 10.59%.

Utilizing a phased recovery approach, many of our services are beginning to open to near normal capacity. CNDH primary care/mental health teams have implemented a robust telehealth service with almost 90% of chronic care visits being obtained through telehealth. Mail order pharmacy services as well as drive through services have remained a successful service throughout the pandemic.

The Chickasaw Nation developed a COVID-19 website which contains necessary information for employees and citizens of all the Chickasaw Nation programs, services and dashboards. As of March 16, 2021, the Chickasaw Nation reports 43,905 cases, 527 deaths, with 1,215 active cases and 42,163 recovered cases. For the same date, the State of Oklahoma reports 433,025 cases, hospitalizations at 266, deaths at 4,788 and recoveries at 416,604.

IV. Chickasaw Nation Efforts to Address COVID-19

Screening Efforts:

Since early in the pandemic, all employees of the Chickasaw Nation are required to perform daily screening using an app from Qualtrics which integrates screening, surveillance, testing, vaccination and other employee data into the Chickasaw Nations COVID-19 data management solution. The solution allows our contact tracing, case investigation, employee and public health teams and epidemiology and population health management teams to make data driven decisions.

Testing Efforts:

CNDH identified the need for expansion in operations, testing and planning for vaccinations to respond to the COVID-19 public health emergency.

Since the CNDH initiated testing operations on March 9, it has performed over 106,000 COVID-19 tests with a median of 1883 tests per week. Roughly 50% of our testing has been performed on our employees and associates and roughly 50% has been performed on members of the community which include patients who are AI/AN as well as non-native persons.

The Chickasaw Nation reservation is located in an area where Chickasaw Citizens actually compose a minority of the general population. Access to testing for our citizens, patients and the community was identified early on as a barrier to testing and a barrier to identification and suppression of the SARS CoV0-2 virus. Against this backdrop, Governor Anoatubby made testing available to all persons who needed a test at one of our four drive through mass testing clinics.

CNDH COVID-19 Testing was provided at seven geographically distributed drive-through testing sites open between the hours of 0900 and 1600 to Chickasaw Nation employees and family members, patients, and the general public

The clinics are designed using a Lean/Toyota Production System methodology, combined with role-based positions and an electronic application which allows pre-arrival sign-up. Online assistance for persons unable to complete the application as well as multi-lingual translation are also available. The mass testing centers combine effective and efficient process engineering with our Chickasaw hospitality and customer service and allows rapid access and throughput for testing to many people.

Our app has been widely advertised and is available on multiple sites including the Chickasaw Nation website: www.Covidtesting.chickasaw.net.

To share our process and learnings about our mass testing process with other interested organizations we published and made available at no charge our Chickasaw Nation Testing Center and Test Results Center Guidebook.

CNDH's Laboratory has been instrumental in providing testing supplies and personnel, as well as partnering with Regional Medial Laboratory and LabCorp for diagnostic testing of COVID-19. On April 9, 2020 five (5) Abbott ID NOW®, point-of-care coronavirus testing instruments were received from the IHS national supply warehouse. Additionally, CNDH has received sufficient quantities of Abbott ID NOW instruments at each satellite clinic as well as purchased 3 additional lab instruments to include the Cepheid® and Panther® for COVID-19 testing, and the Abbott Alinity® for antibody testing.

Personal Protective Equipment Procurement:
The Chickasaw Nation moved to secure essential PPE for its employees and citizens. By networking through federal, state and local agencies, the Indian Health service and through commercial sources, the Chickasaw Nation was able to secure stocks of PPE to include masks, protective gowns, gloves, face shields and goggles and hand sanitizer. The Chickasaw Nation also purchased PPE to send to its citizens and employees via mail in an effort to encourage best public health policies in the home setting.

Medical Equipment and Therapeutics:
The pandemic exposed needs for medical equipment such as ventilators, CPAP/BiPAP machines, negative pressure rooms, tent based and modular structures, testing equipment and supplies, needles and syringes, hospital beds/equipment that enabled pronation and robust oxygen generation and oxygen storage to name a few. Similarly, medical therapeutics such as antivirals, antibiotics, steroids, convalescent plasma and monoclonal antibody therapy were at times in short supply. The Chickasaw Nation continues to work with our many suppliers as well as the Indian Health Service to assure that adequate stocks of medications and supplies are available.

Our staff and leaderships perseverance to secure necessary supplies enabled the Chickasaw to:

- Provide over 106,000 COVID-19 tests and expand lab testing to increase the capacity to test over 1000 COVID-19 tests in-house per day.
- Provide over 141 monoclonal antibody therapy treatments, preventing a number of deaths and preventable hospitalizations.
- Become a referral site during the pandemic surge for our patients and patients in community hospitals without resources who were in need of ICU based ventilator therapy. This was possible due to our ability to convert to negative pressure rooms and double-bed in our ICU and the addition of twelve (12) new ventilators and fourteen (14) new CPAP/BiPAP machines.
- Provided transfer relief to Oklahoma Region 3 MERC for critical COVID-19 positive patients who were not always tribal beneficiaries

Contact Tracing:
The CNDH Research and Public Health Nursing teams performs case investigations and contact tracing for all non-health employees that are positive with COVID-19. Currently there are 25 CNDH employees serving on the contact tracing team. Two tracers were assigned by the CDC and Prevention Foundation to assist our employees. CNDH works closely with the local and federal, state health departments and other internal partners to ensure all close contacts of our positive employees are monitored to prevent further spread of COVID-19.

Vaccine Administration:
Due to our ultra-low freezer capacity (3 available), the CNDH received our first shipment of 975 Pfizer vaccines on December 14, 2020. By that afternoon we began administering the vaccine to our frontline healthcare teams in our first walk-in clinic and by Dec. 21st we were administering vaccines through a drive-through site at our CNMC followed shortly thereafter at first one and then all of our outpatient health centers.

As all Tribes, the Chickasaw Nation established vaccination priority groups. Initially we had attempted to forecast the total population to which we might provide vaccination administration. Early on, this number appeared to be as high as 235,000 individuals which at the time was forecasted as 470,000 potential vaccine we would need to administer. Later estimates rounded this number down to around 150,000-170,000 individuals who would need vaccine and as many as 300,000 vaccine injections

administered. We set a goal to have a significant proportion of our population vaccinated by July and calculated the vaccine supply, site capacity and personnel we would need to administer the vaccine. We continue to engage in an aggressive communications campaign to our most vulnerable populations to attempt to increase vaccine participation. This campaign is informed from data from multiple ongoing surveys and patient sentiments expressed from outreach visits.

On the week of December 15, we began holding special vaccination events:

- Special Event 1: CNDH and CH Healthcare Staff, Elected Officials, Leadership
- Special Event 2: CN Elders
- Special Event 3: CN Employees, Vendors, Elders
- Special Event 4 & 5: CNDH Patients and CN Employees

In an effort to increase our vaccination efforts we opened a dedicated vaccination center, the CNDH Emergency Operations Facility (EOF), on March 8, 2021. This facility, connected to a 40,000 square foot emergency operations and emergency supplies warehousing facility includes, 16 toll-booth vaccine modules that are wind and weather protected by a permanent canopy and that can deliver vaccine in arms at a rate of 1 per every 90 to 270 seconds. Total cycle time in this facility and all Chickasaw Nation facilities averages 22 minutes, from drive in to drive out and includes a mandatory 15-minute observation period. In our drive through lanes, all processes are generally touchless, with sign up and electronic messaging and follow-up performed by the Qualtrics app. In our sites, all vaccinations are performed with the patient in their vehicle.

With this opening we expanded the vaccine eligibility criteria to include the general population down to age 16 (or age 18 depending on the vaccine brand) across all CNDH vaccination sites. With this expansion we had a new high for vaccines given in a single week and the first administrations of the Johnson & Johnson vaccine. In the first week of operations the EOF vaccinated 2,491 individuals.

The Chickasaw Nation received 3.85% of the total IHS allocation and administered 3.73% of all IHS vaccines. We have also administered 1.9% of the total Oklahoma COVD-19 vaccines to date. The week of March 12, had the highest number of vaccines administered to date across all of our CNDH sites at 6,247. As of March 19, 2021, our total vaccines given to date stands at 34,418 doses administered. 22, 570 vaccines have been first dose vaccines and 11,848 have been second dose vaccines. Not counted in this total is roughly 50-100 Janssen vaccines administered.

Capacity for vaccination across the Chickasaw Nation is robust with regular week day administration at our four clinical sites as follows:

- EOC: 2640-4500 per day
- Purcell: 120-260 per day
- Tishomingo: 120 per day
- Ardmore: 240-360 per day

In total, the Chickasaw Nation has the capacity to deliver 3120-5220 vaccines per day or 15,600-26,100 vaccines per week.

Given the increased capacity to vaccinate provided by the EOF, and a successful vaccination campaign with continued availability to our original priority groups, the benefit provided to the entire community where CNDH facilities exist is significant. The expansion of vaccine eligibility criteria follows a wider

trend among organizations receiving their vaccine supply from IHS. IHS, along with tribal and urban partners, have been praised for their planning, logistics and implementation of vaccine administration efforts and also for helping serve the wider community in hopes of ending the pandemic nationally.

The Johnson and Johnson vaccine has been made available and administered in multiple small events in Purcell and Tishomingo. A limited amount of this vaccine, 2,000 doses, were received the previous week with a total of 50 doses given to date. There is no plan to receive additional doses from IHS for at least 3-4 weeks due to availability.

Special populations being considered for the Johnson and Johnson vaccine given its small inventory are:

- Healthcare staff that may have been reluctant in taking one of the other two mRNA vaccines (Moderna or Pfizer)
- Inpatient candidates at CNMC
- Homebound individuals through Public Health home visits
- Homeless or transient individuals who may come to our Emergency Department
- Chickasaw Nation Employee Health (to meet the ongoing need for all Chickasaw Nation employees).

Our vaccination efforts were recently highlighted in several national stories:

- March 16, 2021, entitled "Anyone in Oklahoma can now get the COVID-19 vaccine, thanks to several Native tribes". The article can be found at: https://www.cnn.com/2021/03/16/us/oklahoma-tribes-offers-vaccine-to-all-trnd/index.html.
- March 17, 2021, entitled "Native tribes have expanded vaccines to everyone in Oklahoma". The article can be found at: https://abcnews.go.com/Health/native-tribes-expanded-vaccines-oklahoma/story?id=76509074

Loss of Third-Party Funding due to COVID-19:

An American Hospital Association (AHA) analysis released on February 24, 2021 shows that the COVID-19 pandemic will continue to impact the financial health of hospitals and health systems through 2021, jeopardizing their ability to care for their communities during the pandemic. The analysis forecasts that total hospital revenue in 2021 could be down between $53 billion and $122 billion from pre-pandemic levels. This sustained financial squeeze on the hospital field could result in the slowdown of vaccine distribution and administration, continued pressure on tired front-line caregivers and diminished access to care, including in rural areas. During the pandemic, people have put off needed care, in some cases to the detriment of their health. The costs of labor and supplies have increased, adding to the financial stress.

In 2020, COVID-19 undermined our nation's health and severely tested our hospitals and health systems. At the same time that a series of spikes in COVID-19 cases and hospitalizations put intense pressure on hospital staff and resources, steep declines in non-COVID-19 patient volume led to sharply lower revenues.

COVID-19 has greatly impacted the finances of many health care facilities. **For the CNDH health care system, projected workload during COVID-19 continues to be less than it would have been without COVID-19. This downward workload obviously makes third party less as compared to Pre-COVID-19 due to less in person patient visits and surgeries.**

CNDH Facility Projects:

CNDH identified needs for increased capacity and ability to care for patients, provide space to educate and train staff on COVID-19, and improve mitigation measures due to the COVID-19 public health emergency. As a result, the Chickasaw Nation began construction or remodeled several facilities to respond to the public health emergency:

With the COVID-19 funding Chickasaw Nation received we did the following projects ($43.8m to date):

1. Expand inpatient service capacity
2. Expand professional training and education space
3. Expand laboratory capacity
4. Secure PPE supplies
5. Expand epidemiology efforts
6. Support public health efforts and education
7. Improve nutritional/food services
8. Provide workforce support and communication

Chickasaw Caring Cottages

The Chickasaw Caring Cottages (CCC) opened on January 25th, 2021. The ability to isolate from others during a COVID-19 infection is key to preventing community spread. Some people have living situations that make safely isolating very challenging. In order to provide a place to recover from COVID-19, CCC provides a new opportunity with 9 individual units on the Ada South Campus. These units are available to:

- Chickasaw Citizens; and
- Patients of the CNDH; and
- Chickasaw Nation employees and their immediate, household family.

The units are fully furnished and include groceries, cable TV, WIFI, a kitchen, washer and dryer, linens, and an emergency phone. The cottages are not a medical facility and no medical services are provided. The units are non-ADA compliant and guests must be able to care for themselves for the duration of their stay. During their stay, guests are expected to remain isolated on the property. No visitors will be allowed. Total length of stay is determined by medical necessity.

In order to qualify, applicants must provide documentation of a positive COVID-19 diagnosis and be referred by certain Chickasaw Nation programs.

Acceptances is on a first-come-first-serve basis and CCC staff will attempt to review and respond to applications within a 24-hour (one day) period.

CNMC Expansion and Alternative Care Site

The Alternative Care Site (ACS) is a necessary improvement to the CNMC Campus in order to increase CNMC's capacity and ability to care for patients, provide critical testing and training, and improve mitigation measures due to the public health emergency. The lab will gain appropriate space to expand services, increase testing ability and house a dedicated air handling unit which requires a specialized negative pressure room for testing viruses. Medical supply capacity will be increased to ensure sustainability and provide space for the Nursing Education department to educate and train staff on COVID-19 procedures, treatments and protocols. The ACS will have a large, open, and easily convertible space available to plan, train, and equip as needed for COVID-19 surges. In fact, it adds 48 beds to treat

COVID patients. The ACS is a necessary addition to the CNMC framework to enable the CNDH to appropriately prepare, prevent, and respond to the public health emergency.

ACS Capacity:

- Hospital Unit with 6 functional hospital rooms, 2 offices that can be converted to basic hospital rooms, supply room, med room with Pyxis
- ACS Overflow, 20 bed open unit, Nurse's station
- ACS Overflow B, 20 bed open unit, Nurse's station

The ACS planned usage is for overflow. At this point, we would be utilizing most of our available inpatient space, double bedding where allowed, will have already pulled experienced providers and nurses to assist in all inpatient areas. The ACS is mainly for low acuity, non-COVID med/surg patients, recovering COVID (no longer contagious) low acuity patients.

<u>Emergency Operations Facility:</u>
Due to COVID-19 and its disruption to the Chickasaw Nation's health operation causing relocation/reassignment of employees, intermittent cessation of outpatient clinic operations and second order economic effects, the department of health proposed the completion of a temporary and necessary annex site.

A vacant K-Mart building located in Ada, Oklahoma provided a superior location for this necessary annex site based on convenience, proximity to the CNMC, numerous access points, available acreage and square feet under one roof and was completely renovated to become the Nation's EOF.

The EOF is used to provide a temporary COVID-19 joint operational and unified incident command center, COVID-19 drive-thru testing and vaccination center, and optional COVID-19 conditioned storage space for personal protective equipment and other essential equipment and supplies relevant to the Chickasaw Nation COVID-19 response. The EOF will be temporarily dedicated to mitigating or responding to the COVID-19 public health emergency. The specific uses are as follows:

1. COVID-19 temporary incident command center dedicated to the mitigation of and response to the public health emergency include but are not limited to the following:
    a. Integrated joint operation center for unified incident command.
    b. Point of distribution (POD) site for strategic stockpile supplies and push packs. Push packs are pre-packed modules which contain apportioned supplies that can be sent out to other entities during times of emergency.
    c. Site and infrastructure for the coordination of Chickasaw Nation emergency management activities amongst local, state, tribal, federal and other emergency management systems.
2. COVID-19 drive-thru testing dedicated to the mitigation of and response to the public health emergency include but are not limited to the following:
    a. Mass community based COVID-19 testing using touchless drive-thru service.
    b. Mass community immunization for COVID-19 using drive-thru service. The site may be used as a mass immunization prophylaxis site (MIPS).
3. COVID-19 conditioned storage space was needed as the COVID-19 supply chain and high demand for personal protective equipment was limited. The Chickasaw Nation must develop a strategic stockpile of COVID-19 supplies to ensure the functioning of its tribal government. The strategic stockpile shall be dedicated to the mitigation of and response to the public health emergency.

CNDH Food Related Programs:

The CNDH employed various methods of ensuring our citizenry had safe and adequate nutrition available during the public health emergency. A few of the programs to highlight are:

- Food Distribution Program (FDP) - Provides a food package in a grocery store setting to eligible participants. In August 2020, more than 3,700 individuals were served at one of 5 Food Distribution locations.
- Women's, Infants and Children (WIC) - Provides eligible pregnant or postpartum women, infants and children 5 and younger, food which is secured at WIC approved grocery stores, as well as nutrition education. More than 4,000 participants are participating.
- Farmers' Market - Provides checks/vouchers for the purchase of fresh fruits and vegetables from authorized farmers' markets and farm stands. This year, nearly 3,900 Seniors participated in this Summer program.
- Winter Fruit and Vegetables - Provides fresh, frozen or canned fruits and vegetables to Chickasaw seniors and Warrior society members during the winter months of November – March.
- Impa'chi Kids Meal Program (Summer Food) - Free shelf-stable meal for youth ages 1-18 at various locations including CNMC, 4 nutrition centers, and other locations throughout the summer. More than 70,000 meals were served at various locations through this program in summer 2020.
- Summer EBT for Children - Provides a $30 monthly food package via an electronic benefit card to school-age children who qualify for free or reduced-priced school meals and attend a school in the Chickasaw or Choctaw Nation. More than 31,000 children were served during this past summer.
- Packed Promise - Provides a monthly food box (approximately 30-pounds) and $15 Fresh Food Voucher shipped directly to the homes Chickasaw students who receive free school meals. In August, more than 1,800 children received boxes of food.
- Walmart Food Donation in April - Received 35,000 pounds of in-kind food donation from Walmart Distribution Center in Arkansas. Hosted two Food Distribution Drives in April serving approximately 2,250 vehicles.
- PepsiCo Foundation Food-For-Good Donation in April - The PepsiCo Foundation provided a $75,000 in-kind donation of meals to the Chickasaw Nation Impa'Chi Program to assist in serving children during the COVID-19 crisis. This donation provided 312 Chickasaw children two boxes of ten shelf-stable breakfasts and ten shelf-stable lunches.
- Impa'Chi Delivered (an extension of Summer Food program) in July and August - Provided three shipments of 10 shelf-stable breakfasts and lunches to students receiving free or reduced-price meals at school, but temporarily could not receive school meals due to school closures. Nearly 500 Chickasaw children were served.
- Share our Strength – Received $50,000 grant which was utilized to order food boxes from Regional Food Bank. The boxes of food were mailed to approximately 450 identified low-income Chickasaw children identified through other programs with a focus on low-income eligibility.
- Farmers to Families Food Box Partnership – Drive-thru food distribution events in each of our 13 tribal jurisdictional counties where attendees receive boxes of meat, produce and, in some cases, milk. Each event has served at least 500 households. To date, this program allowed 242,220 pounds of food to be distributed.
- Food Distribution Program CARES Act Infrastructure Grant – thru FY23 - Received two rounds of funding totaling $90,000:
    - $40,000 for Development of Online Food Ordering and Scheduling
    - $50,000 for Tishomingo Nutrition Center Dock Modifications

Summary of Chickasaw Nation Coronavirus Relief Fund Programs:

In March 2020, Congress enacted the CARES Act, which established the Coronavirus Relief Fund (CRF) to provide monies to support Tribal governments in their response to the COVID-19 public health emergency. In May 2020, Chickasaw Nation Executive Order 20-01 ordered the establishment of the Chickasaw Nation Emergency Coronavirus Relief Fund (CNECRF) and directed the development of programs, oversight, and administration relating to the use of CNECRF monies in accordance with the CARES Act and applicable Federal guidelines. The Chickasaw Nation holds CRF monies in the CNECRF and Governor Anoatubby created the Chickasaw Nation Funding Rules Committee to oversee the allocation and expenditure of the CRF monies in accordance with Federal and tribal law, Chickasaw Nation policies and standard operating procedures.

The Chickasaw Nation has developed a number of programs to assist Nation citizens and local communities during the COVID-19 public health emergency. As a sovereign tribal nation the Chickasaw Nation has taken great care and pride in providing support and assistance to its citizens and community members during this time of hardship and adversity. The Chickasaw Nation set out to establish practical and necessary programs funded with CRF monies with the objectives of keeping citizens and employees safe and ensuring that citizens received the support necessary to endure the economic hardships resulting from this unprecedented public health emergency.

One of the most comprehensive programs established by the Chickasaw Nation is the Prevent, Prepare and Respond (PPR) Program. The PPR Program sets out multiple important priorities:

(1) Personal protective equipment (PPE). Through this portion of the program the Nation provided PPE to Chickasaw Nation employees and citizens to enable compliance with established public health precautions and mitigate the spread of the virus. In furtherance of this objective the Nation established a PPE stockpile for employee use and distributed PPE care packages to every Chickasaw citizen. Very early in the pandemic the Chickasaw Nation established a mask mandate for employees and patrons at all Chickasaw Nation workplaces and facilities, setting the standard and example for other local governments, businesses, and community organizations.

(2) COVID-19 testing. The PPR Program utilized CRF monies to quickly establish multiple testing centers across the Chickasaw Nation's 13 county jurisdictional area. In the early months of the pandemic testing was critical to the prevention and mitigation of the virus and the Chickasaw Nation capitalized on its strong internal resources to ensure access to testing was established for citizens, employees, vendors and other community members. A large testing operation was established at the CNMC. Additionally, the Nation created a COVID-19 testing center and lab at the Nation's WinStar World Casino in Thackerville, Oklahoma to provide rapid testing, procured equipment for mobile testing labs and outfitted other of the Nation's local medical clinics with testing capabilities to provide greater access to testing in the Nation's rural locations. Chickasaw Nation employees are subject to random COVID-19 testing to curtail the spread of the virus.

(3) Medical facilities. A formidable undertaking by the Nation was constructing temporary medical facilities and other structures to increase COVID-19 treatment capacity and improve mitigation measures. The Nation looked to its Health and Construction departments to evaluate needs and existing resources and plan, design and manage the construction and renovation of medical facilities. The CNMC ACS, a 12,000 square foot medical facility for COVID-19 patient care, was constructed in six months. The CNMC lab and pharmacy areas were expanded to accommodate COVID-19 testing equipment and laboratory instruments. Additionally, the Nation renovated and repurposed an existing vacant building

to create the Chickasaw Nation COVID-19 EOF. This facility serves as the COVID-19 incident command center, provides drive-through testing and vaccinations and serves as a climate-controlled PPE storage location. One of the more innovative uses of the CRF was the establishment of nine "caring cottages" on the CNMC Ada South Campus. These tiny homes provide a place for COVID-19 positive Chickasaw citizens, other First Americans and Chickasaw Nation employees to quarantine and recover from the virus.

(4) Telework. One core component of the PPR Program was establishing telework capabilities for Chickasaw Nation employees. With CRF monies the Chickasaw Nation has purchased hardware, software, licenses, security and other technology tools and equipment to allow Chickasaw Nation employees to safely and efficiently work from home during the public health emergency.

(5) Public safety measures. Funds distributed through the PPR program have allowed for the installation of touchless systems, plexi-glass barriers, temperature scanners and other similar items at Chickasaw Nation workplaces and public facilities to mitigate the spread of the virus and allow some Chickasaw Nation facilities to remain open during the pandemic.

(6) Communications. Another vital aspect of the Nation's efforts to mitigate the spread of the virus is communicating with citizens, employees and the community at large regarding COVID-19 and distributing important public health information. The Chickasaw Nation continues to develop important public health information content to distribute online and via social media in order to convey critical communications regarding COVID-19. The Nation has purchased equipment and other items necessary to transition traditional events, meetings, trainings, classes and citizen outreach programs to virtual formats.

(7) Other. Other expenditures under the PPR program supported implementing telemedicine and tracing technologies, carrying out unplanned maintenance, deep cleaning, disinfecting, and the procurement of COVID-19 related signage. With CRF monies the Nation purchased and installed new air filtration/ventilation systems and equipment at Chickasaw Nation facilities in order to improve air quality, increase the delivery of clean air and dilute potential contaminants to help reduce points of COVID-19 exposure in accordance with CDC guidelines to help slow or stop the spread of COVID-19. A critical aspect of the Nation's COVID-19 plan is ensuring the safety of the Nation's employees and patrons. Primary to this objective was establishing a daily electronic screening tool for all employees to inventory possible COVID-19 symptoms and exposure risk factors to reduce and mitigate the spread of the virus in Chickasaw Nation workplaces. A call center was established and staffed to assist employees with questions or concerns regarding their daily screenings and direct employees to further medical resources if necessary. At risk employees were able to shelter in place at home and continue to receive compensation through the Nation's COVID-19 Emergency Paid Leave Program. This CRF funded program allows Chickasaw Nation employees to take leave, without regard to accrued sick or annual leave, due to COVID-19 exposure or infection.

The Chickasaw Nation has also developed the Emergency Citizen Support Program as a mechanism to assist Chickasaw individuals and families impacted by loss of income or low income due to the COVID-19 public health emergency. This program includes the following emergency assistance components: Funds for PPE and sanitation products, assistance for utilities and internet, distance learning and telework grants, food service programs, student debt and rental and mortgage assistance, unemployment supplement, stipend for COVID related funeral expenses, assistance with mental health counseling services, home health, medication and child care expenses, and funding for immediate

essential needs (toiletries, infant supplies, school supplies, quarantine assistance, homelessness, food, and fuel).

The Chickasaw Nation's Community & Business Support Program (CBS) provides direct financial assistance through the issuance of grants to eligible beneficiaries (community entities, non-profits, schools, localities, other government entities, public employers, hospitals, Chickasaw-owned businesses, Chickasaw Nation subsidiaries and vendors) in need of financial assistance due the COVID-19 public health emergency. The awards may reimburse costs of uninsured business interruption caused by business closures, costs of the implementation of social distancing measures, losses due to reduction in volume of business, the cost of maintaining personnel, and other necessary expenditures associated with the COVID-19 PHE.

The Chickasaw Nation's mission, to enhance the overall quality of life of the Chickasaw people, is paramount in every decision the Nation makes and every goal the Nation strives to achieve. The programs developed by the Chickasaw Nation with the resources provided by the CRF have helped the Nation meet its mission during this catastrophic public health emergency.

V. Importance of Self-Governance in the Chickasaw Nation

Today, Tribal Governments have three choices of how to have these health services provided. The first choice is to have their health services provided by the Federal Government, primarily through the agency, the IHS. The second choice for Tribes is to contract with the IHS for those programs or services they wish to provide for their own members. And the third choice Tribes have is to choose to assume, through compacts, the total operation and control over their health systems from the IHS; we refer to those Tribes as Self-Governance Tribes. As of January 2021, approximately 45% of the Indian Health Service budget is administered by tribes through self-governance, representing more than 375 of the 574 federally recognized tribes, to fund services and programs.

The Chickasaw Nation, being a self-governance tribe, has once again shown perseverance in addressing the many challenges the COVID-19 public health emergency has presented to the Nation.

VI. Mental Health and Substance Abuse Services Delivery during the Public Health Emergency

The Department of Family Services (DFS) mental health services programs dealt with the challenges directly by immediately modifying provider schedules, transitioning to telehealth services and supporting tribal wide mitigation strategies. Our programs are continuing to revise our response plans as we continue to learn and adjust to regulations and best practices set forth by billing and regulatory agencies, as well as recommendations from the CDC that are distributed through tribal leadership.

In March 2020, our programs responded to the immediacy of the COVID-19 threat by modifying provider schedules. Our teams at all sites began an onsite/work from home rotation. This has allowed us to continue to provide visits in the event one of our provider's contract or become exposed to COVID-19. This has proven to be extremely helpful in minimizing service disruptions.

Our teams worked closely together to obtain used and/or new laptops from other DFS programs to assist staff working remotely.

Providers are actively using telehealth services when working from home. Provider are also available to provide primary care consultations, emergency crisis visits and therapy sessions when working onsite.

Our programs were able to initiate telehealth services in one week, although it took many weeks to refine the process. Mental Health Services (MHS) worked rapidly with our clinical informatics and billings teams to adjust our documentation and billing processes. While we initially selected Zoom and Microsoft Teams as our HIPAA compliant platforms for communications, we are currently transitioning to Doximity as a platform for delivering telehealth services.

MHS staff have been participating in online telehealth training self-study to ensure that staff members are competent in providing these services.

Since the start of the pandemic, our programs have delivered over 24,000 Virtual Visits as of March 10th. In many ways, the addition of telehealth services has allowed us to reach more patients by reducing barriers and access to care.

Partnerships with State or Local Resources to Provide Mental Health and Substance Use Services

The SAMHSA CTSE grant, awarded in April, expanded crisis coverage services through a partnership with Lighthouse Behavioral Wellness Center in Ada. Seven iPads were purchased to support the expanded 24/7 crisis coverage.

Improvements in Services Provided from COVID-19 Funds

The Department of Family Services applied for two SAMHSA emergency COVID-19 funding opportunities.

Our first application in April was awarded $484,762 and provided funding to support direct services like financial support for a telehealth platform, training in evidence-based practices and intentional set aside for a focus on healthcare worker support. The project has recently been provided an additional one million dollars in funding.

The healthcare worker support has included bi-monthly Zoom groups on topics related to mental health, substance use and family relationships. Additionally, therapist in DFS have provided several hundred individualized check-ins for nursing staff and providers working on the front lines. Over 800 employees have attended the virtual support groups.

These funds have supported DFS programs to procure needed equipment for telehealth services. This includes laptop computers, headsets, webcams and a telehealth platform.

Our second application in July was also awarded $785,000 and provided funding for programs and services relative to high-risk individuals with suicidality and/or domestic violence.

With this project, we have been able to expand understanding of Zero Suicide, train staff in evidence-based practices and support domestic violence programming and additionally plan for a training for tribal law enforcement.

The Chickasaw Nation appreciates this opportunity to provide written testimony on these important matters. The Chickasaw Nation is committed to ensuring the highest quality of health care for our citizenry and we look forward to working with each of you in these endeavors to do the same.