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HEARING ON VA AND INDIAN HEALTH SERVICE COOPERATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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NOVEMBER 5, 2009

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HEARING ON VA AND INDIAN HEALTH SERVICE COOPERATION

THURSDAY, NOVEMBER 5, 2009

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:06 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Tester, Begich, and Burr.

Also present: Senator Murkowski.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. The hearing of the Senate Committee on Veterans' Affairs will come to order.

Aloha and good morning, everyone. I am delighted that the Committee is focusing on the joint efforts of the Department of Veterans Affairs and the Indian Health Service to improve care for Native American veterans.

Native American veterans have a rich and storied history of service to our Nation, and like all veterans they deserve the care and benefits that they have earned. Many Native American veterans served with distinction, but returned home to a very difficult transition. Substance abuse, extreme poverty, and unemployment still plague parts of Indian Country. American Indian and Alaska Native veterans are nearly 50 percent more likely than other veterans to have a service-connected disability and twice as likely to be unemployed. And as we will hear from a witness from my home State, challenges also extend to other Native veterans, including the many Native Hawaiians who have and are serving our Nation.

Today's hearing focuses on health care. Despite dual eligibility for VA and IHS health care, American Indian and Alaska Native veterans report unmet health care needs at four times the rate of other veterans. In 2003, VA and IHS signed a Memorandum of Understanding agreeing to mutual goals and actions to improve cooperation and collaboration. I look forward to hearing from today's witnesses on the progress being made toward those goals.

Senator Tester has been a leader on this issue and an advocate for Native Americans in Montana and across the Nation. Indeed, today's hearing is in response to his request, and I will be turning the gavel over to him momentarily.

Also, I want to say that Senator Murray has also been a leader in this area from the State of Washington.

As I speak, Tribal leaders are gathering for a White House summit, as you know. Such summits remind us of the government-to-government relationship the U.S. has with Tribal Nations and their members. Therefore, for VA to effectively serve the many Native Americans who have shared in our mutual defense, it must also collaborate with the federally-recognized Tribal governments whose citizens serve with pride and patriotism.

And now, I would like to call on Senator Tester for any statement that he has to make, and I will call on Senator Murray following that. Senator Tester.

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. I want to thank you, Mr. Chairman. Thank you for your remarks, and I want to thank you for agreeing to hold this hearing as quickly as you did.

I want to thank the witnesses for being here today. A special thanks to Kevin Howlett for being here to lend his considerable expertise on the subject of Indian health care. As the Director of Tribal Health for the Confederated Salish and Kootenai Tribes in Montana, Kevin is literally on the front lines of American Indian health care.

I also want to thank Buck Richardson for being here. Mr. Chairman, I know you will do a full introduction of the witnesses, but let me just say this. Buck is a fine man, has a great reputation, and does some great work for the VA as it applies to our Native Americans and VA folks across the board.

This is a critically important topic in my State. We have 11 tribes and seven reservations—over 4,500 American Indians who are enrolled in the VA alone. Of course, the number of American Indian veterans is likely much, much higher. Over the short time that I have been a U.S. Senator, I have heard many VA and Defense Department officials discuss the problems that they have had in assuring a seamless transition of a veteran from the DOD health program to the VA. Many veterans have told me firsthand about how they have fallen through the cracks caused by imperfect records, transfers, and red tape. It seems to me that if an agency as well-funded as the DOD has problems ensuring a seamless transition with the VA, we are facing an especially tall order with Indian Health Service.

Some of this is about resources. Everyone in the room knows how underfunded IHS has been. The agency actually spends less per American Indian for health care than the Federal Bureau of Prisons spends on Federal inmates. And it has only been in the last couple years that the VA has been adequately funded.

But beyond the question of dollars and cents, it is clear that neither agency has the unique needs of the Indian veterans front and center. As a result, we hear the horror stories of a veteran walking into an IHS facility, only to be told to go to a VA hospital hundreds of miles away, and of the veteran walking into a VA facility, only to be sent to an IHS facility. This so-called ping-ponging veterans is at odds with each agency's mission to care for the patient first.

We have no reliable data on the progress being made between VA and IHS on their 2003 Memorandum of Understanding. In the age of information we live in, I see this as not acceptable.

The lines of command and the role of each agency in providing assistance to the veteran are not always as clear as they need to be. One of the most important aspects of a true government-to-government relationship is communication. Tribes, clinics, and individual Indian veterans need to know what their options are for obtaining the quality health care that they deserve.

One of the areas that seems to be working, where we have had decent results is the roll-out of the telehealth capabilities. As you know, Mr. Chairman, telehealth is particularly important in rural States, like my State. Many times, it is the only opportunity for folks in frontier areas to see a doctor or a mental health provider. Many of these telehealth opportunities are the product of funding approved by Congress in the past year for VA rural health programs. That is a good story for both the VA and the IHS, and we need to build on it. We have made good progress, but the work is not done.

Our goal today is to find out about some of the progress. At the same time, we need the VA to be a willing partner at all of its levels to work with us to find ways to improve health care and the quality-of-life for American Indian veterans.

So, I look forward to this hearing very, very much. From the witnesses, we are going to hopefully gain some ground on where we are and move forward. We all know there is much more work to be done, but by working together, we can get a lot of good things done.

I want to thank you again, Mr. Chairman, for calling this hearing and appreciate the witnesses for their presence here.

Chairman AKAKA. Thank you very much, Senator Tester.

Senator Murray, your opening statement.

STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Mr. Chairman, Senator Burr, Senator Tester, for holding this hearing today. I am looking forward to a discussion on cooperation between the Department of Veterans Affairs and the Indian Health Service so that we can improve health care and benefits for American Indian, Native Alaskan, and Native Hawaiian veterans.

I join in thanking all of our witnesses who are appearing before this Committee today. I look forward to hearing your thoughts and perspectives on the cooperation between these two agencies since the implementation of the Memorandum of Understanding.

Mr. Chairman, I especially want to welcome and thank Councilman Andrew Joseph. He comes from the Confederated Tribes of Colville and has traveled all the way across the country to be here today to testify from my home State of Washington and I really appreciate his being here today.

I do want to take a moment to say how proud I am of all the veterans in this room. All of you have sacrificed so much in service to our country. We owe it to you to honor the promises we have made to take care of you when you come home. And one of the

most important ways to do this is by making sure that veterans have access to a system that treats you fairly.

Tribal veterans, in particular, have made tremendous sacrifices for our country. In fact, Native Americans serve in the Armed Forces at a higher rate per capita than any other ethnic group. And I also know that Tribal veterans face some of the toughest barriers to accessing the services they have earned. Many Tribal veterans don't live anywhere near VA services. They face communication barriers. And too often, Tribal veterans face issues with coordination between the Indian Health Service and the VA. So, it is our job to do everything within our power to break down those barriers and help our Tribal veterans access the care they need. You fought for us. We need to fight for you now.

We began moving in the right direction 6 years ago when the Memorandum of Understanding was signed, but enough time has gone by for us to see some tangible results from the cooperation this agreement was meant to develop.

So, Mr. Chairman, I appreciate your holding this hearing and I look forward to hearing from our witnesses today on the progress of this cooperation. Thank you.

Chairman AKAKA. Thank you, Senator Murray.

And now, the Ranking Member of this Committee, Senator Burr.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Thank you, Mr. Chairman. Aloha. Welcome to our witnesses this morning.

We are here today to ensure the resources of the Department of Veterans Affairs and the Indian Health Service are being used to deliver timely, quality, and coordinated care services to Native American veterans.

Mr. Chairman, Native Americans have the highest record of military service per capita when compared to other ethnic groups. I believe this record of service to our Nation and to the country is rooted in their culture and their traditions. Courage, duty, honor, sacrifice—these are values that make up our military men and women and make them second to none, and they are the values that run thick in the culture of so many from Indian Country.

And when they return from military service with medical needs, they should expect a well-coordinated health care system. Today, I hope to learn how VA and the Indian Health Service coordinate the health care for those enrolled in both systems. For example, the Tribal Hospital in Cherokee, NC, has 700 enrolled veterans. One hundred forty of them are also enrolled in VA care. I hope to learn whether the remaining 560 veterans are aware of the VA health care benefits they may be entitled to.

This is just a snapshot of an issue I am sure exists for North Carolina's 7,600 Native American veterans and others across the country. VA and IHS need to do a better job in sharing information to determine whether a patient is dual eligible. This information will lead to a more efficient allocation of resources, better planning, and well-informed sharing agreements.

In 2003, VA and Indian Health Service developed a Memorandum of Understanding outlining five mutual goals. One, im-

prove access to quality care; two, improve communications; three, encourage the development of partnerships and sharing agreements; four, ensure appropriate resources are available; and five, improve health promotion, disease, and preventative services. Today, I hope to learn where we are meeting these important goals, but more importantly, where we still need work.

It is extremely important that these goals be taken seriously. For too long, when it comes to fair dealing with Indian Country, our actions have not matched our words. We must not let this be the case here, especially when we are talking about those who have worn the uniform of our country.

Mr. Chairman, again, I thank you for convening this hearing and I look forward to what our witnesses might instill with us.

Chairman AKAKA. Thank you very much, Senator Burr.

Now I will call on Senator Begich for any opening remarks.

STATEMENT OF HON. MARK BEGICH, U.S. SENATOR FROM ALASKA

Senator BEGICH. Thank you very much, Mr. Chairman. And to the first panel, thank you for being here. Thank you for patiently waiting as we go through our opening remarks, because to be honest with you, I am looking forward to your comments, and I really am looking for the next panel because we are going to have a lot of questions for them.

In my State of Alaska, a huge percentage—120,000 of the population are Alaska Natives. We have the very unique problem of delivery of services to our veterans in rural parts of Alaska, which is much different than the Lower 48, where in some cases you can drive to facilities. But in Alaska, you may not even be able to get to a facility until the weather is correct, when you can then fly or snow machine, depending on the conditions of the area.

I am interested not only in the dual enrolled recipients, but also for Alaska, for unique opportunities in how we deliver services to those veterans that are in very remote areas—literally a plane ride away—yet a very short distance away are Indian Health Service facilities and how they can access those. Maybe they need not be dual-enrolled, but may need access because we don't have a VA hospital in Alaska, and also the distance travel can put great pressure onto the health issue they may be moving forward on and getting services for. So, I am anxious for that.

I am anxious for the first panel because hopefully you will give us your very open thoughts on what is working, what is not, but also where you can see some improvements. Even though it is not necessarily from an Alaska perspective, I think it is very important from the first people's perspective of what we need to do to improve a service that is earned, but also important to deliver to our veterans, especially in rural communities, and Alaska Native American Indians have unique situations.

I can only tell you that in Alaska I hear from veteran after veteran who has served and now lives back in their home village, that when they need services it is very difficult at times to get that access. We have some demonstration projects up there that seem to have some success and we are anxious to share those. But I am anxious to talk to the next panel in specific regard to how do we

ensure that the veterans in rural communities, and especially in Alaska, access health care in a reasonable timeframe and get quality health care.

But again, thank you to the first panel. Thank you for patiently listening to us giving our opening remarks. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Begich.

I want to welcome the witnesses on our first panel. Clay Park, Native Hawaiian Veterans Program Director at Papa Ola Lokahi, will begin our discussion by giving voice to a sometimes neglected portion of the Native American community, and that is the Native Hawaiians.

Our second witness is Mr. Kevin Howlett, Director of the Salish and Kootenai Tribal Health Department.

Our third witness, I am pleased to introduce, is Andrew Joseph, a Councilman from the Confederated Tribes of Colville, who is testifying on behalf of the National Indian Health Board.

Mr. Park, we will please begin with your statement.

STATEMENT OF WILLIAM CLAYTON SAM "CLAY" PARK, DIRECTOR, NATIVE AMERICAN HAWAIIAN VETERANS PROJECT, PAPA OLA LOKAHI

Mr. PARK. Good morning. Welina. Chairman Akaka, members of the Senate Committee on Veterans' Affairs, Papa Ola Lokahi wishes to express to you its sincere gratitude for inviting us to participate today in this important hearing.

My name is William Clayton Sam Park, Director of Papa Ola Lokahi's Native Hawaiian Veterans Project. I am a retired Master Sergeant with 3 years active duty, 21 years of service with the Hawaii Army National Guard. I am also retired from the Department of Veterans Affairs and a disabled veteran.

Mr. Chairman, in your letter, you specifically wanted us to address Papa Ola Lokahi and the Native Hawaiian Health Care Systems collaborating with the VA and the Indian Health Service. Papa Ola Lokahi has had a longstanding relationship with the VA, going back more than 10 years to a time when Mr. David Burge, a Native Hawaiian, served as its Hawaii Director. We have participated in past trainings and provided training to the local VA on cultural trauma and other areas around cultural competency.

Recently, we have established at each of our five Native Hawaiian Health Care Systems, which operate throughout the State, veterans "Aunties" and "Uncles" groups, which act as enablers for Native Hawaiians and other veterans with issues and/or concerns. These men and women serve as volunteers to hear out our veterans and their issues and offer advice. In turn, these groups are facilitated by health care professionals from the Native Hawaiian Health Care Systems, who are trained specifically in VA programs and, in turn, serve as links for veterans on their respective islands into the VA structure.

Likewise, Papa Ola Lokahi has developed a relationship with the Indian Health Service over the past 15 years. This relationship has afforded the provision of primary care service for American Indians and Alaska Native residents in Hawaii. Presently, these services are provided through Ke Ola Mama, one of the largest Native Ha-

waiian Health Care Systems, directed by Lisa Mao Ka'anoi, an Alaska Native of Native Hawaiian ancestry.

Over the years the Indian Health Service has provided guidance to Papa Ola Lokahi on, one, formation of its Institutional Review Board, which currently reviews and approves all health research undertaken by researchers through the Native Hawaiian Health Care Systems and other service providers. Two, establishment of the Native Hawaiian Epi Center, which is similar in form and function to the 11 Native American Epi Centers across Indian Country. And three, the RPMS reporting system, which some of the Native Hawaiian Health Care Systems are considering adopting.

In conclusion, these two agencies have continued to support the efforts of Papa Ola Lokahi in the Native Hawaiian Health Care Systems and we have supported their missions as well. Presently, we receive our base Federal support through the Native Hawaiian Health Care Improvement Act and the Health Resources and Services Administration, U.S. Department of Health and Human Services.

Thank you again, Chairman Akaka and members of the Senate Committee on Veterans' Affairs, for this opportunity to share with you my thoughts today. There is an olelo, a verse, in my traditional language which states, "Ke kaulana pa'a 'aina on na ali'i," which is simply translated as "The famed landholders of the chiefs." The meaning here is the best warriors were awarded the best lands by our chiefs because of their bravery and service. This is why we are here today. We simply want the best health care possible for our warriors who have given so much, often sacrificing their own health for this Nation's benefit. Our recommendation for specific actions to accomplish this objective has been submitted in the written testimony.

Mr. Chairman, I will be pleased to answer any questions you or Members of the Committee have. Mahalo.

[The prepared statement of Mr. Park follows:]

PREPARED STATEMENT OF WILLIAM CLAYTON SAM "CLAY" PARK, DIRECTOR, NATIVE HAWAIIAN VETERANS PROJECT, PAPA OLA LOKAHI

Welina. Chairman Akaka and Members of the Senate Committee on Veterans' Affairs, Papa Ola Lokahi wishes to express to you its sincere gratitude for inviting us to participate today in this important Hearing.

My name is William Clayton Sam Park, director of Papa Ola Lokahi's Native Hawaiian Veterans Project. I am a retired Master Sergeant with 3 years active duty and 21 years of service with the Hawaii Army National Guard. I am also retired from the DVA with 28 years of service and a disabled veteran.

Papa Ola Lokahi is the Native Hawaiian Health Board that was established by the Native Hawaiian community in 1987 to plan and implement programs, coordinate projects and programs, define policy, and educate about and advocate for the improved health and wellbeing of Native Hawaiians, an Indigenous Peoples of the United States. These tasks were incorporated within U.S. policy when the U.S. Congress established its policy in 1988 "to raise the health status of Native Hawaiians to the highest possible level and to provide existing Native Hawaiian health care programs with all the resources necessary to effectuate this policy" (Public Law 102–396).

Native Hawaiians have served in the military services of the United States almost from the very beginning of the Nation. Young Prince George Kaumuali'i enlisted in the U.S. Navy and fought in the War of 1812 in the Mediterranean. In following conflicts including the American Civil War, the Spanish-American War, World Wars I and II, Korea, Vietnam, Iraq, and, now, again Iraq and Afghanistan, Native Hawaiians have continued to serve and serve with distinction. As a side note, a num-

ber of Native Hawaiians historically have also served in the Armed Forces of other countries including England and Canada.

In 1997 when the VA released the results of the late Senator Spark Matsunaga-initiated study on the impacts of exposure to war zones on Native Hawaiian and Asian veterans, it became clear that along with American Indians and Alaska Natives, Native Hawaiians have borne a larger burden of battle-related stress and trauma. More than one in every two Native Hawaiian veterans experienced war-related trauma in Vietnam. The report goes on . . . Upon returning home after one or more tours in Vietnam many Native Hawaiian veterans struggle with extremely severe problems that neither they nor their families, friends, or communities know how to understand or cope with: depression, shame, guilt, isolation and emotional emptiness, alienation, unable to relax, addiction. One in three Native Hawaiians have full or partial PTSD currently . . . More than one in two Native Hawaiians have had full or partial PTSD sometime since Vietnam.

With conflicts in the 1990s in Iraq and now on-going conflicts in Iraq and Afghanistan, and with Reserve and National Guard units being heavily utilized along with regular military and the particularly brutal nature of the current warfare, these PTSD episodes will only greatly increase. An additional factor in these conflicts is the full participation of women now integrated into positions which formerly were all male forces.

Current US Census data indicates that there are about 30,000 Native Hawaiian and Pacific Islander veterans in the United States. A large portion of this number is resident in Hawaii and Native Hawaiians have been actively engaged with the Hawai'i Office of the VA (Veterans' Affairs) for many years. Increasingly, however, almost as many Native Hawaiians now live on the continental United States and more and more, Native Hawaiians will become part of the VA structure throughout the Nation. In previous testimony before this Committee, Papa Ola Lokahi provided historical reviews and analysis of VA activities and the Native Hawaiian community in Hawaii.

Mr. Chairman, in your letter you specifically wanted us to address Papa Ola Lokahi and the Native Hawaiian Health Care Systems' collaboration with the VA and the Indian Health Service. Papa Ola Lokahi has had a long-standing relationship with the VA going back more than ten years to a time when Mr. David Burge, a Native Hawaiian, served as its Hawai'i Director. We have participated in past trainings and provided training to the local VA in cultural trauma and other areas around cultural competency. Recently, we have established at each of the five Native Hawaiian Health Care Systems which operate throughout the State, veterans "Aunties" and "Uncles" groups which act as "enablers" for Native Hawaiian and other veterans with issues and/or concerns. These men and women are Native retirees who serve as volunteers to hear out veterans and their issues and offer advice. In turn, these groups are facilitated by health care professionals from the Native Hawaiian Health Care Systems, who are trained specifically in VA programs and, in turn, serve as links for veterans on their respective islands into the VA structure.

Likewise, Papa Ola Lokahi has developed a relationship with the Indian Health Service over the past fifteen years. This relationship has afforded the provision of primary care services for American Indians and Alaska Natives resident in Hawaii. Presently, these services are provided through Ke Ola Mama, one of the larger Native Hawaiian Health Care Systems, and directed by Lisa Mao Ka'anoi, an Alaska Native with Native Hawaiian ancestry. Over the years, the Indian Health Service has also provided guidance to Papa Ola Lokahi on (1) formation of its Institutional Review Board which currently reviews and approves all health research undertaken by researchers through the Native Hawaiian Health Care Systems and other service providers, (2) establishment of the Native Hawaiian Epi Center which is similar in form and function to the twelve Native American Epi Centers across Indian Country, and (3) the RPMS reporting System which some of the Native Hawaiian Health Care Systems are considering adopting.

In conclusion, these two agencies have continued to support the efforts of Papa Ola Lokahi and the Native Hawaiian Health Care Systems as we have supported their missions as well. Presently, we receive our base Federal support through the Native Hawaiian Health Care Improvement Act and the Health Resources and Services Administration, US Department of Health and Human Services.

Given our relationships and vantage point, we come before you today with the following recommendations:

1. Enhance VA capacity to address health and wellness issues not only of the VA beneficiary but also those of the VA beneficiary's family;

While addressing the VA beneficiary's health needs is critical to the VA mission, there needs to be the ability within the VA also to address the resultant health issues and needs of the VA beneficiary's family. This is particularly true with those

VA beneficiaries with TBI and/or PTSD. Without this ability, there is often a family breakdown and a less than satisfactory outcome for the VA beneficiary, the family and the community.

2. Develop VA capacity to contract with Native groups and organizations to provide outreach services to VA beneficiaries and their families;

In Hawai'i, the VA has not been able to reach out to rural communities and provide needed services to VA beneficiaries living in these areas. We would ask that the VA contract with Native Hawaiian and other appropriate groups and organizations to provide outreach services to VA beneficiaries and their families.

3. Develop VA capacity to contract with FQHCs and tribal and Native Hawaiian Health Care Systems to provide VA beneficiaries and their families with primary care services in rural areas;

For the same reasons noted previously, the VA simply does not have the capacity at this time to reach out into rural areas where there are currently primary care service providers. It would make sense for the VA to contract for primary care services with these existing entities in these rural communities. In Hawai'i, there are only 3 VA community-based outpatient clinics (CBOC) while there are 14 community health centers and 5 Native Hawaiian Health Care Systems, all of which provide primary care

4. Train VA service providers working with Native populations in history, cultural sensitivity, and cultural competency;

historical context and cultural sensitivity and competency can improve VA service provider and VA beneficiary understanding and compliance with good outcomes.

5. Expand VA capacity to provide traditional Native healing practices and alternative and complementary healing practices to VA beneficiaries and their families;

Native cultures have traditional healing practices such as lomilomi (Hawaiian massage), ho'oponopono (counseling), and la'au lapa'au (herbal medicine) in our Native Hawaiian culture. This includes traditional practices and protocols transitioning the 'warrior" back into civilian society. All of these have demonstrated effectiveness for the Native VA beneficiary. The VA needs to support these traditional methods and practices. In addition, there are numerous alternative and complementary health care practices such as acupuncture, chiropractic, Chinese medicine, and naturopathy which may be of particular interest and therapeutic to VA beneficiaries. These, too, should be allowable and available.

6. Support and develop specific work plans for each of the recommendations of the Advisory Committee on Minority Veterans' July 1, 2008 and July 1, 2009 reports;

In 1994, legislation was passed which established the Advisory Committee on Minority Veterans. The work and recommendations of this Committee need to be actively supported and implemented respectively. It is strongly recommended that a Native Hawaiian representative be added to the Committee as soon as appropriate. In addition, Native Hawaiians look forward to participating with the federally-chartered National American Indian Veterans group and applaud the recently produced DVD entitled "Native American Veterans: Storytelling for Healing," which includes American Indian, Alaska Native, and Native Hawaiian veterans' stories produced by the Administration for Native Americans, US Department of Health and Human Services.

7. Collect, analyze, and report data on VA beneficiaries and their families in accordance with 1997 OMB 15 revised standards, including disaggregating Native Hawaiian from Other Pacific Islander data;

In 1997, OMB disaggregated the Asian Pacific Islander (API) identifier and established two distinct categories; Asian (A) and Native Hawaiian and Other Pacific Islander (NHOPI). The VA needs to incorporate this disaggregation within its reporting systems. Additionally, "Native Hawaiians" need to be distinctively identified apart from "Other Pacific Islanders" as Native Hawaiians have put forth their self-determination efforts. This is critical for Native Hawaiians as, like American Indians/Alaska Natives, they need to be identified as a body of individuals with a special political relationship to the Federal Government.

8. Enhance VA capacity to undertake research on ways to improve health and wellness outcomes for VA beneficiaries and their families.

The VA's research budget has been limited over the past decade. Additional funds need to be allocated to research how better outcomes can be accomplished for VA beneficiaries and their families. This is particularly critical for those with TBI and PTSD.

Additionally, we strongly recommend that the VA increase its research capacity to investigate what the health and wellness issues are for returning Native men and

women veterans from today's war zones. It is hoped that many of these studies could be undertaken by Native health researchers themselves.

Thank you again Chairman Akaka and Members of the Senate Committee on Veterans Affairs for this opportunity to share with you my thoughts today. There is an "olelo, a verse, in my traditional language which simply states:

KE KAULANA PA'A 'ALNA ON NA ALI'I

Which is simply translated as "The famed landholders of the chiefs." The meaning here is that the best warriors were awarded the best lands by our chiefs because of their bravery and service. That is why we are here today. We simply want the best health care possible for our warriors who have given so much and often sacrificed their own health for this Nation's benefit. Mahalo.

Chairman AKAKA. Thank you very much, Mr. Park.

Mr. Howlett, we will receive your testimony.

STATEMENT OF S. KEVIN HOWLETT, DIRECTOR, CONFEDERATED SALISH AND KOOTENAI TRIBAL HEALTH DEPARTMENT

Mr. HOWLETT. Mr. Chairman, Members of the Committee, I am pleased and honored to appear before you today to present testimony related to health care of Native American veterans. For the record, I am Kevin Howlett, a member of the Salish Kootenai Tribes, and Director of the Tribes' Health and Human Services Department.

I would like to thank Senator Tester for his recognition and support for my being here and his commitment to providing health care to Native American veterans.

Today, I will address those areas I feel that affect the access and quality of care I spoke of when then-Secretary Peake visited Montana. Let me assure you that while I speak as one Tribal health director, the issues I will address span the universe of Indian Country and the needs I believe exist in every reservation community.

Specifically, there has been a longstanding belief that health care for Native Americans is the responsibility of the Indian Health Service. While I agree that the IHS has principal responsibility as the Federal agency designated to provide care, I also know that as citizens of the States in which Indians live, they are entitled to the services provided to the citizens of that State. In addition, by having served our country in the Armed Services, veterans have earned the right to care provided by the Veterans Administration medical system.

Most reservations are remotely located, underfunded, understaffed, resulting in a very real rationed care scenario. While Tribal or IHS clinics do the best they can, the level of care is often less than needed. This is amplified by a severe shortage of clinical personnel evident in virtually every clinic setting.

When the level of care is not available in the local IHS clinic, IHS uses what is referred to as a Contract Health Service Program to refer care to outside specialty providers or inpatient facilities when that care is not available. The CHS program has operated on a shoestring budget for many years. The care that can be approved utilizing CHS funds must be threatened if IHS assumes financial responsibility. Consequently, these services are not provided.

We are aware of the existence of a Memorandum of Understanding between the Indian Health Service and the VA. We are

also aware that it represents more symbolism than action. Without question, the full implementation of the existing MOU linked to specific Tribal recommendations would go a long way in providing a more comprehensive level of care to our veterans. Specifically, the agencies agreed to many things, including the sharing of information technology and an interagency work group to oversee proposed national initiatives.

Mr. Chairman, if the agencies who are a party to this agreement would, as a matter of priority, establish an internal and external—including Tribal—work group to begin developing a strategy, then they could discuss how that strategy should be resourced and implemented.

An item not covered in the existing MOU concerns payment to Tribal facilities for care rendered to eligible veterans in Tribal clinics. The Tribes rely heavily upon third-party collections to support clinic operations. It seems logical that for Medicare and Medicaid and privately insured individuals, the clinics can seek reimbursement. We are aware that the VA does have the ability to contract with the private sector to pay for the care of veterans, yet Tribally-operated clinics cannot, as we understand, seek the same. It would be easily incorporated into statute if this Committee were so inclined. Absent the reimbursement, we will still provide what care we can, but the resources or the absence of resources controls the scope of care.

Mr. Chairman, I could speak for hours about the specific needs of the 480 veterans living on my reservation. My purpose and goal today is to enlighten you from my perspective about the organization, structural, and resource issues that comprise the maze of health care for veterans on the Flat Head Indian Reservation. I truly believe that the level of care that is afforded must equal the services they have rendered. I also believe that we can find solutions if we stay focused on the task and spend less time trying to point fingers. We need to utilize the tools we have and the commitment all of us have in this room share.

I look forward to this Committee providing the guidance and direction to the VA and IHS to ensure that those who have worn the uniform have the best care possible, to maximize limited resources, and to work collectively in all areas of health care, including behavioral health. We owe these dedicated men and women nothing less.

Mr. Chairman, I have attached the MOU to my testimony. I have also attached some correspondence from the manager of my behavioral health program, correspondence that she relates to me from her personal observations as a behavioral therapist, the issues she has dealt with, and I think it will give you a perspective that sometimes people in bureaucracy don't or can't appreciate.

I would be happy to answer any questions the Committee may have. Thank you.

[The prepared statement of Mr. Howlett follows:]

PREPARED STATEMENT OF S. KEVIN HOWLETT, DIRECTOR, HEALTH AND HUMAN SERVICES DEPARTMENT, CONFEDERATED SALISH AND KOOTENAI TRIBES OF THE FLATHEAD NATION

Mr. Chairman and Members of the Committee: I am pleased and honored to appear before you today to present testimony related to the health care for Native American Veterans.

For the record, I am S. Kevin Howlett, a member of the Salish and Kootenai Tribes and Director of the Tribes Health & Human Services Department.

Let me thank our Senator Jon Tester for his recognition and support for my being here and his commitment to providing health care to our veterans.

Today, I will address those areas I feel that affect the access and quality of care I spoke of when then Secretary Peake visited Montana. Let me assure you that while I speak as one Tribal Health Director, the issues I will address span the universe of Indian country and the needs I believe exist in every reservation community.

Specifically, there has been a long-standing belief that health care for Native Americans was the responsibility of the Indian Health Service. While I agree that IHS has principal responsibility as the Federal agency designated to provide care, I also know that as citizens of the states in which Indians live they are also entitled to the services provided to the citizens of that state. In addition, by having served our country in the armed services, veterans have earned the right to care provided by the Veterans Administration Medical system.

Most reservations are remotely located, under funded and under staffed resulting in a very real rationed care scenario. While Tribal/IHS clinics do the best they can, the level of care is quite often less than needed. This is amplified by a severe shortage of clinical personnel evident in virtually every clinic setting.

When the level of care is not available in the local clinic IHS uses what is referred to as the contract health services (CHS) program to refer to outside specialty care providers or in-patient facilities when in-patient care is not available. The CHS program has operated on a shoestring budget for many years. The care that can be approved utilizing CHS funds must be life threatening if IHS assumes financial responsibility; consequently these services are not provided.

We are aware of the existence of a Memorandum of Understanding between the IHS and the VA. We are also aware that it represents more symbolism then action. Without question the full implementation of the existing MOU, linked with Tribal specific recommendations would go a long way in providing a more comprehensive level of care for our veterans. Specifically, the agencies agree to many things including the sharing of information technology and an interagency workgroup to oversee proposed national initiatives.

Mr. Chairman, if the agencies who are a party to this agreement would as a matter of priority establish an internal and external (tribal) work group to begin developing a strategy then we could discuss how that strategy should be resourced and implemented.

An item not covered in the existing MOU concerns payment to Tribal facilities for care rendered to eligible veterans in Tribal clinics. The tribes rely heavily upon third-party collections to support the clinic operations. It seems logical that for Medicare/Medicaid, and privately insured individuals, the clinics can seek reimbursement. We are aware that the VA does have the ability to contract with the private sector to pay for the care of veterans, yet tribally operated clinics cannot as we understand seek the same. It would be easily incorporated into statute if this Committee were so inclined. Absent the reimbursement, we will still provide what care we can, but resources or the absence of resources controls the scope of care.

Mr. Chairman, I could speak for hours about the specific needs of the 480 veterans living on my reservation. My purpose and goal today was to enlighten you from my perspective about the organization, structural and resource issues that comprise the maze of health care for veterans on the Flathead Indian Reservation. I truly believe that the level of care that is afforded must be equal to the services they have rendered.

I also believe that we can find solutions if we stay focused on the task, and spend less time trying to point fingers. We need to utilize the tools we have, and the commitment all of us in this room share.

I look forward to this Committee providing the guidance and direction to the VA and IHS to ensure that those who have worn our uniform have the best care possible, to maximize limited resources, and to work collectively in all areas of health care including behavioral health. We owe these dedicated men and women nothing less.

B. To further the goals of this MOU, VA and IHS agree to:

1. Facilitate collaboration on effective healthcare delivery for American Indian and Alaska Native veterans and shared responsibility for implementation of appropriate health promotion and disease prevention efforts. Ensure that IHS and VA facilities develop and provide effective linkages between facilities to support health promotion for American Indian and Alaska Native veterans that benefit their communities.
2. Identify needs and gaps between the VA and the IHS to develop and implement strategies to ensure optimal health for the American Indian and Alaska Native veteran population.
3. Promote activities and programs designed to improve the health and quality of life for American Indian and Alaska Native veterans.
4. Develop and implement strategies for information sharing and data exchange.
5. Collaborate in the exchange of relevant programmatic communications and other information related to American Indian and Alaska Native veterans.
6. Co-sponsor and provide reciprocal support for Continuing Medical Education, training and certification for IHS and VA healthcare staff.
7. Develop national sharing agreements, as appropriate, in healthcare information technology to include electronic medical records systems, provider order entry of prescriptions, bar code medication, telemedicine, and other medical technologies, and national credentialing programs.
8. Create an interagency work group to oversee proposed national initiatives.
9. Develop a common methodology to track VA and IHS interagency activities and report progress.

IV. Other Considerations:

A. All VA Medical facilities and the IHS will comply with all applicable Federal laws and regulations regarding the confidentiality of health information. Medical records of IHS and VA patients are Federal records and are subject to some or all of the following laws: the Privacy Act, 5 U.S.C. 552a; the Freedom of Information Act, 5 U.S.C. 552; the Drug Abuse Prevention, Treatment, and Rehabilitation Act, 21 U.S.C. 1101, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, 42 U.S.C. 4541, the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1301, VA's Confidentiality of Certain Medical Records, 38 U.S.C. 7332; Confidential Nature of Claims, 38 U.S.C. 5701; Medical Quality Assurance Records Confidentiality, 38 U.S.C. 5705, and Federal regulations promulgated to implement those acts.

B. Care rendered under this MOU will not be part of a study, research grant, or other test without the written consent of both the IHS and the VA facility and will be subject to all appropriate HHS and VA research protocols.

C. The VA and the IHS will abide by Federal Regulations concerning the release of information to the public – and will obtain advance approval from either VA or IHS before publication of technical papers in professional and scientific journals – for articles derived from information covered by this MOU. The VA and the IHS agree to cooperate fully with each other in any

investigations, negotiations, settlements or defense in the event of a notice of claim, complaint, or suit relating to care rendered under this VA/IHS MOU.

D. No services under this MOU will result in any reduction in the range of services, quality of care or established priorities for care provided to the veteran population or the IHS service population.

E. The VA may provide IHS employees with access to VA automated patient records maintained on VA computer systems to the extent permitted by applicable Federal confidentiality and security law. Additionally, the IHS will likewise provide VA employees access to Veteran IHS records to the same extent permitted by applicable Federal confidentiality and security law.

F. Both parties to this MOU are Federal agencies and their employees are covered by the Federal Tort Claims Act, 28 U.S.C 1346(b), 2671-2680, in the event of an allegation of negligence. It is agreed that any and all claims of negligence attributable to actions taken pursuant to this MOU will be submitted to legal counsel for both parties for investigation and resolution.

V. **Termination:** This MOU can be terminated by either party upon issuance of written notice to the other party not less than 30 days before the proposed termination date. The 30 days notice may be waived by mutual written consent of both parties involved in the MOU.

VI. **Effective Period:** The VA and the IHS will review the MOU annually to determine whether terms and provisions are appropriate and current.

FOR THE DEPARTMENT VETERANS AFFAIRS

LEO S. MACKAY, JR.
DEPUTY SECRETARY OF VETERANS AFFAIRS

Feb 25, 2003
Date

FOR THE DEPARTMENT OF AND HUMAN SERVICES OF HEALTH

CLAUDE A. ALLEN
DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES

February 25, 2003
Date

Tribal Health and Human Services
Behavioral Health Program
P.O. Box 427, 308 Mission Drive
St. Ignatius, MT 59865-0427
(406) 745-4363

MEMORANDUM

TO: S. Kevin Howlett, Department Head

FROM: Kim M. Azure, Program Manager

RE: Veterans Services

DATE: October 29, 2009

Unfortunately, our data system does not keep data regarding veteran status and that may need to be a recommendation to IHS to modify their data gathering instruments to include veteran status.

Fist we must always remember that American Indians have volunteered to serve their Country at a higher percentage in all of Americas' wars and conflicts than any other ethnic group on a per capita basis. They have earned and should receive the full recognition of their service to the Nation. The American Indian veteran is the most underserved veteran in the Nation.

Without any electronic way to gather data about numbers of veterans requesting services and being provided services I am left to my recollection. Typically, Veterans do not request services from Behavioral Health.

Research tells us that veterans are highly sensitive to the stigma associated with accessing Behavioral Health Services and my experience tell me that applies here. Most often our contact with veterans comes through the on-call system and typically the veteran and his/her family have reached a crisis point and partners are separating or talking about separation and it may involve the veteran loosing contact with minor children. Often there is suicidal ideation and the need to hospitalize the veteran. We have frequently utilized the VA's psychiatric hospitals and inpatient behavioral health units. The VA has done an excellent job of making those units available and providing transportation however the great distance they must travel is a barrier.

The challenges facing Native American veterans today include access to healthcare, substance abuse, unemployment, homelessness, and mental health issues, including post-traumatic stress disorder (PTSD). Veterans may have different needs depending on the era in which they served and the social climate regarding service; WW II veterans may be hesitant to apply for benefits, feeling they were just doing their duty. Korean Veterans may have health needs related to the cold weather that they endured during their service. Vietnam veterans may experience physical issues related to Agent Orange, and younger veterans may have symptoms of Gulf War syndrome. Veterans who served during peacetime also need to be aware of the benefits for which they are eligible and how to apply.

Veterans from all eras may experience some level of post-traumatic stress, but not all do. For those who do have post-traumatic stress, the severity can vary. One factor influencing the severity is the type of duties the veteran performed during his/her service. In some cases, institutionalized racism may have influenced the extent to which certain groups are susceptible to PTSD. Native American veterans, for example, commonly confronted stereotypes held within the military regarding natives. They were called names such as "chief," and were often treated as if they had instinctual or mystical powers on the battlefield. This resulted in some Native American soldiers being assigned hazardous combat duties such as walking the "point," and being more exposed to hostile fire than others in the unit. In these cases, the level of post-traumatic stress may be more severe and the use of coping mechanisms, including alcohol and drug use, may be more common

Upon returning home, Native American veterans may face challenges in accessing care. Often, veterans' hospitals are located great distances from the rural, remote homes of many veterans. These logistical challenges make it more important for tribes, agencies, and communities to be creative in how they approach working with native veterans. We must also be aware of the unique needs of native veterans, but also recognize the ways that cultural practices can be applied in healing veterans. Language, culture, and ceremony are being revived and acknowledged as integral factors in the healing process.

Given the complexity to trying to design health care services for Veterans, it is hard to identify single steps that may improve the access and quality but improving upon collaboration between the VA and Indian Health Service and Tribal Health organizations could facilitate improved services. I have especially been interested in trying to incorporate VA services such as telemedicine with our primary care clinics. I believe a Veteran may be more comfortable seeking behavioral health services in a primary care clinic.

Memorandum of Understanding
Between the
VA/Veterans Health Administration
And
HHS/Indian Health Service

I. Purpose: The purpose of this Memorandum of Understanding (MOU) is to encourage cooperation and resource sharing between the Veterans Health Administration (VHA) and Indian Health Service (IHS). The goal of the MOU is to use the strengths and expertise of our organizations to deliver quality health care services and enhance the health of American Indian and Alaska Native veterans. This MOU establishes joint goals and objectives for ongoing collaboration between VHA and IHS in support their respective missions.

II. Background: The mission of the Indian Health Service is to raise the physical, mental and spiritual health of American Indians and Alaska Natives to the highest level. The IHS goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

The mission of the Department of Veterans Affairs is to "care for him who shall have borne the battle and his widow and orphan." Those words were spoken by Abraham Lincoln during his second inaugural address and reflect the philosophy and principles that guide VA in everything it does. The Veterans Health Administration six strategic goals, are: put quality first until we are first in quality; provide easy access to medical knowledge, expertise and care; enhance, preserve, and restore patient function; exceed patient's expectations; maximize resource use to benefit veterans; and build healthy communities.

The IHS and the VA enter into this MOU to further their respective missions. It is our belief, that through appropriate cooperation and resource sharing both organizations can achieve greater success in reaching our organizational goals.

III. Actions:

A. This MOU sets forth 5 mutual goals:

1. Improve beneficiary's access to quality healthcare and services.
2. Improve communication among the VA, American Indian and Alaska Native veterans and Tribal governments with assistance from the IHS.
3. Encourage partnerships and sharing agreements among VHA headquarters and facilities, IHS headquarters and facilities, and Tribal governments in support of American Indian and Alaska Native veterans.
4. Ensure that appropriate resources are available to support programs for American Indian and Alaska Native veterans.
5. Improve health-promotion and disease-prevention services to American Indians and Alaska Natives.

RESPONSE TO POST-HEARING QUESTION SUBMITTED BY HON. DANIEL K. AKAKA TO S. KEVIN HOWLETT, DIRECTOR, HEALTH AND HUMAN SERVICES DEPARTMENT, CONFEDERATED SALISH AND KOOTENAI TRIBES OF THE FLATHEAD NATION

Question. Mr. Howlett, you testified that the VA can contract with the private sector for services through contract health services (CHS) but not with tribally-operated clinics. If the VA were able to contract with tribally-operated clinics, would that greatly increase accessibility for Native American veterans?

Response. Absolutely, in many places across the country, the only care available is Indian Health Service or Tribal Health Services.

Chairman AKAKA. Thank you very much, Mr. Howlett. We will include the information in the record that you mentioned.

Now, we will receive the statement of Mr. Joseph.

STATEMENT OF ANDREW JOSEPH, JR., CHAIRMAN, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD, NATIONAL INDIAN HEALTH BOARD (NIHB), AND TRIBAL COUNCIL MEMBER, CONFEDERATED TRIBES OF THE COLVILLE RESERVATION

Mr. JOSEPH. Chairman Akaka and Ranking Member and distinguished Members of the Committee, [untranslated] is my name in my language. I am Andy Joseph, Jr. I chair the Health and Human Services Committee for the Confederated Tribes of Colville. I am the Chair of the Portland Area Indian Health Board and Delegate to the National Indian Health Board. Thank you for inviting the National Indian Health Board to testify today.

NIHB serves all federally-recognized Tribes by advocating for the improvement of health care to all American Indians and Alaskan Natives. Our organization believes that the Federal Government must uphold its trust responsibility in the delivery of quality health care to Indian people, especially our Native veterans.

Native veterans are a special part of our Tribal communities. American Indians and Alaskan Natives have a long history of serving the U.S. Armed Forces. Indians have volunteered to serve in the military at a higher percentage than any other ethnic group. Our Native veterans are also fellow Tribal members who are assured health care as part of the Federal Government's trust responsibility to Tribes. As veterans, the U.S. Government has made a commitment to provide health care in honor for their military service. Therefore, our Native veterans deserve quality health care.

The IHS and VA have collaborated to promote greater cooperation for the improvement of health care for Native veterans. In some areas, this coordination in care is working out well. However, many Native veterans report a higher rate of unmet health care needs and continue to deal with high rates of illness associated with combat service. The lack of access and coordination of care has created some of these issues.

There are Native veterans who may not consider the VA as an option for their health care. Tribal members live in remote, rural areas and must travel great distances to access any medical facility, including VA. Another potential barrier is the perception that VA will not appreciate, understand, or accommodate the cultural needs of Native veterans. Some Native veterans have expressed the frustration when VA has not accepted a diagnosis from IHS. In these instances, Native veterans have to travel long distances to a VA hospital so the VA doctor can administer the same test and give the same diagnosis that the IHS provided.

Other issues include lack of communication that exists between VA and IHS regarding treatment. Some Native veterans who access health care through both VA and IHS must manage their own care by maintaining medical records, sharing the medical diagnosis and care between VA and IHS. Without these agencies directly talking with one another, there may be increased risks, such as side effects from counteracting medications.

We have provided some recommendations in our written testimony. I would like to raise a couple here. First, a key recommendation to address the health needs of Native veterans is the need for additional funding to provide care to Native veterans. Many times,

IHS is the only facility in the area to provide care for Native veterans. Supplemental funding to IHS and Tribal facilities for services provided to Native veterans would help ensure all the care needed can be provided to Native veterans.

Second, more information must be shared about the available services. One option is to expand the Tribal Veterans Service Officers Program by establishing it as part of the VA with permanent paid positions. In many areas, these representatives help Native veterans navigate the VA system and serve as advocates for Native veterans.

Another option is to bring VA health professionals specialized in behavior and mental health treatment to Tribal communities to treat Native veterans. Many of the IHS and Tribal facilities have behavior health departments, but deal with veterans returning home from combat requires specialized care and treatment.

In closing, thank you for this opportunity to provide these comments and I am happy to answer any questions the Committee might have.

I would like to thank each of you for serving our country, also. As a Tribal leader, I know you swore an oath to protect and care for all of our people, the same as Tribal leaders have, and your time is greatly appreciated. Thank you.

[The prepared statement of Mr. Joseph follows:]

PREPARED STATEMENT OF ANDREW JOSEPH, JR., CHAIRMAN OF THE NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD, NATIONAL INDIAN HEALTH BOARD (NIHB), AND TRIBAL COUNCIL MEMBER, CONFEDERATED TRIBES OF THE COLVILLE RESERVATION

Chairman Akaka, Ranking Member Burr and Distinguished Members of the Committee, I am Andrew Joseph, Jr., testifying on the behalf of the National Indian Health Board (NIHB). Also, I serve as a Tribal Council Member of the Confederated Tribes of the Colville Reservation and as the Chairman of the Northwest Portland Area Indian Health Board.

Thank you for inviting the NIHB to testify today regarding the cooperation and coordination between the Veteran Affairs and the Indian Health Service (IHS) in providing care to our American Indian/Alaska Natives (AI/AN) Veterans. Since 1972, the NIHB serves all federally recognized Tribes by advocating for the improvement of health care delivery to AI/AN. It is the belief of the NIHB that the Federal Government must uphold its trust responsibility to AI/AN populations in the provision and facilitation of quality health care to our people. The results that we all wish to achieve are the enhancement of the level and quality of health care and the adequacy of funding for health services that are operated by Tribal governments, the Indian Health Service and other Federal programs. As health care is the top priority of Tribes across the Nation, and delivery of health care is unique and individual to each Tribal nation and their tribal members in the United States, it is fitting that the NIHB provides testimony regarding the health care provided to our Native Veterans. Thank you for inviting us to do so.

HEALTH CARE AVAILABLE FOR OUR AI/AN VETERANS

AI/AN who have served in the US Armed Forces are a special segment in our communities as they are both Tribal members and honored veterans. They are fellow members, relatives and friends of the 564 federally recognized tribal communities in United States. As well as, the long history of AI/AN serving in the United States Armed Forces should never be forgotten.[1] AI/AN have volunteered to serve the United States at a higher percentage in all of America's wars and conflicts than any other ethnic group on a per capita basis. In addition, 25% of AI/AN population serve in military, which is higher than any other in the U.S. Based on the associa-

[1] See "American Indian and Alaska Native Veterans: Lasting Contributions" by Lindsay Holiday, Gabriel Bell, Robert Klein and Michael Wells, US Department of Veterans Affairs, Office of Policy Assistant Secretary for Policy, Planning, and Preparedness, September 2006.

tion with both the AI/AN and Veteran communities, AI/AN Veterans are entitled to health care both as a right as a tribal member and as a benefit for their military service.

Indian Health Service

As a member of federally recognized Tribe, AI/AN Veterans are entitled to health care. The provision of health services to AI/AN is the direct result of treaties and executive orders that were made between the United States and Indian Tribes. This Federal trust responsibility forms the basis of providing health care to AI/AN people and reaffirmed by judicial decisions, executive orders, and congressional law.

The Indian Health Service (IHS) is responsible for health care to all enrolled members of the 564 federally recognized Indian tribes, bands, and Alaska Native villages in the US. The current Indian health care delivery system provides culturally competent health care to AI/AN, who reside in the most remote, isolated and poorest parts of this Country. There is no consistent health benefits package across Indian country. This health care delivery system consists of various health care facilities across the country, including 45 hospitals, 635 ambulatory facilities (288 health centers, 15 school-based health centers, 132 health stations, 34 urban Indian health program, and 166 Alaska Native village clinics).[2] These health care facilities can be grouped into three categories: those operated directly by IHS, those operated by the tribes via contract or compact with IHS, and those providing services to urban AI/AN (individuals not residing on or near an Indian reservation).

What is consistent, however, is that there is an overwhelming lack of funding to support even the basic health care demands in all three delivery models. Along with ambulatory primary care services, Tribal, IHS or Contract Care facilities may offer inpatient care, sporadic medical specialties, traditional healing practices, dental care, child and emergency dental care, mental health care, limited eye care, and substance abuse assessment or treatment programs. Many tribes are also served by community health (e.g., childhood immunizations, home visits) and environmental health (e.g., sanitation, injury prevention) programs, which may be administered by the IHS or the Tribes. Specialty services and types of medical care that are not available at a given facility are often purchased from providers in the private sector through contract health service (CHS) program. Due to lack of adequate funding, the IHS and Tribes apply stringent eligibility criteria to determine which patients qualify for CHS funding. The severely limited pool of CHS dollars also means that most CHS programs limit reimbursement to those diagnostic or therapeutic services that are needed to prevent the immediate death or serious impairment of the health of the patient. Long lists of denied or deferred CHS care are commonplace at all IHS and Tribal facilities.

Veteran Health Administration

AI/AN veterans may be eligible for health care from the Department of Veterans Health Administration (VHA). The eligibility of Veterans to access health care through the VHA depends on factors such as service-connected illness, income, the character of discharge from active military service, and the length of active military service.[3] VHA provides comprehensive, free or low cost health care to eligible veterans through facilities located throughout the entire country.

Memorandum of Understanding between HHS and the Veterans' Health Administration

Since 2003, the IHS and the VHA have collaborated via a memorandum of understanding (MOU) between the two Federal agencies to promote greater cooperation and resource sharing to improve the health of AI/AN veterans. The MOU encourages VA and IHS programs to collaborate in numerous ways to improve beneficiary's access to healthcare services, improve communications between IHS and VHA and to create opportunities to develop strategies for sharing information, services, and information technology.

The MOU has served as an impetus for improving the coordination of care between IHS and VHA. In some areas, this coordination between IHS and VHA has improved but while in other areas, such coordination necessitates improvement. A recent study examined the AI/AN veteran's utilization of the IHS and VHA health services. Based the study's survey, 25% of AI/AN Veterans receive care through both IHS and VHA, while over 25% of AI/AN Veterans accessed care through VHA only

[2] Indian Health Service Year 2009 Profile. Available at http://info.ihs.gov/Profile09.asp. Assessed October 31, 2009.

[3] VA Health Care Eligibility & Enrollment. Available at http://www4.va.gov/healtheligibility. Last accessed on October 31, 2009.

and nearly 50% of AI/AN Veterans accessed care through IHS only.[4] Of the dual use AI/AN Veterans, these individuals were more likely to receive primary care from IHS and to receive diagnostic and behavioral healthcare from VHA. Although such AI/AN Veterans are eligible to receive health care from the VHA and IHS, AI/AN Veterans report a high rate of unmet health care needs and exhibit high rates of disease risk factors for Post Traumatic Stress Disorder (PTSD).[5]

Some of the issues that lead to the unmet health care needs of AI/AN veterans:

Access of Care: Tribal members are located in isolated areas and must travel great distances to attend any medical facility—IHS or VA. AI/AN veterans who live in rural, remote areas pay for the cost of such travel more than cost of gas but also time away from their home and families. Yet the decision to travel to the nearest facility may also take into consideration what type of care the patient would receive at that facility.

Type of Care: Although the VHA offers more specialized behavioral and mental health care, AI/AN veterans may not consider the VHA as an option. First, the criteria for establishing eligibility for VHA services are much more stringent than IHS, which acts as a disincentive for Indians to access VHA services. Whereas, an AI/AN Veteran, if located on his/her home tribal community, may assessed IHS with less paperwork. Another potential barrier is the perception that the VHA will not appreciate, understand or accommodate the cultural needs of AI/AN veterans. For example, when working with the behavioral health PTSD issue, traditional treatment should be considered as an option for tribal veterans. At some sites currently, if a tribal veteran comes to the facility and requests a traditional healer, the Tribal Veterans Representatives may provide a list of traditional healers and call a traditional healer for the veteran. However, this arrangement is not present at VA facilities.

Coordination of Care: For the AI/AN Veterans who accessed care at VHA and IHS, many tribal veterans have expressed that the frustration of VHA not accepting diagnosis from IHS. To resolve this issue, the Native Veteran may travel for hours to a VA hospital so that the VHA doctor could administer the initial tests and provide the same diagnosis that IHS provided. In addition to the lack of communication of appropriate coordination of care regarding diagnosis, there is also minimal communication between VHA and IHS regarding treatment and prescriptions. Those who assessed the care through VHA and IHS increase the risk of receiving medications which create the risk of conflicting medicine.

RECOMMENDATIONS

Funding: The first and obvious answer to addressing the health needs of AI/AN veterans is the need for additional funding providing care to AI/AN veterans. Many times, IHS is the only facility in the area to provide care to Indian Veterans. Supplemental funding to IHS/Tribal facilities for services provided to AI/AN veterans would help ensure all the care needed can be provided to AI/AN veterans.

Coordination of Care: Shared information about the services provided and needed by AI/AN veterans would help facilitate improved care. One option is to expand the Tribal Veteran Service Officers program in VA and expand these roles into paid VA positions. Another option is to bring the specialized the mental professional to the AI/AN veterans. Many of the IHS facilities have behavioral health departments but dealing with Veterans returning home form combat zones requires a specialized type of treatment. If IHS could work with the VA on collaborating efforts to address the Gulf War syndrome, such efforts would benefit a majority of majority of current Veterans. For example, the VHA and IHS could share mental health providers and public health nurses who would work out of the tribal facility while treating the AI/AN veterans. By sharing or rotating VHA employees—the health professional would have the knowledge and expertise that the VA could provide in addressing these issues, but IHS and Tribes could house the provider in the community. Likewise, IHS facilities may want to consider incorporate more specialization of PTSD for current veterans coming home.

In closing, it is exciting to be a part of the Federal/tribal partnership and all of us working together can improve the care offered to our veterans better. Thank you for this opportunity and I will be happy to respond to any question.

Chairman AKAKA. Thank you very much, Mr. Joseph.

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[4] Veterans Health Administration and Indian Health Service—Healthcare Utilization by Indian Health Service Enrollees, by B. Josea Kramer, Mingming Wang, Stella Jouldjian, Martin Lee, Bruce Finke, and Debra Saliba. Medical Care, Vol 47, Number 6, June 2009Id.

[5] Id.

Let me ask one question and I will turn the gavel over. Mr. Park, our discussion today regarding VA and IHS cooperation revolves largely around an MOU, Memorandum of Understanding, signed by the two parties. My question is, is there any similar agreement between VA and the Native Hawaiian Health Care Systems?

Mr. PARK. Mr. Chairman, at this time, there is no Memorandum of Understanding between the Native Hawaiian Health Systems and the VA in Hawaii.

Chairman AKAKA. Would you see any benefit in that kind of sharing?

Mr. PARK. We had a meeting with your VBA Director and we are still working on that, sir.

Chairman AKAKA. I will be following up with you in writing, Mr. Park, and I have other questions.

But at this point, I am going to turn the gavel over to Senator Tester, who called for this hearing, and he will be leading this hearing. Senator Tester, the gavel is yours.

Senator TESTER [presiding]. Thank you, Mr. Chairman.

I will see if the Ranking Member has any questions. Senator Burr?

Senator BURR. I thank the Chair.

Mr. Park, if I understand you correctly, there are three VA outpatient clinics in Hawaii, and 14 community health centers and five Native Hawaiian Health Care Systems. Is that pretty accurate?

Mr. PARK. There are four CBOCs.

Senator BURR. OK, four CBOCs. Your recommendation is that VA should do more contracting with non-VA providers. Let me ask you, to what degree is there contracting right now going on?

Mr. PARK. At this point, I don't see any partnering with the community health centers or Native Hawaiian Health Systems.

Senator BURR. Share with us, if you can, what dialog you have had with VA about expanding either the use of those facilities or the increased use of contracting.

Mr. PARK. We haven't talked with them about that, sir.

Senator BURR. Are veterans in Hawaii asking you if they can just simply receive care under a contract?

Mr. PARK. The veterans are trying to seek—we are seven islands, and we are like Alaska in that in order to get to the VA you have either got to fly or you have got to take a boat. The veterans are looking for services that they can access on the seven islands as best they can. And I think the community health service—there are 14 on all the islands—to access the community health service is one of the best ways to go. We have only five Native Hawaiian Health Systems in the State, and to access the CHS is the best way to go.

So, with only four CBOCs in Hawaii—and some of the problems are if the veteran needs to go to Maui, to the CBOC Maui, they need to fly to Honolulu first and catch a plane to go to Maui. And there's a clinic in Honolulu, so if they're going to fly to Honolulu, why don't they just go to the clinic in Honolulu? So, I think the problem we're looking at is there are not enough services for veterans on the neighbor islands.

Senator BURR. Clearly, I understand the challenge that you have and that Senator Begich has in Alaska. My understanding of the Memorandum of Understanding is that for some Tribes it is working pretty good; for others, it is nonexistent.

Mr. PARK. Like in Hawaii, it is nonexistent.

Senator BURR. I guess I would ask you, or any of the three of you, what do you think needs to be done to look at those meaningful partnerships that are working and emulate those elsewhere? What would it take, Mr. Howlett?

Mr. HOWLETT. Mr. Chairman, Senator Burr, I think, first, it takes a real commitment from the agency, not a piece of paper that says how great we are. I really feel that solutions can be found, as I said in my testimony. But I think that there needs to be established a framework for finding that solution, and that framework really needs to be an honest and candid discussion of legislative barriers, of policy barriers, of distance barriers, of weather barriers, and all these discussions are things that are going to have a reflection on the capacity to provide care.

If you don't factor those in or you don't discuss those, there is a tendency to pretend they don't exist, and then when you run up against them, you can't deliver. I just feel like if the agencies would say this is a priority and they would set about a task force to really examine these things—and fund that task force—then I think you could come forward with the legislative issues that are problems or the policy issues that are problems.

I think this notion of one-size-fits-all really is misguided when it comes to trying to provide health services in Indian Country because of location, because of remoteness, because of transportation, and because of weather. I mean, all of these things are really important factors. So to me, let us establish a framework for trying to find out what the issues are.

Senator BURR. Would I be correct if I made the statement, it would be a step in the right direction if VA was just proactive?

Mr. HOWLETT. That would be—yes, yes, for sure. I agree.

Senator BURR. Thank you.

One last statement, Mr. Chairman, if I may. For all the challenges we have got between VA and Indian Health, Senator Coburn and I met with representatives from Indian Country recently and pledged our commitment that if Indian Country would work with us—we understand it needs more money, but we didn't feel that it was just money alone. We need to make Indian Health structurally work to provide the level of care that is expected everywhere else. I say this to our representatives today. That offer is still on the table. We look forward to working with any and all to fix the Indian Health Service and to fund it at a level that would provide that level of care, that quality of care for all in Indian Country.

I thank you.

Senator TESTER. Thank you, Senator Burr.

Yes, Mr. Joseph?

Mr. JOSEPH. I guess I would like to answer that question, also. In this building, in the White House, or anyplace where law is written, it is just like our treaties. They are Orders that the government is supposed to abide by. I take that very seriously. I believe the VA should take this work that you do here very serious.

You have the ability to make the law the way that you write it. Once you are given orders in the military, you have to abide by those orders—and somebody needs to give the VA orders. But I think that you have the power here to make things happen. Thank you.

Senator TESTER. Thank you.

Chairman Akaka has conferred to me that he is pleased with the progress—this is for you, Mr. Park—is pleased with the progress of the Hawaiian Uncles and Aunties project, having used a kinship model to assist transitioning and distressed veterans. The question to you is this. Do you believe that something like the Uncles and Aunties model would work outside Hawaii, perhaps as a model for Indian and Alaska Native communities? And if you do believe it would work, how would it work?

Mr. PARK. Senator, I do believe that it is important to extend the Uncles and Aunties program across the Nation. I have on Maui three Uncles—actually four Uncles, one in a remote area called Hana; I have eight on Oahu; one on the Island of Lanai; one on the Island of Hawaii; and one on Molokai. I also have five Uncles from Alaska and one from Guam. So, we are expanding. And a lot of the Uncles, they are married. Their wives are the Aunties. So, we have expanded the Uncles and Aunties program within the State of Hawaii as well as on the Mainland.

It will work because of the trust issue. The veterans, they don't trust government, and I will give you an example. I have just been to Hana to talk with the Vietnam veterans there and I tell them, this is an insurance policy. You paid the premiums, it is time for you to collect. The only way you are going to do it is you need to put in your application, VHA and VBA applications.

The Vietnam veterans are saying, when we came back, they hated us. They spat on us. They called us baby killers. Why would I want to go through that again? I can understand what they are saying, but I can also understand the hurt. So, I really try to get them to put in their application.

What I tell the veterans is if you don't put in your application, they are not going to see you, so you need to do that. And as far as the Aunties and Uncles program, I think it will work anywhere because of the trust issue.

Senator TESTER. Thank you.

Kevin, if a veteran comes to one of the facilities you oversee, whether he or she is eligible for care from the VA—say that he or she is—do you know where to direct them? If they are eligible for VA care, they come to one of your facilities, has anybody contacted you? Do you know where to send them?

Mr. HOWLETT. Mr. Chairman, I wouldn't want to send them anywhere. I would want to treat them.

Senator TESTER. Right.

Mr. HOWLETT. If we have the capacity to meet their needs, I would want to treat them. But, you know, in Montana, we have two options, Fort Harrison or Spokane, depending on where you live in the State. So, the answer to your question is, if they are a veteran, we have personal relationships, although we don't have formal agreements, with both VA centers. I have visited with them both personally. They welcome the veterans. They do the best they

can. But there is no formal process in place. I would think that we could treat within our capacity their needs if they came to our particular clinic.

Senator TESTER. You said in your testimony that the Indian Health Service has primary responsibility for health care, and I don't want to put words in your mouth, for Native Americans that come in. Let me just put it this way, what determines—if you have a veteran that comes through the door and you know your budget is strapped, which for the most part you are dealing with difficult budgets, what do you do? I mean, whose responsibility is it then if you know——

Mr. HOWLETT. Well, they don't get turned away. I mean, we will provide what care we can. And again, if it is something that requires a level of care beyond our capacity which would trigger CHS expenditures, then the Indian Health Service in all likelihood, unless it is life-threatening, isn't going to pay for it. That veteran then—we would do everything that we could to get them connected to a VA center. But that is where it is at this point.

Senator TESTER. OK. You said in your testimony that you felt they may be able to set up internal and external working groups. I think your answer to Senator Burr's question was spot-on when you talked about the different kind of factors that impact the ability to provide the health care.

In your vision for the working groups to try to, as the President would say, quit working in silos and start working across agency lines, how would you do it, by region, or would you have one working group for the entire country, or how do you envision that working out?

Mr. HOWLETT. Somehow, I anticipated that question. I think, initially, you would look at a national group that would be comprised of a cross-section of people. And then I think you would, of necessity, need to dissect that a little further to deal with issues like Alaska and distance and weather and other things. I think, initially, you would take this work group—and it would take a lot of time and a lot of energy, believe me—to really sit down and analyze the issues affecting health care for Native American veterans. You are going to have a lot of crosswalk between health care in general, but it just—it is just confusing to a health administrator now. You know that a veteran is eligible, but you don't know what an agency is going to sponsor in terms of getting them to another place.

You were very instrumental in just getting mileage reimbursement increased for veterans. That was a big deal. That was a big deal. I mean, some of these people are having a really difficult time, as we well know.

So, I would look at a national group first comprised of Tribal people, Tribal health people. You need obviously some Indian Health people with a willingness and a vision to solve the problem. You need some VA people with that same kind of capacity.

Senator TESTER. OK. Could you just very briefly tell me, the MOU between VA and Indian Health Service has been referred to several times. There is really no lead agency, just work together and try to find ways you can make things better. Have you seen—

that MOU, I think, went into effect about 6 years ago. Have you seen any difference?

Mr. HOWLETT. Let me say, Senator, that there are many very dedicated and hard-working people in the Indian Health Service. But the agency itself, to the best of my knowledge and as much as I have participated with them, has not forwarded the recommendations or the body of that agreement.

Senator TESTER. Thanks. Before I turn it over to Senator Murray for questioning, I want to welcome Senator Murkowski. She serves on the Indian Affairs Committee. We will get to your comments as soon as we get through the first line of questions.

Senator Murray?

Senator MURRAY. Mr. Chairman, thank you very much, and let me just follow up on the Chairman's last line of questioning on the MOU that was signed 6 years ago between the IHS and VA. I think it is fair to say that a lot of the goals haven't been realized. Now, as the VA works over the next year, I would like to ask each one of you what the top three priority items you think the VA ought to be working on to improve Tribal health care, and Mr. Park, I will start with you.

Mr. PARK. At this time in Hawaii, we don't have an MOU with the VA——

Senator MURRAY. So it doesn't apply to——

Mr. PARK. Yes. We have nothing with them. So, I think we need to partner with them and see where we can go with this.

Senator MURRAY. All right. Mr. Howlett?

Mr. HOWLETT. Senator, I would reflect back on my testimony. First of all, a commitment to the structure, to the organization, to the things that are already a part of the MOU and how they would go about organizing that as an agency. I think that would be first.

The second item in terms of a priority for Native American veterans would be the whole issue of access and making sure that they do appropriate outreach to the Native communities in their region, and I think that could come about in a number of different ways.

And probably the third item—and I am grasping here for priority—I believe it would be the prevention and wellness kinds of activities that I think they could put some resources behind through some sort of a structured document with Tribes to get some of these veterans, not just Iraq and Afghanistan veterans, but some of these veterans that are older veterans, involved in more preventative kinds of care.

Senator MURRAY. OK, excellent.

Mr. Joseph?

Mr. JOSEPH. I think it would be really great and maybe it would help the VA if there was an office and a position in the VA that is in there for Native Americans—Native American Indian Affairs Office, and I would welcome the Native Hawaiians be part of that, also. I think that the Native Alaskans and all of us share the same situations. So, if we had an office in the Veterans Affairs, maybe then they could see how everything is working and make sure that we have this MOU actually working the way it was intended to.

Second, I would say that the VA could learn from IHS. IHS scored the highest out of any HHS Department on their report

card. With the limited funding that we have in IHS, I believe that the VA could learn from how IHS is run. So I think that would be my second thing.

You know, if they could help with their big budget, help fund IHS to help serve our veterans, I think that would be another way. I always wanted to see the Government utilizing Public Health nurses and mental health providers to come and get stationed right at our clinics so that they can go throughout our reservation and serve any of our veterans, whether they are Native or not.

Believe me, my reservation covers two counties and the surrounding areas. I can relate to the Senator from Alaska in his ruralness. Some of the people on our reservation have to wait, and hopefully there is a ferry that is operating to get to services. They have to travel over 2 hours just to go to the VA, and that is if they can afford it to begin with. With the economy the way it is, some of our veterans can't afford to even get to a VA hospital. We don't have any hospitals—IHS hospitals—in our area like Alaska or some of the other rural areas. If there was funding to help work in IHS, it would be a real benefit. Thank you.

Senator MURRAY. OK. I appreciate that.

And just really quickly, Mr. Chairman, I did want to ask about cultural sensitivity. It comes up time and time again to me as I am traveling around my State and talking to Tribal veterans. Each of our 564 federally-recognized Tribes have some unique cultural traditions. In my home State, we have made some progress with sweat lodges, but I just wanted to ask quickly if there is anything else that we could be doing to really be more culturally sensitive.

Mr. JOSEPH. Well, in our State, I know I have personally gone to the VA and had a sweat there. It is a place where we—I guess it is kind of like our own type of psychology. We can get to our young veterans that are having a hard time in a way that we were brought up and taught to respect and honor different things in life. It is like—I guess it is more like best practices, where we have a better success rate than, say, sending somebody to a talking circle that just makes them angrier——

Senator MURRAY. So, just being more aware of those issues that impact different Tribes differently?

Mr. JOSEPH. Yes. It saves lives. A lot of these people were suicidal and they are living today. Thank you.

Senator MURRAY. OK. And my time is out, so I will pass to the next. Thank you very much to all of you.

Senator TESTER. Thank you, Senator Murray.

Senator Begich?

Senator BEGICH. Thank you very much, and thank you again for your testimony.

I want to follow up, if I can, on a couple of things. Mr. Howlett, your idea in your commentary to Senator Tester regarding kind of—and I think it was your words—internal-external working group, or a process that could help down the road in setting up a better relationship in a sense. You talked about kind of a national model and breaking it down by regions. Do you see that in the process of setting that up, because I read the MOU and it is a few pages. It has great one-liners; they sound great. If we could achieve all that, the world would be fantastic. But there are no goals; there

are no measurable timelines. There is nothing that you can come back and say, how did you do it, when did you do it, who did you serve, and how many did you serve?

I am assuming—it is kind of a leading question. Is that your view of kind of how you set up this external-internal work group, but also set some real measurable efforts here, because what I have learned over at least my 10 months here is we do a lot of this paper, but accountability is sometimes lacking. Let me—I am trying to be very polite here. So, give me your thoughts on if you could go one more step, how you would see that.

Mr. HOWLETT. Well, I guess maybe a definition of where we are, in its truest sense is abstract at this point. But good things happen with ideas. So, I think you can take that and you can move it to the next level and say, given that, what are some realistic goals that could be established? But that would be part of this work group's goals——

Senator BEGICH. So that is how you see it?

Mr. HOWLETT. Right. It currently doesn't define anything; so, yes, I really believe that you could define that, and I think that you have got to be honest. It took a long time to get to where we are and it is going to take some time to get these issues resolved. But I think that is a good start.

Senator BEGICH. As you develop that, do you think there is a role for that working group? Let us assume they set a plan, an action plan. Do you see a role for that working group after the fact, in other words, kind of a reviewer and ensurer. Or do you see that more of a Congressional role like this Committee, for example, to ensure——

Mr. HOWLETT. I think, Senator, that their role would really be dependent upon the issues that arise from that, whether there are legislative barriers or there are policy barriers or whatever, because I think that, obviously, if it is legislative, there needs to be some input here. But, I would give it enough life to, in your best estimate, complete the job. But I don't think there is a necessity for a committee in perpetuity.

Senator BEGICH. Good. OK. Thank you.

One other comment you made, and I want to explore this just for a couple of seconds here, and that is the reimbursement issue for Medicaid-Medicare. VA does it. From your perspective, you are unable to——

Mr. HOWLETT. We do not have the ability to collect for services on a fee-for-service basis for services provided in our Tribal clinics to veterans through the VA. We can through Medicare and Medicaid and private insurance now.

Senator BEGICH. Right, but not the VA?

Mr. HOWLETT. Right.

Senator BEGICH. When I campaigned, I talked about an idea—because all three of you have mentioned kind of the uniqueness of Alaska and it is very remote, and we have a very good Indian Health Service delivery, but through nonprofit organizations, travel consortiums, in some cases, very—I just talked on the Senate floor about our South Central Foundation and the success they have had in integrating traditional as well as cultural and other medicine techniques.

And I have always had this idea, it seems so simple with especially dual eligible veterans that you just issue them a card that they, for example—the example you gave of flying from one island, you are going through Honolulu, and it seems so logical just to go in and get the service rather than extend the time. You take the card in. You get the service. The patient doesn't sit there and try to figure out who pays, but the system manages that for them, in other words, makes it seamless for the patient. Is that too simplistic? One thing I have also learned around here is simple ideas are not the ones that usually get implemented, but let me throw that out to any one of you. Maybe, Mr. Park, from your example—that was a great example.

Mr. PARK. I think it is too simple.

[Laughter.]

Senator BEGICH. I thought so.

Mr. PARK. I think one of the problems is when the VA puts it onto a vendor and the VA doesn't pay the vendor, then the vendor bills the veteran and now the veteran gets all amped out and what have we got?

Senator BEGICH. What have we got, yes. It puts some additional pressure, then, on the veteran.

Mr. PARK. Yes.

Senator BEGICH. Mr. Howlett? Then my time is up.

Mr. HOWLETT. I, too, think it makes too much sense. No, there are significant issues with Federal agencies paying their bills. In Indian Health Service, there are thousands of people whose personal lives have been ruined, their credit has been ruined because IHS hasn't paid their bills on time. I mean, these people have been turned over to collection and that is just—that is the way it is. I don't know about the VA. We have not worked with them. But that needs to be worked on.

Senator BEGICH. Very good. Thank you very much. My time has expired. Thank you all.

Senator TESTER. Thank you, Senator Begich.

Senator Murkowski, did you have a statement?

STATEMENT OF HON. LISA MURKOWSKI, U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. I do, Mr. Chairman, and I appreciate the indulgence of the Committee giving me the opportunity to be here and listen to the witnesses and to just take no more than 5 minutes this morning to put on the record a statement about some of the Alaska issues. I appreciate the leadership of my colleague, Senator Begich, on this Committee as we try to find solutions.

It is interesting to hear the responses to Senator Begich's comment about it being just too simple, just too much common sense. Well, I think the obligation that we owe to our veterans is to provide for that level of care that was promised then; and unfortunately, I think we find more and more that with the systems that we have in place we have effectively disenfranchised our veterans from their earned benefits. I am hopeful that with the leadership that we have here in this Committee with what we are attempting to do on the Indian Affairs Committee, that we ought to be able to provide for this more seamless transition within the systems.

I do appreciate, Chairman Akaka and Senator Burr, your leadership in calling attention to the plight of our Native veterans. I often refer to them as our forgotten veterans. What a tragedy that is, because we recognize that from the very beginning Native peoples throughout this country have served in the Armed Services and the Armed Forces in greater numbers than any other group.

So, I hope that this hearing and what you are doing here is the first step in a very comprehensive examination of how well the VA is serving our first Americans. I encourage your Committee to work collaboratively with us on the Indian Affairs Committee as we also follow these issues.

While I was the Vice Chairman of the Indian Affairs Committee, I conducted a field hearing on the difficulties that our Alaska Native veterans were encountering in accessing their veteran health benefits, and the focus at that time was on the Alaska National Guard's Third Battalion. They come from about 81 different communities scattered around the State of Alaska, and a sizable number of these Guardsmen lived in the very small bush villages. They live in communities that are not connected by roads, by any connectors that we would imagine here.

To reach the nearest VA facility in Anchorage, they would first have to take a single-engine or perhaps a twin-engine bush plane to a hub, like Bethel or Dillingham or Nome, and then they catch the jet into Anchorage. The total cost of the trip could exceed well over $1,000, way out of reach for our Native people who many of them live off subsistence resources of the lands and the rivers.

But back in October 2006, the Third Battalion deployed to Kuwait and they were going off to Southern Iraq after that. They returned in October 2007, but the very notion of taking our subsistence hunters and fishermen and sending them off to the Middle East, I think was more than a little bit distressing to some. They wondered out loud whether or not the VA was going to be able to deal with them, to treat them with issues like PTSD and other service-connected injuries. How are they going to do this, are they going to treat them in remote Alaskan communities? I certainly wondered the same.

And long before that deployment date, I called the VA in and I asked them. I said, let us work with the Alaska Native Tribal Health Consortium. Let us develop this unified plan for caring for our Native veterans when they return. We had an opportunity to discuss it with the Secretary of Veterans Affairs, Secretary Nicholson. We continued to bring the VA together with ANTHC during that year, and in spite of all these discussions, in spite of the Memorandum of Understanding between the VA and the Indian Health Service, there was very little progress that was made in formulating that unified plan during the year.

We knew that they were going to be gone for a year. We had a whole year to put it together. But the VA took the position that it is the payer of last resort and it disclaimed the obligation, and to a large extent, the authority to reimburse our Alaska Native Health System, which is a Tribal-run, not a government-run, system for care that was provided to our Native veterans.

So, you drill below the surface here and what I learned was that there is just a very wide distrust—and I think, Mr. Park, you men-

tioned that as I was coming in—a very wide distrust between the VA and the Native Health System. The VA expresses their concern that it would neither be able to control access to care nor the cost of the care delivered in the Native Health facility. The VA was concerned that the Native Health System was really asking the VA to subsidize Congress's inadequate funding of IHS. And for their part, the Native Health System argued that, hey, we are only funded at 50 percent of the level of need. They can't afford to subsidize the better-funded VA. So, you have got this impasse going on here.

But it became very, very clear that the situation we face is the needs of 6,000 of our Native veterans mired in the bureaucracies, which is absolutely inappropriate. But under the auspices of the Senate Committee on Indian Affairs, we conducted a field hearing back then in November 2007. I think 2 years after the fact now, we are seeing a slight improvement in services to our Native veterans. Senator Begich mentioned some of the great successes that we have with South Central. We are blessed with one of the Nation's best telemedicine systems. The VA does make extensive use of this system to deliver care to our veterans using the VA personnel. They have also hired a few Native Veteran Benefits Representatives who are posted at the Tribal Health facilities, and that is a good idea.

But, they also attempted to train Tribal employees to serve as Tribal Veterans Benefits Representatives without any compensation. I was told that a handful of Alaska's 229 Tribes showed up for the training, but the problem was that the VA declined to cover the travel expenses of the people who were there attempting to train. The Tribes don't have the money to cover those expenses. And the VA initially argues that, well, we don't have the authority to cover those expenses.

So, I asked whether they had considered the invitational travel authorities in the Federal Travel Regulation. They said they had never heard of the authorities. And then following consultation with their counsel, they came back and they admitted that they do have the authority to cover the travel expenses. But the VA has yet to implement a viable Tribal Benefits Representative program in the State of Alaska. It is just not happening.

The VA has recently implemented a Rural Alaska pilot, which allows Community Health Centers and Tribal Health facilities to bill the VA for a closely-controlled number of primary care visits. But at the outset of this pilot, they didn't include behavioral health visits, which seems incredible. So, we called this omission to the VA's attention and they changed the pilot. The protocol for this pilot requires that the veterans sign up for it, and unfortunately, what we are hearing is the word is not sufficient to get out to them and we have very few veterans that have signed up. So, I don't know whether there is a better way to implement the pilot. Time will tell on that.

In spite of what limited progress that is out there, I regret to say that we are far from building this seamless relationship between the VA and the IHS in Alaska that I have long been working for and Senator Begich has, as well. And the gaps aren't just affecting our Alaska Native veterans of Iraq and Afghanistan, it goes back to our Vietnam-era veterans that are living in rural Alaska.

Again, I appreciate the emphasis that this Committee is placing on this. Collaboratively, we ought to be making better progress, because we are certainly not keeping our commitment to veterans. Right now, you can have the benefits that you have earned as a veteran if you happen to live in the right spot, and that was simply not the promise that we made.

Thank you, Mr. Chairman, for allowing me the opportunity to make some comments this morning and to work with you on this issue.

Senator TESTER. Thank you, Senator Murkowski. I want to thank the panel for their insight and their service. Now we will call up the second panel. Thank you, folks, for being here.

We will call up the second panel, and while the second panel is coming up, I will introduce them. It is Mr. James Floyd, Network Director for the VA Heartland Network, VISN 15, for the Veterans Health Administration. He will testify on VHA's IHS for Native American veterans. He will be accompanied by Mr. Buck Richardson, Minority Veterans Program Coordinator for the Rocky Mountain Health Network and the Montana Health Care System, as well as Dr. James Shore, psychiatrist and Native Domain Lead, VA Salt Lake City Health Care System.

We also have the pleasure on the Indian Health Service side of hearing from Mr. Randy Grinnell, Deputy Director of the Indian Health Service. He is accompanied by Dr. Theresa Cullen, IHS Director of Information Technology.

I want to thank you all for being here. Your full written testimony will appear in the record. I have been informed that we have a vote at about 12:15. I personally would like to get this hearing wrapped up by then, so I would ask you to be concise in your testimony. I know that the Ranking Member, Senator Burr, and Senator Begich have a bevy of questions, as well as myself, and we will get to them as quickly as possible.

With that, I would like to ask Mr. Floyd to begin with your testimony. Thank you all for being here.

STATEMENT OF JAMES R. FLOYD, FACHE, NETWORK DIRECTOR, VA HEARTLAND NETWORK (VISN 15), VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY W.J. "BUCK" RICHARDSON, MINORITY VETERANS PROGRAM COORDINATOR, ROCKY MOUNTAIN HEALTH NETWORK AND THE MONTANA HEALTH CARE SYSTEM, HELENA, MONTANA; AND JAMES SHORE, M.D., PSYCHIATRIST AND NATIVE DOMAIN LEAD, SALT LAKE CITY VA MEDICAL CENTER

Mr. FLOYD. Thank you, Senator Tester. Again, thank you for inviting me to be here this morning at this important hearing. My name is James Floyd. I am Creek and Cherokee, a member of the Muscogee Creek Nation of Oklahoma. As a Native American, I have worked with my own tribe, the Muscogee Creek Nation of Oklahoma, and their Tribal Health Program. I have also worked with the Indian Health Service and currently work with the Department of Veterans Affairs since 1997.

With me on this panel this morning, to my right, who needs no introduction to you, is Buck Richardson, who is the Minority Vet-

erans Program Coordinator for the Rocky Mountain Health Network, based out of Helena, Montana. To his right is Dr. Jay Shore. Jay is the psychiatrist and Native Domain Leader from the VA Salt Lake City Health Care System.

VA remains committed to working with the Department of Health and Human Services to provide high-quality health care for the thousands of American Indian, Alaska Native, and Native Hawaiian veterans who have courageously served our Nation and deserve exceptional care. My written statement, which I request to be submitted to the record today, provides general background information on our work with the Indian Health Service. It reviews accomplishments secured because of our collaboration and concludes with a discussion on the need for the VA and the Indian Health Service to work together to continue to care for our veterans.

The VA and the Department of Health and Human Services, as mentioned earlier, signed a Memorandum of Understanding on February 25, 2003. The MOU expresses the commitment of both Departments and it expresses the need to continue to expand our common efforts to provide quality policy support to local planning and collaboration efforts and charges local leadership to be more innovative and engaged in discharging our responsibilities. The VA has encouraged its field facilities to initiate and maintain effective partnerships at the local level, especially in areas such as clinical service delivery, community-based care, health promotion, and disease prevention activities. We are also interested in promoting management and prevention of chronic diseases, a challenge facing both Departments.

We assess whether we can achieve success through local partnerships or on a national mandate on a case-by-case basis. Both methods have proved effective and productive and these projects have been successful in elements of each.

For example, we recently supported a collaborative expansion of home-based primary care, where 14 VA medical centers have funded to collocate home-based primary care teams at Tribal and Indian Health Service clinics and hospitals. In September of this year, the first veterans began receiving care through this project at two sites.

Much of the progress on the objectives outlined in the MOU have been accomplished through local partnerships. However, national initiatives also influence collaboration between VA and the Indian Health Service. For example, the national focus on outreach in rural health has led both the VA and IHS to develop improved strategies for sharing information and services, such as educational resources, traditional practices, and information technology.

Improving communication and partnerships are essential components of our collaborative efforts and we continue to nurture our relationships both nationally and locally. Our goals include improved access, communications, partnerships, sharing agreements, resources, and health promotion and disease prevention. We have found already incremental expansion of initiatives such as the Tribal Veterans Representative Program and expanded use of telehealth. We are also collaborating to offer more Welcome Home events for returning OEF/OIF veterans, to expand access to care

and develop approaches that address the unique physical, spiritual, economic, and demographic needs of these veterans.

Using shared providers is yet another way to improve access and cooperation. At the local level, several VA and Indian Health Service facilities are sharing providers, including appropriate shared access to the VA's Electronic Health Records for joint projects and patients.

In October 2008, VA established Native Domain, an infrastructure with a Native American focus. It is a national resource on issues related to health care for rural Native American veterans. It includes policy analysis, collects best practices, supports clinical demonstration projects, establishes collaboration with agencies and Native communities, and disseminates information about these populations.

The VA and the Indian Health Service need to continue to work together to ensure within current legal authority that veterans who are eligible for health care from both the VA and the Indian Health Service receive all needed care. The VA and the Indian Health Service continue to discuss changing existing policies and processes in regard to payment for veterans' health care. A resource sharing provision was included in the MOU that I referred to earlier to encourage the development of responsible sharing services to meet the needs of patients and communities.

In conclusion, Mr. Chairman, I thank you again for the opportunity to be here to discuss the importance of establishing and maintaining strong relationships and programs and services between the VA and the Indian Health Service. We are available to answer any questions you may have.

[The prepared statement of Mr. Floyd follows:]

PREPARED STATEMENT OF JAMES R. FLOYD, FACHE, NETWORK DIRECTOR, VA HEARTLAND NETWORK (VISN 15), VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good Morning Mr. Chairman and Members of the Committee: Thank you for inviting me here today to discuss the cooperation and collaboration between the Department of Veterans Affairs (VA) and its Veterans Health Administration (VHA) and the Department of Health and Human Services (HHS) and its Indian Health Service (IHS). Joining me today are Mr. W. J. "Buck" Richardson, the Minority Veterans Program Coordinator, Rocky Mountain Health Network and the Montana Healthcare System in Helena, Montana, and Dr. James Shore, Psychiatrist and Native Domain Lead, VA Salt Lake City Health Care System.

VA remains committed to working internally and in partnership with HHS to provide high quality health care for the thousands of American Indian/Alaska Native (AI/AN), and Hawaiian Native Veterans who have courageously served our Nation and deserve exceptional care. This commitment, in relation to AI/ANs, is principally fulfilled through VHA cooperation and collaboration with IHS. My testimony will provide general background information on our work with the IHS, review accomplishments secured because of our collaboration, and conclude with a discussion on the need for VHA and IHS to work together to take care of these Veterans. I would like to note at the outset that VHA looks forward to working with IHS to improve the quality and availability of care for Native American Veterans throughout the country. We will strengthen our existing partnerships and build new and even stronger associations between VHA and IHS.

GENERAL INFORMATION

VA and HHS signed a Memorandum of Understanding (MOU) on February 25, 2003. In summary, the MOU:

• Expresses the commitment of both Departments to expand our common efforts to improve the quality and efficiency of our programs;

• Provides policy support to local planning and collaboration; and
• Charges local leadership to be more innovative and engaged in discharging our responsibilities.

We expected at that time that most of our progress would be made with effective local partnerships formed between IHS, VHA, and Tribal governments, because these would be best suited to identify local needs and develop local solutions. In this regard, VHA field facilities have been encouraged to initiate and maintain effective partnerships at the local level especially in areas such as clinical service delivery, community-based care, and health promotion and disease prevention. We are also interested in promoting the management and prevention of chronic diseases, a challenge that confronts both VHA and IHS. We anticipated the MOU would lead to creative solutions in case management, home- and community-based care, and primary prevention activities to improve the health of AI/AN Veterans.

Whether success is achieved most effectively through the efforts of local partnerships or with a national mandate is assessed on a case-by-case basis. Both methods have been effective; the challenge is to use the appropriate tool, at the correct time, and in a suitable location. Many times, success is achieved with a combination of national and local efforts. We recently supported a collaborative expansion of home-based primary care (HBPC) that exemplifies how national initiatives can be implemented locally. In this effort, 14 VA medical centers have been funded to co-locate HBPC teams at Tribal and IHS clinics and hospitals. Our goals are to improve access to primary care services and to foster mentoring relationships between VHA staff with geriatric expertise and IHS and Tribal staff. In September, the first Veterans began receiving care through this project at two tribal sites, one in Jackson, MS and the other in Sacramento, CA. We expect the other facilities to be active by the end of the calendar year.

Much of the progress on the objectives outlined in the MOU has been accomplished through local partnerships. However national initiatives also influence collaboration between VHA and IHS. For example, a national focus on outreach and rural health has led VHA and IHS to develop improved strategies for sharing information and services such as educational resources, traditional practices, and information technology (IT) sharing.

Experts in information technology at the Department as well as the VHA and IHS levels are working together to enhance health-care information sharing. This April, representatives from the Office of Information Technology at IHS, VHA's Office of Health Information, and VA's Office of Information and Technology met to develop a comprehensive list of actions needed to strengthen the relationship. The group identified a list of specific activities for collaboration, and work continues to address the tasks identified on that list.

ACCOMPLISHMENTS

VHA and IHS, as the primary implementers, have used the MOU's goals and objectives as a framework for establishing partnerships and accomplishing individual achievements. Our goals include improved access, communications, partnerships and sharing agreements, resources, and health promotion and disease prevention.

Access. A mutual goal of IHS and VHA is to improve beneficiaries' access to quality health care and services. As a tool to ensure steady and effective progress, VHA established a performance monitor for Veterans Integrated Service Networks (VISNs) with significant American Indian/Alaska Native (AI/AN) populations to track and monitor how VISNs were achieving the goals and objectives of the MOU.[1] Examples from the performance monitor reports of how VA's local facilities have brought about easier access to VA services include:

• Establishing transportation programs;
• Using home visits to provide both clinical care and assistance with claims processing;
• Providing supplies and equipment to clinics on Reservations;
• Expanding VA community-based outpatient clinic hours and services; and
• Using fee basis care to facilitate more timely, accessible care, when necessary.

In fiscal year (FY) 2009, the Office of the Deputy Under Secretary for Health for Operations and Management established a new template for VISN semi-annual reporting of VHA/IHS activities. There appears to be steady, incremental expansion of certain types of initiatives across the country demonstrating an increased alignment with current national priorities. These initiatives include:

[1] Four of the 21 VISNs are exempt from this monitor because of the small size of their AI/AN Veteran populations. These include VISNs 4, 5, 9 and 10.

• Increased interest in, training for, and development of the Tribal Veteran Representative (TVR) role across the country;
• Expanded use of information technology and telecommunications efforts, particularly to support telehealth initiatives and tele-mental health;
• Increased number of "Welcome Home" events for Operation Enduring Freedom and Operation Iraqi Freedom Veterans, as well as education and outreach efforts;
• Steady expansion of rural health care initiatives with progress toward bringing services closer to the Veterans being served;
• Continued growth in culturally specific, holistic approaches that address the unique physical, spiritual, economic, age and gender specific needs of the population served; and
• Coordinated efforts between local VHA and IHS entities to increase awareness and communication regarding Veterans' needs and available VHA services, as well as cooperative and creative outreach efforts.

Another tool that VHA and IHS use to improve access is telehealth. Telehealth uses information and communication technologies to provide health care services in situations in which patient and provider are separated by geographical distance. Telehealth, thus, provides a means of providing health care services directly to Tribal communities, obviating the need for AI/AN Veteran patients to travel long distances to receive services. It also supplements health care services available within Tribal communities.

VA has been collaborating with the IHS and other Federal agencies to provide telehealth services in Alaska since 1997, when the Alaska Federal Health Care Access Network began. Subsequent to that first effort, the functionality of the telehealth and telecommunications technologies has improved, and research has substantiated the benefits of telehealth as a means of providing health care to the AI/AN Veterans VA serves. Currently there are seven operational telehealth programs providing services to Tribal communities and nine programs in deployment. VHA telehealth programs to Tribal communities predominantly involve clinical video-conferencing to provide mental health services and home telehealth services for diabetes and mental health conditions.

A cultural competency training program also has been developed and is in use to ensure that providers are sensitive to the particular circumstances of using telehealth to reach into Tribal communities to deliver services. In addition to cultural awareness, other critical success factors to implementing and sustaining telehealth services to Tribal communities include adequate telecommunications bandwidth and meeting appropriate credentialing and privileging requirements.

Using shared providers is yet another way to improve access. At the local level, several VHA and IHS facilities are sharing providers, including appropriate shared access to VA's electronic health records for joint patients; this is demonstrated through the partnership between VHA's Black Hills Health Care System and the Rosebud IHS facility. Nationally, VA and IHS conducted a one-year pilot to test the feasibility of using VA's electronic credentialing system, VetPro, to credential IHS providers. Both VA and IHS participants believed the pilot met its stated goals of ensuring a consistent credentialing process that met all regulatory and agency requirements for IHS facilities and demonstrating the feasibility of national sharing agreements for information sharing between VA and IHS. Decisions about expanding the pilot are pending.

Communications. There have been accomplishments in efforts to improve communications among VA, VHA, AI/AN, HHS, IHS, and Tribal governments and other organizations with assistance from IHS. Sharing information and improving cultural awareness and competencies are crucial to achieving this goal. Relevant information is shared through several methods, including:

• Participation at VHA/IHS conferences and VHA/IHS/Tribal Veteran Service Organization (VSO) meetings, as well as Pow Wows and local community events;
• Outreach to IHS organizations and Tribal Governments, including liaison with VA staff and leadership; and
• Attendance at AI/AN cultural events.

IHS and VA continue to have regular communications at the national level with a working group that meets regularly to exchange information and track the status of several national programs, such as a recent initiative to establish a pilot partnership between VHA's Consolidated Mail Outpatient Pharmacy (CMOP) and IHS' pharmacy program. This pilot will enable IHS beneficiaries to have access to pharmacy services through VHA's nationally recognized CMOP program to process outpatient prescriptions, based upon the electronic prescription data provided from the IHS facilities. The possibility of IHS decreasing capitalization costs, the reduction of needed space to house more drugs and personnel in a centralized space, reduction

of outdated medications, and reduction in the numbers of patients entering IHS facilities on a daily basis will make the use of the CMOP programs an attractive technology for dispensing refills within the IHS. Rapid City, South Dakota and Phoenix Indian Medical Center are currently identified as the participating IHS locations. The coordinating CMOP is in Leavenworth, KS. The necessary service agreement is in place, and IT connectivity and testing have been accomplished. A formal interagency agreement (IAA) is being developed. The pilot will commence as soon as the IAA is in place. The working group ensures that projects such as this remain on track and also identifies other new collaborations that would lead to improvement of services.

The Tribal Veteran Representative (TVR) program is another example of developing and maintaining effective communications at the local level. This program uses volunteers who receive training on VA's health care services and benefits to educate their Tribal members. The concept used in the TVR program has been quite successful. VA and IHS held several coordinated training sessions this spring for IHS Community Health Representatives and the Contract Health Service program to bring the TVR concept to them. The annual TVR training was held at the Naval Reserve training facility at Ft. Harrison, MT during the last week of April 2009. Seventy-two participants from VA, IHS, and different Tribal organizations attended. Also, in May, VISN 7 held a training session for VA's Transition Patient Advocates using the TVR model.

Partnerships and Sharing Agreements. Encouraging partnerships and sharing agreements among VA Central Office and VA facilities, IHS headquarters and IHS facilities, and Tribal governments in support of AI/AN Veterans has been an important to improving access. Local VHA facilities use sharing agreements and partnerships to operate clinics, provide social work, offer laboratory services, and make available other benefits. Again, the success of these projects depends on the strength of local relationships. Building a strong partnership or sharing agreement depends on fostering a trust relationship between the AI/AN community and VHA facility staff and leadership. Meeting the specific needs of a particular community is best done by fostering communications at the local level.

Resources. Resources needed to support programs for AI/AN Veterans include more than just funding projects and services. Time and staffing resources are essential elements to supporting these endeavors and helping AI/AN communities to identify needs, devise mutually agreeable solutions that meet local requirements, and implement projects effectively. In FY 2009, VA, through the Office of Rural Health, acknowledged the need for increasing resources in this area by funding specific projects and establishing a Native American Resource Center.

In October 2008, the Veterans Rural Health Resource Center-Western Region established a Native Domain, an infrastructure with a Native American focus. It is a national resource on issues related to health care for rural Native American Veterans. It conducts policy analysis, collects best practices, supports clinical demonstration projects, establishes collaborations with agencies and Native communities, and disseminates information about these populations.

Health Promotion and Disease Prevention. The final part of the official MOU goal and objective framework is to improve health promotion and disease prevention services to AI/ANs. This has been addressed at the local level with projects ranging from health fairs to diabetes prevention and other educational efforts.

MEDICAL CARE OF DUAL ELIGIBLE VETERANS

VHA and IHS need to continue to work together to ensure, within current legal authority, that Veterans who are eligible for health care from both VA through VHA and HHS through IHS receive all needed care. VHA and IHS continue to discuss changing the existing policies and processes in regard to payment for Veterans' health care. A resource sharing provision was included in the MOU to encourage the development of responsible sharing of services to meet the needs of patients and communities.

There are circumstances where VA, through VHA and its local facilities, contracts with or enters into sharing agreements with IHS, Tribal governments, or Tribal organizations to provide health care services to AI/AN Veterans. Many of these Veterans also are eligible for services from IHS or through Tribal governments or organizations. VA endorses the use of sharing agreements in these circumstances.

CONCLUSION

Thank you again for the opportunity to discuss the importance of establishing and maintaining strong relationships, programs, and services between VHA and IHS at both the national and local levels to effectively meet the health care needs of

AI/AN. VHA is strongly committed to continuing to make VA health care services more accessible to AI/AN, and Hawaiian Native Veterans. In this regard, it may be time to update the MOU and identify additional opportunities for collaboration between VA, IHS, Tribal governments and organizations. We are ready to do whatever it takes to find the best ways to serve the needs of these Veterans. Thank you again for the opportunity to testify. My colleagues and I are available to answer your questions.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO JAMES R. FLOYD, FACHE, NETWORK DIRECTOR, VA HEARTLAND NETWORK (VISN 15), VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. How many sharing agreements has VA entered into with tribes, tribal facilities and Indian Health Service (IHS) facilities? Please provide a list broken down by tribe, tribal and IHS facility, describing these sharing agreements.

Response. Since the initial Memorandum of Understanding (MOU) between VA and IHS in 2003, the amount and variety of activities has steadily increased. Many of the activities are at the national level and reflect an impact on many, if not all, federally recognized tribes. Attached is a spreadsheet that reflects completed and ongoing activities as of March 2010, itemizing partnerships, projects, status, and where appropriate, the tribe(s) or IHS facility.

Question 2. Please provide the Department's best estimate of the number of dual eligible and dual enrolled Native American Veterans. Please also describe how these estimates were determined.

Response. This information is not currently available. A match is technically possible, but extremely difficult. Challenges include, but are not limited to, getting an overall estimate of Native American Veterans from any source and exchanging demographic data.

Standards defining Veterans differ in the VHA and IHS systems. VHA verifies past military service as a condition of enrollment and provides care on the basis of degree of service-connected disability and degree of impairment to determine Veteran status. In contrast, IHS records rely on self-reported Veteran identification.

VHA and IHS continue to explore how to share clinical records and are working through information security, privacy and other issues.

Question 3. Your testimony described a "comprehensive list of actions" to strengthen the VA-IHS relationship. Please provide that list.

Response. VA and IHS have embarked on a comprehensive series of information technology activities as evidenced by the attached spreadsheet. (See Attachment following the response to Question 9.) The list of actions and/or activities referenced in Mr. Floyd's testimony can best be seen on attachment pages 13 to 17. There are also other information technology projects listed throughout the document.

Question 4. Your testimony described a "performance monitor" for Veterans Integrated Service Networks (VISNs) with a significant American Indians and Alaska Native populations to track progress toward achieving the MOU's objectives. Please provide a description of that performance monitor.

Response. A comprehensive monitor was developed in response to the signing of the VA/IHS MOU in 2003; it has been periodically updated since then. This performance monitor defines the MOU's desired outcomes and currently requires the submission of quarterly progress reports from each VISN. The purpose of the monitor is threefold:

- To support continuous improvement in the coordination of patient care between VHA and IHS;
- To encourage referrals between IHS and VHA; and
- To ensure that dual eligible American Indian and Alaskan Native Veterans have coordinated access to appropriate services from both agencies.

For quarterly reports, VISNs are instructed to report their activities in the context of the five objectives set forth in the MOU. These objectives are:

- Improve beneficiary's access to quality health care and services;
- Encourage partnerships and sharing agreements among VA Central Office and facilities, IHS Headquarters and facilities, and Tribal Governments in support of American Indian and Alaskan Native (AI/AN) Veterans;
- Ensure appropriate organizational support for programs targeted to AI/AN Veterans;
- Improve health promotion and disease support for programs targeted to AI/AN Veterans;

• Improve communication among VA, AI/AN Veterans and Tribal Governments with the assistance of IHS.

Question 5. Is VA considering entering into an MOU or sharing agreement with Papa Ola Lokahi and/or the Native Hawaiian Health Systems or other Native Hawaiian entities, to improve care and services for Native Hawaiian Veterans?

Response. Yes. Papa Ola Lokahi is the Governance Structure/Entity that represents the Native Hawaiian Consortium of health care programs active throughout the state on every island. "Papa," as they are referred to, has an executive director, staff, and advisory board.

At this time, VA Pacific Islands Health Care System (VAPIHCS) is exploring the enhancement of services to Veterans residing in the Hana area of Maui. Both a federally Qualified Health Center and a Native Hawaiian Health Care Clinic are serving the health care needs of Hana's population. VAPICHS plans to visit Hana to meet with both entities and discuss their potential roles as partners with VA to care for Veterans.

Question 6. Is VA considering expanding the concept of the Tribal Veteran Representative to be inclusive of Native Hawaiians?

Response. Yes. The Tribal Veterans Representative (TVR) program is national in scope and the VA Pacific Islands Health Care System is identifying Native Hawaiian candidates to train as TVRs. The Native Hawaiian TVR program will likely be somewhat different than the AI/AN TVR program because it will serve a different population.

Question 7. Please provide a description of the Native American Resource Center mentioned in VA's testimony.

Response. Over the past decade, VHA has taken important steps toward meeting the health care needs of Native Veterans who reside in rural areas. These have occurred nationally and at the local level as collaborations have developed between regional VHA medical centers and tribal programs. VHA's Office of Rural Health (OHR) recently established the Veterans Rural Health Resources Center—Western Region (VRHRC-WR) with a special population focus on rural Native Veterans—the Native Domain. The Native Domain is intended to serve as a national resource on issues surrounding health care for Native rural Veterans through conducting policy analysis; collecting best practices; fostering clinical demonstration projects; coordinating and partnering with agencies and Native communities; and disseminating information about these populations.

The Native Domain has defined Native Veterans to include American Indians, Alaska Natives, Native Hawaiians, and Pacific Islanders. Of note, Native Veterans comprise the largest proportion of Veterans living in rural areas. The major philosophy of the Native Domain is defined by the theme of national scope with a local focus.

Given the considerable cultural, social and geographic diversity of rural Native Veteran populations, it is important to acknowledge that while VHA policy is national in scope by its very nature, VHA programs and activities targeted at this population may benefit from policy strategies that embrace a national scope while maintaining a local focus. Such programs effectively honor the cultural uniqueness of each tribal, village, and islander group to address their health care needs.

Question 8. During a pre-hearing briefing, a VA representative told Committee staff that VA has replaced the Chaplain guidelines concerning American Indian and Alaska Native traditional practitioners with a more comprehensive guideline. Please provide a copy of that guideline.

Response. The Revised VHA Handbook 1111.02, "Spiritual and Pastoral Care Procedures," dated July 18, 2008, did not replace the Chaplain Service Guidelines concerning American Indian and Alaskan Native Practitioners. The Chaplain Service Guidelines and the VHA and Indian Health Service (IHS) Memorandum of Understanding from November 2005, are referenced in the Handbook, which is official VHA policy. Both documents are still in use by VHA and the Handbook strengthens the Chaplain Service Guideline document. The four references to "American Indian and Alaskan Native Veterans" are highlighted on pages 11, 13 and 24, in the attached Handbook 1111.02. The Chaplain Service Guidelines Concerning Native American Indian Traditional Practitioners are also attached.

Question 9. An FY 2005 VHA-IHS issue update stated that ". . . the leadership of each organization has been asked to develop a joint policy for the coordination of health care for dual use Veterans." Please comment on progress toward that joint policy, and whether VA and IHS are still working toward that goal.

Response. In FY 2007, a Work Group was established to develop VHA Directive entitled, "VHA and IHS National Inter-Departmental Coordinated Care Policy." VA and IHS continue to make strides toward this goal.

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Completed VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goal**	**Project Actions**
Steering Committee	Coordinate collaborations between Veterans Health Administration (VHA) and IHS	**12/06/09** - VHA and IHS decision made to combine steering and advisory committees into one.
Behavioral Health/American Indian and Operation Iraqi Freedom Welcome Home	Reintegration materials creation and use by VISN 19. Identify sites for materials and partnership with National Indian Health Board (NIHB) and Tribes.	Project is complete at the national level. VISN 19 created and is using reintegration materials. Additional sites need to be identified and partnership with NIHB and Tribes need to be pursued. Follow-up with Arizona and Oklahoma (Cherokee, Choctaw) tribes is needed.
Administration on Aging Federal Interagency Task Force on Older Indians	Participate in the Administration on Aging's (AoA) National Training and Technical Assistance Forum and Listening Session from April 30 to May 3, 2007	National Project is completed. At the meeting of the Federal Interagency Task Force on Older American Indians convened by the AoA on October 24, 2006, consensus was reached that those agencies present would participate in the National Training and Technical Assistance Forum and Listening Session from April 30 to May 3, 2007 at the Radisson Plaza Lord Baltimore Hotel in Baltimore, MD. The Forum brought to Baltimore officials representing most of the 243 tribes that AoA funds under Title VI of the Older Americans Act. VA participated in the Forum and Listening Session.
Diabetes Prevention Program	Develop Diabetes Prevention Program to impact Native American Veterans	**5/20/08** - Presented the final report for the Diabetes Prevention Program. Minutes from this meeting are available for discussion of the report. Specific purpose funds were given to 3 locations (San Diego and Los Angeles, CA and Albuquerque, NM) to develop diabetes prevention programs. The three projects were each given about $60,000 for the initial year and $52,000 for the second year.

Last updated: 7/2/2010

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
IHS/VHA Joint Website	VHA/IHS collaborations regarding websites	**1/20/10** - VHA is ready to work with IHS regarding the review previously completed. **10/23/09** - A review has been completed. Work continues on establishing connections between VA and IHS websites.
Tribal Veteran Representative (TVR)	On-going program to recruit and train tribal volunteers to become knowledgeable about VA benefits and programs (i.e., VBA, VHA, and NCA)	**10/27/09** - There have been several informal trainings over the summer for the TVRs and the Tribal Outreach Workers (TOWs) of the telemental health program. There have also been outreach efforts at 10 powwows in an effort to enroll new Veterans and also help Veterans and their families begin new claims or work on existing claims. During August, a TVR was asked to go to CS&K College at Pablo, MT, and tape a show for "Good Medicine" which is aired on the public broadcast network of the college station of the Tribal network in the community about the TVR program, telemental health program, and VA outreach in Native communities. In September, 12 TVRs traveled to South Dakota for the "Gathering of the Healers" which is held in the Black Hills by VISN 23. These TVRs are asked to help with the training for VA employees and the viewpoint of Native Veterans using VA services and returning from service in the military. During October, TVRs attended the Flathead Warrior Society to the Montana Crime Stoppers Convention for a presentation about the TVR program and outreach efforts. The Warrior Society was the Honor Guard for the opening ceremonies of the convention.
Nurse Internships/ Residencies	Establish opportunities for IHS staff to receive clinical nursing training and experience in VHA facilities	**1/20/10** - Nursing leadership from both organizations have met to discuss best practices that support impactful strategic planning for nursing services. Follow-up discussions are planned to concentrate on strategies to advance nursing informatics support to enhance nursing efficiency and effectiveness. **10/23/09** - Work continues to enhance training opportunities in VHA for IHS clinicians. Three face-to-face meetings have occurred between the IHS Division of Nursing (DNS) and VHA Office of Nursing Services (ONS) Headquarters staff and other nursing leadership to explore and facilitate increased collaboration between the nursing programs of the two organizations. It was quickly identified that two areas for collaboration in nursing were nurse training and nurse staffing. IHS has historically had difficulty recruiting experienced nurses for its operating room, post anesthesia care unit, and intensive care unit specialties. Numerous VHA facilities provide these types of complex services and can provide a rich didactic and clinical experience for nurses with minimal or no experience in these specialties. While several IHS and VHA sites were identified for further planning, a changeover in

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
		nursing leadership at those sites occurred and planning was stalled. Discussion however has resumed on this activity between the IHS and VHA in Muskogee, OK area and Phoenix, AZ area. VHA is implementing and testing a nationally standardized staffing methodology for nursing personnel. VHA's system is automated, driven by data on nursing workforce, patient needs, and nurse skill mix. It ultimately will reflect nurse staffing impact on patient outcomes. IHS is in the process of updating its Inpatient Nursing Resource Requirement Methodology (RRM) which defines the nurse staffing required to staff a new facility as well as the Inpatient Patient Acuity Package which identifies the hours of nursing care required in a 24 hour period for patients. In light of these activities, IHS nursing leadership met with VHA nursing leadership at the Jack C. Montgomery VA Medical Center in Muskogee, OK to further explore what each organization was doing. As a result, VHA has offered to work with IHS in further exploring the relationship between nurse staffing, nursing practice, and patient outcomes.
Educational Sharing	Share educational materials between organizations	During the first quarter of FY 2010 VHA delivered 88 training programs to IHS staff and the tribal community. Eight were made available using satellite technology and 80 were made available using web-based technology. The direct cost avoidance generated by the satellite programs is $120,000 and the cost avoidance generated by sharing web-based training is $2,800,000 for an aggregate cost avoidance of $2,920,000.
Traditional Practices	VA-IHS efforts surrounding traditional Indian practices	Next steps include: 1. Increase the satellite training programs shared with IHS during the first quarter of FY 2010. 2. Implement a plan for enhancing the shared training architecture between IHS and VHA to support increased web-based training for IHS. 3. Share additional web-based health care management training courses with IHS during the first quarter of FY 2010.

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
		1/20/10 - At least one additional VA medical center (VAMC) is considering opening a sweat lodge; the National VA Chaplain Center (NCC) is providing guidance. The NCC has submitted a proposal to the Office of Rural Health (ORH) to provide community clergy training regarding the needs of returning Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans in rural settings. While the sites have not been selected, an area with a large population of American Indian/Alaskan Native Veterans is being considered. The NCC now has 10 American Indian/Alaskan Native Traditional Practitioners, having added five in 2009.
Care Coordination (Transfer and Payment Policy)	Care Coordination of VA-IHS Transfer and Payment Policies	**10/23/09** - Projects funded through ORH may provide best practices and models that could be replicated elsewhere. **6/09** - Reported to Workgroup that discussions continue regarding potential pilots of different models of coordination of care. The focus is to identify best practices and then pilot those to confirm what works best.
Employment Initiatives	Increase and strengthen employment opportunities, outreach, and resources	**10/23/09 -** Work continues to enhance materials and recruiting among Native Americans. Currently, a link is established between IHS' and VHA's websites regarding employment.
Telehealth collaboration	Increase access to health care for American Indian and Alaskan Native Veterans via telehealth	**1/20/10** - VISN 19 is applying tele-health and tele-mental health services Veterans Integrated Service Network-wide (VISN) through four VA health care systems (Sheridan VAMC, Montana Health Care System, Salt Lake Health Care System, and Grand Junction VA Medical Center) to 12 Tribes (Northern Arapaho, Eastern Shoshone, Northern Cheyenne, Crow, Gros Ventres/Assiniboines, Chippewa Cree, Sioux, Confederated Saleesh (Flathead), Blackfeet, Shoshone Bannock, Ute, and Navajo). Five locations are operational (Riverton CBOC, Fort Washakie Clinic, Lame Deer Clinic, Crow IHS Clinic, Fort Belknap Service Unit, and Rocky Boy Tribal Health). Fort Hall Service Unit has completed connectivity, has in place a TOW) and is recruiting patients. The Fort Peck Service Unit also has completed connectivity and is currently contracting a TOW. Flathead IHS Clinic, Montezuma Creek Clinic and Blackfeet IHS Hospital are in deployment with connectivity. Blackfeet IHS Hospital also has a TOW in place. The Uinta & Ouray Indian Health Center is awaiting connectivity.

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
Joint Map of VHA and IHS medical facilities	Design map showing VHA and IHS medical facilities	**10/23/09** - Map developed for a Home-based Primary Care (HBPC) project. Decisions pending regarding next steps.
HBPC: Collaboration regarding elder care including Indian Health Service HBPC	Expansion of HBPC to Indian Country via collaboration with IHS and Tribal hospitals and clinics	**2/1/10 -** Fourteen VAMCs funded for this initiative. HBPC teams will be co-located at tribal and IHS clinics and hospitals. Will result in improved access to primary care services and mentoring between VA staff with geriatric expertise and IHS/tribal staff. First Veterans served in September 2009 at two sites. GEC also received funding to convene a Rural Health and Indian Health Conference in the summer of 2010.
Urban Indian Programs	Identify how VA and IHS can collaborate in projects involving the IHS Urban Indian Program.	**5/09** – The TVR reported that the TVR program is discussing how to work the program in more urban areas.
VHA Performance Monitors	Track progress of services provided to American Indian/Alaska Native Veterans	**3/4/10** – VHA delivered a report for Congress (to the Senate Appropriations Committee) on activities conducted in FY 2009. **1/14/10** - VHA prepared a report for Congress on activities conducted in FY 2009. **10/23/09** - Summary report of VA initiatives for FY 2009 was compiled. **6/3/09** - Traditional Practices survey report completed and distributed **11/24/08 -** Deputy Undersecretary for Health for Operations and Management's VHA/IHS monitor template revised for FY 2009 and distributed to the field for semi-annual reporting of network VHA/IHS activities.
VHA Office for Rural Health (ORH)	Identify how VHA can improve health care services to American Indian, Alaskan Native, and Pacific Islander Veterans who live in rural areas	**1/5/10** - Request to increase Office of Rural Health by an additional 4.0 full-time equivalent employees (FTEE) was approved by the Resource Management Committee, including 1.0 Program Analyst (Indian Health Specialist).
VHA ORH - Juneau Outreach Clinic	Provide health care services to American Indian, Alaskan Native, and Pacific Islander Veterans who live in rural areas surrounding Juneau, AK	**3/31/10** – The Coast Guard currently provides lab services for the clinic and this will continue after the move to the new space. **1/20/10** - Continued progress, Operating Agreement with the Coast Guard is in place to provide temporary space for the Juneau Outreach Clinic until their permanent space is completed in the summer 2010. The Juneau Outreach clinic operates 28 hours a week and provides primary care services to patients.

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
	(VISN 20).	The Juneau Clinic in VISN 20 began operations in September 2008 supporting local Veterans. ORH funding provided the start-up and sustainment funding to allow the clinic full operations through 2010.
VHA ORH - Teledermatology	The objective of this project is to implement a teledermatology consultation system with three components: 1) traditional store-and-forward teledermatology; 2) structured follow-up care; and 3) a consistent, defined curriculum of basic precepted training and continuing education at VA sites across VISN 20.	**1/20/10** - Two Alaska Health Care System (AHCS) employees received training in August 2009. Working out of Anchorage, staff has started providing care to patients with the program slowly expanding.
VHA ORH - National Care Coordination Home Telehealth (CCHT) project, which includes a planned expansion into Alaska	This project will support the increase of VHA enterprise-wide telehealth programs that will expand access to care nationally for Veterans living in rural areas by supporting and expanding the care coordination home telehealth (CCHT) program. CCHT focuses on patient self-management and disease management via a range of telehealth technologies that include messaging, monitoring, and	**1/20/10** - A registered nurse was recruited in July 2009 and has received training. She is working out of the Kenai CBOC.

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
	video devices.	
VHA ORH - Care Coordination Store and Forward (CCSF) project, which includes funding for teleretinal imaging equipment planned for the Kenai, Alaska CBOC	This project will support the increase of VHA enterprise-wide telehealth programs that will expand access to care nationally for Veterans living in rural areas by supporting the expansion of the CCSF program. The majority of CCSF activity that takes place in VA is for teleretinal imaging to screen for diabetic retinopathy, teledermatology, or tele-pathology.	**1/20/10** - Staff has received training and has initiated treating patients.
VHA ORH - Care Coordination General Telehealth (CCGT) project, which will benefit Veterans across all of VISN 20, including Alaska	This initiative will support the increase of VHA enterprise-wide telehealth programs that will expand access to care nationally for Veterans living in rural areas by supporting and expanding the care coordination general telehealth (CCGT) program. CCGT uses clinical videoconferencing to provide consultation or care to patients situated at geographically distant sites.	**1/20/10** - Staff has received training and has initiated treating patients.

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
VHA ORH-Expanding Fee Based Care	The project is designed to expand fee-basis primary care for rural and highly rural Alaskan Veterans and impact approximately 600 enrolled Veterans.	**1/20/10** - To date, 100 of the 600 potential Veterans have enrolled in the program.
VHA ORH - Clinical Demonstration Pilot Program-Telepsychiatry Clinics for American Indian Veterans on Rural Reservations	This Clinical Demonstration Pilot Program (CDPP) will establish tele-psychiatry clinics for American Indian Veterans on rural reservations. Residents will be recruited for 2009-2010 and a consultation provided for the clinics to assist in developing tele-family focused therapy (FFT) and tele-geriatric care. The final product will be data gathered from the clinic creation process to be used for mental health guidelines.	**1/20/10** - Continued progress, currently working on MOU solidifying clinic structure.

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
VHA ORH - Creation of an Infrastructure for Native Focus	This project will examine the current health care policies for rural Native Veterans and provide recommendations for further policy development. The Western Region Veterans Rural Health Resource Center has hired a Native Consultant to assist in reviewing health care policies on rural native Veterans. The study leads will then prioritize issues to make healthcare policy recommendations and present three detailed health care policy benchmark reports concerning rural American Indian, Alaskan Native, and Pacific Islander populations. The report will discuss next steps for policy development for health care for each rural native population and prioritize recommendations for further work.	**4/6/10** – Two white papers have been submitted to ORH for review. A third white paper is being developed.

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
VHA ORH - Guidelines for the Design and Implementation of American Indian, Pacific Islander, and Alaskan Native Tele-mental Health Clinics	The purpose of this project is to provide guidelines for the design and implementation of American Indian Veteran Telemental Health Clinics. This project will examine service utilization, cost and semi-structured interview data to assess the programmatic outcomes achieved by tele-psychiatry clinics, with a particular emphasis on the clinics' feasibility, sustainability and cost. This project will further examine factors influencing the diffusion and adoption of tele-psychiatry by tribal, state, and federal organizations. Guidelines and recommendations for developing similar programs will be disseminated at the end of the first project year. During the third project year, project leads will assess the inclusion of these guidelines by the VA and IHS policy bodies. Final products from this project will include a manuscript and conference	**1/20/10** - Hiring Denver-based staff to support work; currently work underway with revised timeline. No applicants for position internally, therefore, posting positions externally.

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
	presentations.	
VHA ORH – Tele-home Care for Rural Veterans with PTSD: Adaptation for Native Focus	Researchers will design a tele-mental health program to address Post-traumatic Stress Disorder (PTSD) in rural and American Indian Veterans as an adaptation and service demonstration project. Final products will include a clinical manual, the dissemination of American Indian experiences, results, and satisfaction levels.	**1/20/10** - Clinical pilot continues on time.
VHA ORH - Establishment of Saipan, Commonwealth of the Northern Mariana Islands (CNMI) VA Outreach Clinic and Rural Health Coordinator	This project will implement a VA Outreach Clinic in Saipan, CNMI, to include contracted part-time providers, on-island VA provider(s), and an on-island tele-health capability. It will also establish a Rural Health Coordinator position at VA Pacific Islands Health Care System (VAPIHCS) who will be responsible for all aspects of the community health needs assessment for all	**3/10/10** -The Saipan, CNMI Outreach Clinic opened March 29, 2010, and provides primary care, mental health, and telehealth services to the native population.

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
	VAPIHCS locations/islands.	
Readjustment Counseling Service (RCS): Services Provided and Use of Mobile Vans	In addition to providing services through Vet Centers on or near Tribal lands, VHA is working on how best to use RCS mobile vans to provide care in rural areas, including Tribal areas.	**1/20/10** - Update on RCS outreach to Tribal areas requested. **1/09 -** First deployment of RCS mobile vans.
National Congress of American Indians (NCAI) Participation	Increase communications between VA and American Indian stakeholders.	**3/20/10 -** Secretary of Veterans Affairs spoke at NCAI's meeting. **10/23/09** - TVR met with NCAI regarding educational opportunities in Montana. Center for Minority Veterans (CMV) provided the presentation given by the Secretary of Veterans Affairs at NCAI's meeting in 2008.
Information Technology	Strengthen VA-IHS Information Technology for American Indian, Native Alaskan and Pacific Islander Veterans.	**1/20/10** - VA currently has seven information technology projects in various stages of developing that include electronic records, VistA Imaging, Implementation of Bar Code Medication Administration, Clinician Graphical User Interface, VA Emergency Department Application, and Implementation of the Master Patient Index.
CMV American Indian/Alaskan Native Veterans Initiatives	Enhance IHS - VA CMV initiatives and outreach	**10/27/09** - United South and Eastern Tribes, Incorporated (USET), signed USET Resolution No 2009:018, FORMATION OF A VETERANS COMMITTEE on February 12, 2009. USET is an intertribal organization comprised of 25 federally recognized Tribes ranging from Maine to Florida and Florida to Texas. Each Tribal Leader will designate one Tribal member (a Veteran) to be a member of the Veterans Committee. Representatives from CMV have attended and will attend several Committee meetings in the fall of 2009.

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
VA/IHS Suicide Prevention Collaboration	1. VHA Suicide Prevention Office and IHS will maintain liaison with other federal agencies to coordinate its suicide prevention activities. 2. VHA and IHS will develop and disseminate public health messages targeting American Indian and American Native Veterans and their families related to suicide prevention, the availability of the Hotline, mental health issues, and the availability of effective mental health care through the VA and IHS.	**3/12/10** - Collaboration is being reviewed at present. IHS will be added to VA Suicide Prevention Communications Committee. Invitation is being drafted. VHA will ask IHS to speak to VA Suicide Prevention Coordinators (SPCs) at the July meeting if Collaboration approved at IHS.
Electronic Health Records Sharing - Nationwide Health Information Network (NHIN)	Explore opportunities to electronically share health records	**2/16/10** - IHS invited to participate in VA NHIN Stakeholder conference calls. Action: VA to take lead on determining next steps in terms of identifying and meeting IHS needs. **1/12/10** - IHS invited to participate in VA NHIN Stakeholder conference calls. IHS staff met with Ann Arbor development staff in October 2009 to discuss Medical Domain Web Services (MDWS). History: IHS wants to implement VistaWeb and VA's Adapter to the NHIN-C gateway to evaluate interfacing with Resource and Patient Management System (RPMS). This entails IHS getting a copy of source and documentation, plus access to some question-answering resources.

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
Pilot test of VHA Central Mail Out Pharmacy (CMOP) services to IHS	Explore opportunities for IHS to use VA-CMOP	**3/23/10 -** "Business agreement" Memorandum of Understanding (MoU) has been signed by VA and is on its way to IHS for signature. The next step will be alpha testing. The initial sites are Rapid City, SD (as soon as the Inter-Agency Agreement (IAA) is signed) and the Phoenix Indian Medical Center (PIMC) (Summer 2010). Action: Pilot planning; a call is being set up for April 6. **1/4/10** - Proceeding as planned. Once signed by VHA, the IAA will be forwarded to IHS for their signature. Initial testing was completed successfully. CMOP build will be released in next IHS pharmacy software patch (but not placed on any menus at that time). Next step will be alpha testing at Rapid City, SD as soon as an IAA is in place. Project contacts to continue current work. History: Opening of all necessary ports has been completed, and the first successful end-to-end messaging loop connecting IHS to VHA CMOP occurred 9/15/09. Next steps will be to exercise full CMOP functionality in pilot test mode. Action: Project contacts to continue current work.
Support for IHS Implementation of VistA Rational Application Developer(RAD)/VistA Imaging	Explore opportunities for IHS to use VA's VistA RAD/ VistA Imaging	**3/23/10** – FY 2010 IAA for funding awaiting final cost figures from VA's Office of Enterprise Development (OED) cost figures. Supplementary Project Agreement (SPA) has been signed in VHA's Office of Health Information and VA's OED, is being sent to IHS for signature. Action: IHS to sign SPA. VA's Office of Information and Technology (O&IT) to provide final numbers for support costs, after which funding IAA will be finalized and concurrence/signature initiated. **1/4/10** – FY 2010 IAA development nearing completion. History: FY 2010 IAA is in under development Implementation planning continues. Changes in VA IT will require more formal business ownership and support in both VA and IHS. New version of SPA drafted for review/signature by OI&T.

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
Shared Use/IHS Implementation Support of Bar Code Medication Administration (BCMA)	Explore opportunities for IHS to use VA-BCMA	**3/23/10** - 1) VHA's Bar Code Resource Office and IHS are discussing how to scope an agreement to support services to IHS and Tribal facilities implementing BCMA. The details have yet to be worked out. 2) Once basic parameters are established, a cross-functional, interagency team will be formed and charged with defining the implementation plan, documentation, support processes, interagency agreements, potential costs, and so forth. 3) Business Requirements document drafted for an IHS implementation project and a charter for a cross-functional team, and IHS staff has reviewed the documents. 4) IHS developed patches to the VA's BCMA applications (server and graphical user interface) to accommodate use in IHS facilities. The patch causes the application to recognize where it is running and to behave accordingly, specifically with recognizing the formatting of the bar code and the display of the patient identifier (health record number as opposed to social security number). 5) The patches were tested and are running at two information technology facilities – Fort Defiance, AZ and Cherokee Indian Hospital Authority (CIHA), NC. However, these facilities are running an older version of BCMA. IHS Pharmacy experts have asked for a moratorium on further deployment of BCMA until it can be updated to the current VA version, for patient safety reasons. 7) VA has the patches and will incorporate them into a national release of BCMA planned for November 2010. 8) The current BCMA version is dependent on certain VistA Pharmacy patches, which are in turn dependent upon Code Set Versioning. That means that until IHS releases and deploys CSV, and subsequently updates RPMS Pharmacy with the VA patches, IHS is holding off on deployment of BCMA to the rest of the field. 9) BCMA will be required for Meaningful Use under the CMS criteria, so the need is now more urgent for IHS. Action: VA OED to incorporate the patches in the next release candidate. IHS to have Medsphere set up an RPMS platform with current VA software by August 1, 2010 so that the VA-generated alpha version of BCMA 3.x with IHS patch included can be tested prior to being finalized.

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
		1/13/10 - 1) VHA Bar Code Resource Office has offered support services to IHS and Tribal facilities implementing BCMA. 2) In the process of putting together a cross-functional, interagency team that will be charged with defining the implementation plan, documentation, support processes, interagency agreements, potential costs, and so forth. 3) Business Requirements Document drafted for an IHS implementation project and a charter for a cross-functional team to look at development of an IAA and Supplemental Agreement and requested review and response. Initial call held between VHA and IHS staff, IHS review of documents pending. History: NSR filed to get IHS patch for non-SSN lookup and for display of ages <1 yr into VA core BCMA release. VA and IHS development staff have discussed what is needed to get the patch in place. Target date for incorporation of IHS patch in BCMA v3 release and testing by IHS is now 9/2010. This is a result of both VA development process and IHS readiness to test v3 (requires getting Code Set Versioning and Pharmacy patches in place). Being on the same version of BCMA software is a pre-requisite for a support agreement. VA-VHA-IHS Management agreed to pursue feasibility of support arrangement. **1/12/10** - VA provided a demonstration which showed the modular worksheet for electronic data information source (EDIS) supported by content containers and clinical components, visited Ann Arbor to review the capabilities of MDWS and Apollo, and participated in an IHS meeting to discuss SOA initiatives including current plans to migrate the EDIS 1.1 software to being a MDWS client and for EDIS to support the wider CPRS-ReEng type features. Discussion of Open Source may or may not influence this. Action: Determine level of IHS interest in pursuing common platform and whether possibility of joint work with VA/VHA will be pursued. While there is overlap with the Emergency Department (ED) project, it is NOT the same thing as establishing a common platform as a shared goal. History: The VA/VHA HealtheVet Desktop project was terminated, and there is no stated VA approach to a component-based framework for GUI applications. IHS is continuing with the ViewCentric framework, and there is some recent indication that "open use" status may be achievable.

Department of Veterans Affairs (VA) – Indian Health Service (IHS) Action Items

Current VHA-IHS Project Areas/Initiatives		
Project Name	**Project Goals**	**Recent Highlights of Actions Taken**
Collaboration on Future Clinician Graphical User Interface (GUI) Application	Exploring opportunities for VA and IHS collaboration on Future Clinician GUI Application	**1/12/10** - VA provided a demonstration which showed the modular worksheet for EDIS supported by content containers and clinical components, visited Ann Arbor to review the capabilities of MDWS and Apollo, and participated in an IHS meeting to discuss SOA initiatives including current plans to migrate the EDIS 1.1 software to being a MDWS client and for EDIS to support the wider CPRS-ReEng type features. Discussion of Open Source may or may not influence this. Action: Determine level of IHS interest in pursuing common platform and whether possibility of joint work with VA/VHA will be pursued. While there is overlap with the ED project, it is NOT the same thing as establishing a common platform as a shared goal. History: The VA/VHA HealtheVet Desktop project was terminated, and there is no stated VA approach to a component-based framework for GUI applications. IHS is continuing with the ViewCentric framework, and there is some recent indication that "open use" status may be achievable.
IHS evaluation of VA Emergency Department Application	Exploring opportunities for IHS to use VA's Emergency Department Application	**3/23/10** - Connectivity to the development and demonstration servers should be available; VA has provided IHS with links for testing the connection. **1/12/10** - Also see updates under Collaboration on Future Clinician GUI Application project (above). Addition of the development and demonstration servers to the VA-IHS virtual private network (VPN) tunnel was approved by VA business owner and ISO, and request was submitted to VA NetOps on 12/17/09 together with a request for the VA ESCCB to approve the ports needed. **History**: IHS has obtained a copy of the VistA and GUI components.
Support for IHS implementation of Master Patient Index (MPI)	Exploring opportunities for IHS to implement VA's MPI	**1/12/10** - Working on the paperwork for the Beta sites (Fort Defiance, Hopi, White River and PIMC). IHS has a flat file extract that will be loaded on the Beta sites. Data will be uploaded into the MPI to refresh it. Resolving which message types that need to be completed that weren't resolved during the pilot. Action: While IHS will not be implementing VA's MPI, some assistance from VHA/VA is required to address questions regarding integration of MPI with Patient Information Management System (PIMS). **History**: IHS has started testing implementation of the SUN open source MPI linked to RPMS.

Last updated: 7/2/2010

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Senator TESTER. Thank you for your testimony, Mr. Floyd. Mr. Grinnell, if you would proceed with your testimony.

STATEMENT OF RANDY E. GRINNELL, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY THERESA CULLEN, M.D., DIRECTOR OF INFORMATION TECHNOLOGY, INDIAN HEALTH SERVICE

Mr. GRINNELL. Mr. Chairman and Members of the Committee, good morning. I am Randy Grinnell. I am the Deputy Director for Indian Health Service. Today, I am accompanied by Dr. Terri Cullen. She is the Chief Information Officer and a family practice

physician, and we are pleased to have the opportunity to testify on the collaboration of the IHS and the Veterans Health Administration.

The Indian Health Service in the Department of Health and Human Services is a health care system that was established to meet the Federal trust responsibility to provide health care to American Indians and Alaska Natives, with the mission to raise their physical, mental, social, and spiritual health to the highest level. The IHS provides the comprehensive primary care services and public health services through a system of IHS-operated, Tribally-operated, and urban-operated programs and facilities that were based on treaties, judicial determinations, and Acts of Congress. This system serves nearly 1.5 million American Indian and Alaska Natives through these health facilities in 35 different States, and in many cases, they are the only source of health care in many remote and poverty-stricken areas of this country.

The partnership between the IHS and the VHA started in the mid-1980s in the area of health information technology. The Resource and Patient Management System, or RPMS, is the IHS's comprehensive health information system that was created to support high-quality care delivered at several hundred facilities throughout the country. This system is a government-developed and owned system that evolved alongside the VHA-acclaimed VISTA system.

IHS and the VHA have also collaborated in the implementation of the VA's VISTA imaging system now in use in the IHS at over 45 sites. This system allows clinicians to have access to images and data that assists them in making better clinical decisions.

Several individuals today have talked about the MOU between the IHS and the VHA. I am not going to go into detail about that for time's sake.

I did want to mention that our system—we currently estimate that there are about 45,000 veterans that are registered within our system, and that includes both the IHS-operated facilities as well as the Tribally-operated facilities. In some cases, these veterans also live in urban locations and may not have access to these facilities that are out on the reservations and within Indian Country and they have to rely on limited urban health programs as well as any local facilities that may be available for their care.

IHS also recognizes the complexity of the Contract Health Care Program that has been mentioned several times today in other testimonies. As identified, there are rules and regulations that we must adhere to. In many cases, this presents a challenge in addressing the care needs of both our elderly users as well as those Indian veterans.

I would like to talk about some of the collaborations that have currently taken place. Because of the IHS's experience with traditional healing, this has assisted the VHA in modeling how to incorporate traditional approaches into healing for Indian veterans. VHA's development and use of the Tribal Veterans Representative Program has been and is critical to communication and reducing barriers for VA services as well as assisting those veterans in understanding the IHS Contract Health Service Program and its rules and regulations.

As mentioned earlier in some of the testimony, the Alaska area has partnered since 1995 via the Alaska Federal Health Care Partnership that includes not only the IHS and the Alaska Native Corporation, but the VA, Army, Air Force, and Coast Guard partners. They have numerous initiatives, including teleradiology, telehealth monitoring, and telebehavioral health, as well. Some of their past projects have also included the Alaska Tribal Health System Wide Area Network.

In Arizona, the IHS and VHA have worked together to increase mental health services by the VA locating social workers in several of the Navajo facilities as well as the Hopi Reservation facility.

In Montana, the Billings Area IHS and the VA have worked together to establish tele-psych at each of the service unit locations to provide mental health services. Each of these service units also have a designated VA liaison to assist the veteran in understanding and accessing the services there.

At this time, there is a pilot project underway between the IHS and VHA to where we are looking at the VA's consolidated Outpatient Pharmacy Program to assist us in processing outpatient prescriptions. This program, we feel like would be a real benefit to our eligible users because it will decrease our cost and also allow more time for our pharmacists to provide clinical care, as well.

Some future opportunities between the two partnerships is intended to improve access and to increase since 2003, but IHS acknowledges that our joint efforts on issues related to access to health care for Indian veterans needs to continue.

I would like to say that because Dr. Roubideaux is not available today—she is currently at the meeting that the President has with the Tribal leaders—but she is totally committed to continuing this partnership and looking at new ways to improve the relationship and also to further services to Indian veterans.

Mr. Chairman, that concludes my testimony. We are here to answer any questions you may have.

[The prepared statement of Mr. Grinnell follows:]

PREPARED STATEMENT OF RANDY E. GRINNELL, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee: Good afternoon. I am Randy E. Grinnell, the Deputy Director of the Indian Health Service (IHS). I am accompanied by Theresa Cullen, M.D., Director, Office of Information Technology. I am pleased to have the opportunity to testify on the Indian Health Service-Veterans' Administration (VA) collaboration.

As you know, the Indian Health Service plays a unique role in the Department of Health and Human Services because it is a health care system that was established to meet the Federal trust responsibility to provide health care to American Indians and Alaska Natives. The mission of the Indian Health Service is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The IHS provides high-quality, comprehensive primary care and public health services through a system of IHS, Tribal, and Urban operated facilities and programs based on treaties, judicial determinations, and acts of Congress. This Indian health system provides services to nearly 1.5 million American Indians and Alaska Natives through hospitals, health centers, and clinics located in 35 States, often representing the only source of health care for many American Indian and Alaska Native individuals, especially for those who live in the most remote and poverty-stricken areas of the United States. The purchase of health care from private providers through the Contract Health Services program is also an integral component of the health system for services unavailable in IHS and Tribal facilities or, in some cases, in lieu of IHS or Tribal health care programs. IHS accomplishes a wide array of clinical, preventive, and public health activities, oper-

ations, and program elements within a single system for American Indians and Alaska Natives.

AMERICAN INDIAN/ALASKA NATIVE VETERANS' DUAL USE OF IHS AND VHA

In 2006, a joint VHA-IHS study was initiated to review dual use of the two systems by American Indians. The findings of this study indicate that American Indians and Alaska Natives using the VHA are demographically similar to other VHA users with similar medical conditions, such as Post Traumatic Stress Syndrome (PSTD), hypertension, and diabetes. To date, the review has found that dual-users are more likely to receive primary care from IHS, and diagnostic and mental health care from the VHA. They are likely to be receiving complex care from VA and IHS.

Many American Indians and Alaska Natives are eligible for healthcare services from both Indian Health Service and Veterans Health Administration. IHS has an estimated 45,000 Indian beneficiaries registered as veterans in the agency's patient registration system. Some American Indian and Alaska Native Veterans who live in urban locations do not have geographic access to care in IHS facilities on or near reservations and must use the local systems of care or urban Indian clinics where they are available. In some of these locations Urban Indian Health Programs provide limited direct care and assist these patients in accessing VA and other services in the local area. Indian veterans residing on reservations in some cases are not easily able to access VA health facilities and services, as well.

IHS recognizes that the complexity of IHS Contract Health Services and VA eligibility requirements may discourage Indian Veterans from accessing care. IHS pays for the care referred outside of IHS for American Indians and Alaska Natives including veterans if all rules and regulations governing the CHS program are met. For the Indian veteran, the VHA is an alternate resource along with Medicare, Medicaid and private insurance under the CHS regulations. Other requirements include membership in a federally-recognized Indian tribe, residence on the reservation or within an IHS Contract Health Service Delivery Area (CHSDA), meeting the CHS medical priority of care, exhaustion of alternative resources of coverage, and compliance with the timelines for notification of IHS. If the Indian Veteran patient is eligible for Contract Heath Services and requires services outside the IHS facility, i.e. specialty inpatient and outpatient services, she or he may be approved for care pending relevant medical priority level on same basis as any other American Indian and Alaska Native.

HHS/INDIAN HEALTH SERVICE-VA/VETERANS' HEALTH ADMINISTRATION MEMORANDUM OF UNDERSTANDING

A Memorandum of Understanding (MOU) between the HHS/IHS and the Department of Veterans Affairs (VA)/Veterans Health Administration (VHA) was signed in 2003 to encourage cooperation and resource sharing between the two Departments. It outlines joint goals and objectives for ongoing collaboration between VA and HHS to be implemented primarily by IHS and VHA. The MOU advances our common goal of delivering quality health care services to and improving the health of the 189,000 veterans who are American Indian and Alaska Native as of 9/30/08. The HHS and the VA entered into this MOU to further their respective missions, in particular, to serve American Indian and Alaska Native veterans who comprise a segment of the larger beneficiary population for which they are individually responsible.

The MOU identifies 5 mutual goals to (1) improve beneficiary access to healthcare and services; (2) improve communication among the VA, American Indian and Alaska Native veterans and Tribal governments with IHS assistance; (3) encourage partnerships and sharing agreements among VHA, IHS, and Tribal governments in support of American Indian and Alaska Native veterans; (4) ensure the availability of appropriate support for programs serving American Indian and Alaska Native veterans; and (5) improve access to health promotion and disease prevention services for American Indian and Alaska Native veterans.

INDIAN HEALTH SERVICE-VETERANS HEALTH ADMINISTRATION COLLABORATIONS

The principal focus of the interagency communication and cooperation is to provide optimal health care for the American Indian and Alaska Native veterans who rely on the IHS and/or VHA for their medical needs. Together we strive to achieve multiple goals outlined by the MOU by developing projects that, for example, improve access to VHA services by allowing VHA staff to utilize Indian health facilities for providing health care to Indian veterans while the joint working relationship expands opportunities for professional development of clinical skills by IHS providers. IHS experience with the use of traditional healing in its system became a model for

the VHA when it began incorporating traditional approaches to healing for Indian veterans. VA's development and use of the tribal veterans' representative (TVR) program has been and is critical to addressing issues related to communicating about and reducing barriers to VA services and to the IHS CHS program for Indian veterans through the coordinated training on benefits and eligibility issues for each of the two programs.

Other collaborations that meet the goals of the MOU range from expansion of access to VHA home based primary care for Indian veterans through the use of IHS and Tribal health facilities to the improvement of interagency partnership on health information and use of tele-health modalities. The home based primary care program expansion will increase availability of services for Indian veterans with complex chronic disease and disability through 14 collaborative projects located in states including New York, North Carolina, Oklahoma, Oregon, New Mexico, South Dakota, California, Mississippi, and Minnesota. In Arizona, the IHS -VHA are working together to increase mental health services by locating VHA social workers in IHS health facilities on the Navajo and Hopi reservations.

In Montana, the Billings Area IHS and the VA Montana Healthcare System (VAMHCS) have on-going collaborative efforts such as tele-psych established at each service unit to facilitate providing VA mental health services for American Indian and Alaska Native veterans. Because of the geographic remoteness and difficulty in accessing transportation to a VA facility, this service greatly benefits the American Indian and Alaska Native veterans. The Billings Area IHS and VAMHCS have formalized a PTSD protocol that is utilized by the service units and Fort Harrison. Among the protocol elements, the VA has created a position designated as a Tribal Outreach Worker (TOW) who works on-site to actively seek and educate veterans who may benefit from the services provided through telepsyche clinics. Each service unit has a designated VA liaison to help the American Indian and Alaska Native veterans needing medical services as well as working with the TOW and local Tribal Veteran Representative. As the primary IHS contact, they can provide information, assistance, and guidance on VA services and health benefits to American Indian and Alaska Native veterans. These collaborative efforts are reviewed on an on-going basis in efforts to address patient related issues, improved services, outreach, rural initiatives, and to assist American Indian and Alaska Native veterans to utilize both IHS/VHA systems.

The IHS and VHA have a long history of working jointly on health information technology (HIT). Since the mid-1980s when the two agencies both successfully fielded the Decentralized Hospital Computer Program (DHCP) software, the VHA and IHS have sought opportunities to collaborate in the sharing of HIT. The Resource and Patient Management System (RPMS) is the IHS' comprehensive health information system created to support the delivery of high quality health care to American Indians and Alaska Natives at several hundred Federal and Tribal hospitals and clinics nationwide. The RPMS is a government-developed and owned system that evolved alongside the Veteran's Health Administration's (VHA) acclaimed VistA system.

In addition, the model for the RPMS Electronic Health Record (EHR) is the Veterans Health Administration (VHA) electronic medical record, the Computerized Patient Record System (CPRS). CPRS has been successfully deployed across the VHA hospital network over half a decade ago. The EHR utilizes a technical infrastructure originally developed for the VHA that displays various clinical functions in a graphical user interface (GUI) format.

CONSOLIDATED MAIL OUTPATIENT PHARMACY (CMOP)

The IHS and VHA will soon begin a pilot-test using VA's CMOP to process IHS outpatient prescriptions, based upon the electronic dispensing data provided from the IHS facilities. Through the IHS use of the CMOP facilities, prescription filling can be centralized while providing more efficient prescription delivery and increased pharmacy billing collections. It will also provide facilities with the capability to fill prescriptions for more than 30-day refills. The VA's CMOP programs offer an attractive technology for dispensing refills within the IHS because it offers the possibility of decreasing capitalization costs, reduction of outdated medications, and freeing up significant IHS pharmacist time for patient counseling, adverse drug event prevention, and primary care. The IHS has been able to successfully transmit prescriptions from an IHS RPMS test system to a CMOP test system and transmit appropriate prescription information back to the RPMS test system. The VA's CMOP is currently in beta testing at Haskell Indian Health Center in Lawrence, Kansas; at the Phoenix, AZ Indian Medical Center; and at the Indian health facility in Rapid City, South Dakota.

VISTA IMAGING

A Memorandum of Understanding between the IHS and the VHA has enabled telemedicine program coordinators from both Departments to identify key areas for cooperation and possible shared resource development. An example is the implementation of the VA's VistA Imaging System (VI) in IHS, which is now up to approximately 45 RPMS systems nationwide. VistA Imaging provides the multimedia component of the VHA's Computerized Patient Record System (CPRS) and is also offered as a multimedia tool to complement the IHS RPMS- EHR. The VI is an extension to the RPMS hospital information system. The RPMS Health Information System and Radiology Information System provide extensive support for imaging and contain a full image management infrastructure. VistA Imaging provides clinicians with access to all images and text data in an integrated manner that facilitates the clinician's task of correlating the data and making patient care decisions in a timely and accurate way. Through this agreement, the VHA also provides the IHS with onsite VI installation and training support.

ALASKA AREA IHS-VA HIT COLLABORATIONS

The Alaska Area IHS has partnered with the VA since 1995 via the Alaska Federal Health Care Partnership (AFHCP) which includes IHS/Tribal, VA, Army, Air Force and Coast Guard partners. The Alaska Federal Health Care Partnership office's primary responsibility is to coordinate initiatives between the partners that result in increased quality and access to Federal beneficiaries, or an overall cost savings to the Federal Government. Current initiatives in the Alaska Area include: joint training offerings, a neurosurgery contract services agreement, a perinatology contract services agreement, tele-radiology, sleep studies, home tele-health monitoring, partner staffing needs assessment, emergency planning and preparedness, and tele-behavioral health.

Past projects of AFHCP include Alaska Tribal Health System Wide Area Network (ATHSAN) Telemedicine and the development of the Wide Area Network. The AFHCP frequently shares workload data during its investigations of possible joint services analyses; a recent example is a study for joint-agency tele-dermatology and tele-rheumatology contracts. One of the AFHCP committees is the Partnership Telehealth & Technology Committee (PT&T) which brings together information technology staff to discuss partner organization needs, identify potential telehealth and technology applications to meet those needs, and find avenues for shared technology resources. PT&T members and their clinical champions will monitor patient results and gather feedback on the use of new technologies to improve clinical outcomes and access to care.

FUTURE OPPORTUNITIES OF PARTNERSHIP

Local HIS-VHA efforts to improve access and develop formal partnerships have increased since 2003 but IHS acknowledges that our joint efforts on issues related to access to health care for Indian veterans need to continue. We are committed to working on these issues, within the Indian Health system, as well as with the Department of Veterans Affairs and the Veterans Health Administrations. Indian communities have always honored their Indian veterans and we are committed to improving the health services they utilize and the quality of their lives.

Mr. Chairman, this concludes my testimony. I appreciate the opportunity to appear before you to discuss the collaboration between the Department of Health and Human Services through the Indian Health Service and the Department of Veterans Affairs I will be happy to answer any questions that you may have. Thank you.

POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO RANDY E. GRINNELL, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Question 1. How many sharing agreements has VA entered into with tribes, tribal facilities and IHS facilities? Please provide a list broken down by tribe, tribal and IHS facility, describing these sharing agreements.

Question 2. Please provide IHS's best estimate of the number of dual eligible Native American veterans. Please also include a description of the methodology used to produce those estimates, and information regarding ongoing efforts by IHS to improve these estimates.

Question 3. How many staff has IHS dedicated to tracking and implementing the VA-IHS MOU and IHS's obligations (consultation included) to Native American vet-

erans? Please provide the names and titles of dedicated staff, and whether they focus on these responsibilities on a full or part-time basis.

Question 4. In a FY2005 VHA-IHS issue update stated that ". . . the leadership of each organization has been asked to develop a joint policy for the coordination of health care for dual use veterans." Please comment on progress toward that joint policy, and whether VA and IHS are still working toward that goal.

[Responses were not received within the Committee's timeframe for publication.]

Senator TESTER. I thank you for that. Thank you for your testimony. We will start the first round of questions with Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

Mr. Floyd, before I get to the issue of the day, I would like to touch base with you about the VA hospital in Marion, IL, that is now under your purview, and from the Inspector General's report it is apparent there are still systemic issues which have not fully been addressed in the last 2 years. Some of those issues that have presented themselves over that period of time: providers not credentialed or privileged; lack of peer review; poor quality management; and not reporting adverse health effects efficiently. Can you share with us your level of commitment to make sure that these systemic problems are solved?

Mr. FLOYD. Senator Burr, in that report, beginning on page 20, are my statements to address those ten recommendations made from that report. I would refer you and your staff to that. But I will also be available to discuss that in further detail, to specifically address any of those with you or other Members of the Committee at an appropriate time.

Senator BURR. I appreciate that. Let me suggest to you that it was unacceptable when it happened and I find it somewhat unbelievable that we still have systemic problems. I realize you have only been there a short period of time——

Mr. FLOYD. Twelve months.

Senator BURR [continuing]. And I hope you will take this as a warning shot, that this will not be the last time this Committee looks at those systemic problems in that facility specifically and across the network.

Let me, if I could, move to a question for one or both of you. As I mentioned in my opening statement, the MOU between the VA and IHS outlines five mutual goals. Mr. Howlett on the first panel described the MOU as, quote, "more symbolism than action." So, let me mention these goals, and if you will, tell me how your agencies are measuring the success or failure at meeting them.

First, access to health care. How do you measure whether access has improved since 2003?

Mr. FLOYD. First of all, about the MOU, it is purposefully vague so that we disregard work with individual areas, Indian communities, urban areas and all, so that we can address unique circumstances of each local community, Tribe, nonprofit organization that exists that has Native American veterans. And we have made strides in that.

If I could give you an example. When I was the Director of the VA Salt Lake City Health Care System, we worked with the Billings Area Indian Health Service and did a comparison of databases between the VA and the Indian Health Service to identify pa-

tients within the Indian Health Service system who were veterans who weren't enrolled within the VA. We used that as a method of outreach for patients in Wyoming, Montana, Idaho, and Utah. That helped us increase the enrollments of these individuals into the VA health care system. That is one example.

Senator BURR. Communication—how do you measure improvements since 2003?

Mr. FLOYD. The VA and the Indian Health Service has ongoing conference calls between the two of us. We have a spreadsheet that identifies projects that we both identified as necessary for action. We have identified the responsible parties for that and on a monthly basis report on the progress of those. That is a method which we use internally within both agencies to gauge our success in improving services.

Senator BURR. The development of partnerships and sharing agreements—how many existed in 2003? How many exist today?

Mr. FLOYD. I am not sure how many existed in 2003. I can speak for the ones that at the present time exist, which are at least 15 of the 21 Veterans Integrated Service Networks within the VA with varying levels of agreements in place, whether that is for telehealth, traditional services, direct primary care, the installation of the Electronic Health Record from the VA into Indian Health Service or Tribal facilities. Those are examples of where we use specific agreements to follow up from the MOU to improve mechanisms for care.

Senator BURR. Ensuring appropriate resources are available, does the VA know how much it provided to Indian Health Services or Indian Health Service contract facilities under the sharing agreement in 2003 versus the level it provides today?

Mr. FLOYD. I am aware of several agreements specifically between the VA and Indian Health Service or Tribal facilities—the Muscogee VA in Oklahoma, for example, their work with the Choctaw and the Cherokee Nations specifically on a contract basis. However, there are other agreements in place, such as what we have experienced in the Rocky Mountain area, where we work with social workers or other transfer coordinators within either Tribal or IHS facilities on specific cases to get them in and coordinate their care, either from that level, primary care, or specialty care in the VA system.

Now, I am not aware of a national database that rolls all those up. However, I know that recently the VA has asked and received information from each one of the facilities of specific agreements that they have in place. So that information is available.

Senator BURR. To improve health promotion and disease prevention services. How do you measure that?

Mr. FLOYD. The VA has benefited, actually, from the development of the Indian Health Service, particularly in diabetes education and hypertension education, and collaborated on a level where they have actually helped train the VA in their preventive practices for diabetes education, hypertension, and the VA has utilized their resources to help improve the knowledge of the VA practitioners. Those are the examples that I am aware of, sir.

Senator BURR. I would like to thank the Chair, because he has been kind to let me go over. Let me make a statement and then I will end with one last question.

The Memorandum of Understanding was meant to cover all the Native American geographical area. I think we have a tendency to focus on certain successes, certain outreaches, and certain partnerships. But I hope you got the gist I did from the first panel, that this is not the overriding theme of the VA, to live up to all the standards in that agreement. I am not sure that there is an overriding commitment on the part of VA to make sure that there is incredible access to quality health care within Indian Country. I am not sure that there is a real focus within the VA to make sure that the communications is open to the degree that in all areas, they know exactly what is available to them. And I could sort of go down the list.

But let me just ask, is there a database at VA of Native American veterans?

Mr. FLOYD. Well, within the electronic health records system of the VA, as a veteran enrolls in the VA health care system, there is a question asked of their racial designation. It is a voluntary request on their part. Those who identify Native American or Alaskan Native as their primary racial group are in our database. Yes, sir, we have that information.

Senator BURR. If they are enrolled in the VA?

Mr. FLOYD. Yes, sir.

Senator BURR. But we don't import into VA potentially all the folks who qualify for VA services that may not be enrolled?

Mr. FLOYD. Not to my knowledge. Not yet. However, as you may be aware, the project especially with these soldiers who are in Afghanistan and Iraq, the War on Terror, at the present time—the project is called VLER, Virtual Electronic Record, which would transmit that information from DOD directly into the Department of Veterans Affairs. That project is in its initial stages, but could address the issue that you just asked about.

Senator BURR. Clearly, I would think that with this Memorandum of Understanding in place, that there would have been some thought process at VA as to how they could proactively go after a population that may not be enrolled yet qualified. Likewise, I would hope that the Indian Health Service would push VA to do this. The first panel, I don't think talked about the successes of the system or about the outreach or, for that fact, about the quality of care within the Indian Health Service. I actually think it has made progress, but I think it falls woefully short of what they deserve from the standpoint of a quality health care system.

So, Mr. Chairman, I do hope you will be persistent that we will continue to follow up on this and that we will be at a point where we can measure progress versus just cite highlights. I think it is important that we have a matrix that is constructive that allows us to gauge what we have done.

I thank all our witnesses. I thank the Chair.

Senator TESTER. And I thank you, Senator Burr.

I am going to follow up on Senator Burr's questions here real quickly, on the measurement aspect. I am going to paraphrase what you said, but you basically merged medical records between

the VA and IHS and found which Native Americans were out there that were veterans that weren't being served by the VA. Is that fairly accurate?

Mr. FLOYD. Yes, sir.

Senator TESTER. And then you said that you did outreach. How did you do outreach?

Mr. FLOYD. Well, one of the things that we drew out of that was the address of those individuals and their zip codes so that we could target them with mailings. Also, as a follow-up at that time, Mr. Richardson and myself, we went out to areas where they had higher concentrations of veterans and held meetings on those reservations or Indian communities.

Senator TESTER. And how many folks did you have?

Mr. FLOYD. In the beginning, sir, very few, but I think with continued follow-up meetings, we began to enroll many more. I am not sure of the exact number. I know in one community in Utah, we were able to get about 300 people enrolled that hadn't previously been using the VA.

Senator TESTER. Does the VA keep metrics on the effectiveness of this sort of stuff?

Mr. FLOYD. With the communication between the VA and the Indian Health Service, these types of initiatives are looked at and discussed in terms of specific metrics. Reporting is requested periodically from Central Office here in Washington to the respective networks, such as the one I am at in Kansas.

Senator TESTER. It would just seem to me that it would be very, very difficult to do measurements if you do it in generalities. How do you measure the effectiveness of your outreach unless you know? I guess that is a statement. You don't have to answer that.

You also talked about contracting facilities with Senator Burr's question, and I had the impression that you do have contracted services with some IHS facilities. Is that correct, or did I hear you wrong?

Mr. FLOYD. Well, we have the ability to contract for primary care within the VA and locally within any facility. They determine where they have the volume of patients to support the contract.

Senator TESTER. Can you tell me if there are any IHS facilities that you have contracts with and where would they be?

Mr. FLOYD. Specifically, with the Indian Health Service, I am not aware of any contracts with them.

Senator TESTER. Why is that?

Mr. FLOYD. Because it seems to be more appropriate for us to comanage the patients, although——

Senator TESTER. But you do have contract agreements with private facilities, correct?

Mr. FLOYD. Yes, sir.

Senator TESTER. So why is there a difference? I am just curious, because as one of the people testified in the first panel, a lot of the areas that the Native Americans live in are pretty darn remote.

Mr. FLOYD. Yes, sir.

Senator TESTER. And one of the things that we have talked about on this Committee is when you are in remote areas, it makes more sense to deal with the veteran there than ship him a few hundred

miles, or in Alaska's case, a lot further than that, to a CBOC or a hospital.

Mr. FLOYD. The traditional usage we have seen in terms of these co-managed patients, if I could use that term, is that they generally receive their primary care locally, either in a Tribally-run facility or Indian Health Service facility.

Senator TESTER. So the reason you don't contract with them is that IHS is already supposed to take care of them?

Mr. FLOYD. No, they have a choice. If they want to be exclusively served by the VA, then we do that. We do that with many patients. We co-manage patients across the country in all kinds of settings.

Senator TESTER. OK. And I have got about a minute, so you guys are going to have to be concise on this. This is for both Mr. Grinnell and Mr. Floyd. If you were to analyze how well your two agencies were working together to service Native American veterans, what grade would you give yourself?

Mr. FLOYD. Umm——

Senator TESTER. No talking across the aisle. [Laughter.]

No bell curve; right?

Mr. FLOYD. I don't know if I can represent the agency to talk about that, Senator, but——

Senator TESTER. The point I am trying to make is that from my perspective as somebody who serves in the U.S. Senate that represents everybody, whether they are Native American veterans or regardless what their race is, I go into Indian Country—and I have got all the statistics right here that talk about how their health isn't as good, which I have heard spoken from many agencies in the Obama administration, and I agree with them wholeheartedly—that we need to figure out ways that we can work together to maximize our ability to serve the people we are serving, because IHS is funded by taxpayer dollars, VA is funded by taxpayer dollars, and we have got an opportunity to work together and get more bang for the buck.

And so that is why I want to know. Would it be accurate to say that we could do better? How is that, Mr. Floyd?

Mr. FLOYD. Well, I think we can always do better, sir.

Senator TESTER. All right. Well, I left you off the hook.

Mr. Grinnell, what grade would you give us?

Mr. GRINNELL. Well, I am going to punt like Mr. Floyd did and not give myself a grade. But in discussions with the Director, Dr. Roubideaux, about future partnerships, we clearly see that there is an opportunity for improvement and ways to bring services to the Indian veterans throughout Indian Country——

Senator TESTER. OK. If there is opportunity for improvement, how does that information flow up and how do you get it ultimately in the end to Dr. Roubideaux?

Mr. GRINNELL. Well, one of the things that Mr. Floyd also talked about is that many of these agreements and these relationships are at the local level.

Senator TESTER. Right.

Mr. GRINNELL. In many cases, the agreement and the relationship is between the VA and the Tribes that now manage those programs, an example is Alaska. All the Alaskan programs are now under 100 percent management of the Tribes up there. I believe

that the opportunities we have before us to bring the partnership of the Tribes and the Alaskan Natives into that partnership in a more open and equal manner, I think that will help us move ahead.

Dr. Roubideaux, one of her priorities is to have more consultation with Tribes on how we deliver health care across this country, and she sees that as an opportunity here, as well.

Senator TESTER. OK. Thank you very much.

Senator Begich?

Senator BEGICH. Thank you very much, Mr. Chairman, and thanks for calling for this hearing. I think it has been very informative, but also gives us a chance to—I was trying to figure out how to do the grading, too. When I went to elementary school, they had "N" for needs improvement, "O" for outstanding, "S" for satisfactory, and this is probably a combination, depending on where you are. I know in Alaska, as you just mentioned, the Tribal Consortium has done, I think, an exceptional job in advancing health care for Alaska Natives. Again, I went on the floor today to explain the great value of what they have done in improving and turning around the system.

Now, saying that, I think there are some improvements that clearly need to be made, especially with, I will use the phrase dual eligible veterans. You know, they are eligible in both your systems. And in Alaska, again, as I said in my opening, they are in areas that are very difficult to access quality health care that is VA-delivered, if they live in rural Alaska, so there has to be a better way.

But I want to go back to the Ranking Member's comment to the VA, how you try to figure out who the folks are, because if you don't know the number, if you can't put that in your database—I understand why it is voluntary—but why can't you have a question that says something like this. Are you qualified under the Indian Health Service for any services? Because you may be qualified for additional services.

Why can't you just ask that question, so then when they check that box, you can actually create a database? I understand the issue about asking their ethnic background, but if you are asking them, are you qualified under Indian Health Services today, a lot of folks will identify that, especially if they are a veteran. So, they just check the box. It then gives you the data to move forward in figuring out how to provide dual services.

Mr. FLOYD. If I could answer that, Senator. The VA in its registration package asks for alternate resources information, which is generally third-party insurance coverage. I know the Indian Health Service is not an insurer——

Senator BEGICH. Right.

Mr. FLOYD [continuing]. But a lot of patients do say, well, it is Indian Health Service. They can note Indian Health Service on there——

Senator BEGICH. But if I can interrupt you, if you ask the question from that perspective, insurance, some will view it differently. But if you ask, are you qualified under Indian Health Service for any benefits, it is a simple yes or no, and it immediately gives you a qualifier.

Mr. FLOYD. We don't ask that specific question.

Senator BEGICH. Can you be more—I mean, can you?

Mr. FLOYD. We could, but let me give you one hesitation on my part to do so. Having run a medical center, I would not want any of my staff to turn that person away and say, then we want you to go to an Indian Health Service facility.

Senator BEGICH. I am not asking that. What I am saying is it helps you create the database, so then as you do this MOU, you now can say, we have 5,000, 2,000, 100, or ten qualified based on the data we have collected. Now, how do we approach that group in order to ensure that we are giving them the benefits and the services earned? And then you can kind of start drilling down. I have done a lot of MOUs as a former mayor and I will tell you, if you don't have the data, there is no way to perform on it. You just can't.

So, I would just encourage you to kind of look at how you ask the question in order to extract the data in order to then work together to figure out who that group is you are trying to target. That is just a comment.

The other thing is, the MOU has been talked about a lot, and like I said, I have developed a lot of MOUs as mayor, but one of the things we always had was kind of, you have interagency discussions on a regular basis. But the last time, I think, that they have taken those issues and updated and where they are, I think, was maybe in 2005 or later.

I am assuming you do this, and if you don't, I would highly encourage you. I am assuming in your interagency group you will have an MOU with your 15 or so items and you will note, here are the action items, here is the progress. Do you have such a chart that shows what you all work off of?

Mr. FLOYD. Between the—if I could answer that——

Senator BEGICH. Between both of you, yes.

Mr. FLOYD. Yes. We do share our database of the projects that we are either working on individually or jointly. Those are identified, then the objective, the status of the actions, and who is responsible as the lead on those types of issues. And then we discuss those on conference calls.

Senator BEGICH. So, you have some document where you keep track of these?

Mr. FLOYD. Yes, sir, we do.

Senator BEGICH. Is that something you can share with the Committee?

Mr. FLOYD. Yes, I think we can provide that information.

[The additional information requested during the hearing follows:]

Population	Project Name	Project Summary	Status
Alaska Native Veterans	Juneau Outreach Clinic	The Juneau Clinic began operations in September 2008 supporting local Veterans. The Office for Rural Health (ORH) funding provided the start-up and sustainment funding to allow the clinic full operations through 2010. (Veterans Integrated Service Network (VISN) 20)	Newly Awarded May 2009
Alaska Native Veterans		The objective of this project is to implement a teledermatology consultation system with three components: 1) traditional store-and-forward teledermatology; 2) structured follow-up care; and 3) a consistent, defined curriculum of basic precepted training and continuing education at VA sites across VISN 20	Newly Awarded May 2009
Alaska Native Veterans	National Care Coordination Home Telehealth (CCHT) project, which includes a planned expansion into Alaska	This project will support the increase of VHA enterprise-wide telehealth programs that will expand access to care nationally for Veterans living in rural areas by supporting and expanding the care coordination home telehealth (CCHT) program. CCHT focuses on patient self-management and disease management via a range of telehealth technologies that include messaging, monitoring, and video devices.	Newly Awarded May 2009
Alaska Native Veterans	Care Coordination Store and Forward (CCSF) project, which includes funding for teleretinal imaging equipment planned for the Kenai, Alaska Community Based Outreach Clinic (CBOC)	This project will support the increase of Veterans Health Administration (VHA) enterprise-wide telehealth programs that will expand access to care nationally for Veterans living in rural areas by supporting the expansion of the care coordination store and forward (CCSF) program. The majority of CCSF activity that takes place in VA is for teleretinal imaging to screen for diabetic retinopathy, teledermatology, or telepathology.	Newly Awarded May 2009
Alaska Native Veterans	Care Coordination General Telehealth (CCGT) project, which will benefit Veterans across all of VISN 20, including Alaska	This initiative will support the increase of Veterans Health Administration (VHA) enterprise-wide telehealth programs that will expand access to care nationally for Veterans living in rural areas by supporting and expanding the care coordination general telehealth (CCGT) program. CCGT uses clinical videoconferencing to provide consultation or care to patients situated at geographically distant sites.	Newly Awarded May 2009
Alaska Native Veterans	Expanding Fee Based Care	The project is designed to expand fee-basis authority to primary care providers serving rural and highly rural Alaskan Veterans and impact approximately 600 enrolled Veterans. (V20)	Newly Awarded May 2009
American Indian Veterans	Clinical Demonstration Pilot Program: Telepsychiatry Clinics for American Indian Veterans on Rural Reservations	This Clinical Demonstration Pilot Program (CDPP) will establish telepsychiatry clinics for American Indian Veterans on rural reservations. Residents will be recruited for 2009-2010 and a consultation provided for the clinics to assist in developing tele-FFT and telegeriatric care. The final product will be data gathered from the clinic creation process to be used for MH guidelines. (VISN 19)	Continued progress, currently working on Memorandum of Understanding solidifying clinic structure
The Indian Health Services website does not include Pacific Islanders in their definition of Indian Population;			

Population	Project Name	Project Summary	Status
American Indian (AI), Alaskan Native, and Pacific Islander (PI) Veterans	Creation of an Infrastructure for Native Focus	This project will examine the current health care policies for rural Native Veterans and provide recommendations for further policy development. The Western Region Veterans Rural Health Resource Center has hired a Native Consultant to assist in reviewing health care policies on rural native American Veterans. The study leads will then prioritize issues to make health care policy recommendations and present three detailed health care policy benchmark reports concerning rural AI populations, rural AN populations and rural PI populations. The report will discuss next steps for policy development for health care for each rural native population and prioritize recommendations for further work. (VISN 19)	Delayed - Sole source contractual issues; addressed with contracting office In progress.
American Indian (AI), Alaskan Native (AN), and Pacific Islander (PI) Veterans	Guidelines for the Design and Implementation of AI/PI/AN Telemental Health Clinics	The purpose of this project is to provide guidelines for the design and implementation of American Indian Veteran Telemental Health Clinics. This project will examine service utilization, cost and semi-structured interview data to assess the programmatic outcomes achieved by telepsychiatry clinics, with a particular emphasis on the clinics' feasibility, sustainability and cost. This project will further examine factors influencing the diffusion and adoption of telepsychiatry by tribal, state, and federal organizations. Guidelines and recommendations for developing similar programs will be disseminated at the end of the first project year. During the third project year, project leads will assess the inclusion of these guidelines by the VA and IHS policy bodies. Final products from this project will include a manuscript and conference presentations. (VISN 19)	Delayed - Hiring Denver based staff to support work, currently in progress, work underway with revised timeline. No applicants for position internally, so . posting was expanded externally
American Indian, Alaskan Native, and Pacific Islander (PI) Veterans	Telehome Care for Rural Veterans with post traumatic stress disorder (PTSD): Adaptation for Native Focus	Researchers will design a telemental health program to address PTSD in rural and American Indian Veterans as an adaptation and service demonstration project. Final products will include a clinical manual, the dissemination of American Indian experiences, results, and satisfaction levels. (VISN 19)	Delayed: Clinical pilot continues on time, analysis and next stage development delayed due to contract delay.
Pacific Islander Veterans	Establishment of Saipan/Commonwealth of the Northern Marianas Islands (CNMI) VA Outreach Clinic and Rural Health Coordinator	This project will implement a VA Outreach Clinic in Saipan, Commonwealth of the Northern Marianas Islands (CNMI), to include contracted part-time providers, on-island VA provider(s), and an on-island telehealth capability. It will also establish a Rural Health Coordinator position at VA Pacific Islands Health Care System (VAPIHCS) who will be responsible for all aspects of the community health needs assessment for all VAPIHCS locations/islands. (VISN 21)	Newly Awarded May 2009

Project/Initiative	Goal	Date of Update	Status of Project and next steps on deliverables
Leadership Meeting	Discuss status of collaborations between Veterans Health Administration and Indian Health Service. To involve Office of Intergovernmental Affairs and perhaps other Admins.	12/7/2009	A formal meeting between new appointees and leadership in VA and Indian Health Service is planned for after the confirmation of the new VA Under Secretary for Health (USH). The current Acting USH and Indian Health Service (IHS) Director have had calls to discuss issues of mutual interest.
Nurse Internships/ Residencies	Establish opportunities for IHS staff to receive clinical nursing training and experience in VHA facilities	10/23/2009	10/23/09 Work continues to enhance training opportunities in VHA for IHS clinicians. Report from Sandra Haldane, IHS: In addition to phone calls and emails, three face-to-face meetings have occurred between the IHS Director of Nursing Service (DNS) and VHA Office of Nursing Service (ONS) Headquarters staff and other nursing leadership to explore and facilitate increased collaboration between the nursing programs of the two organizations. It was quickly identified that two areas for collaboration in nursing were nurse training and nurse staffing. IHS has historically had difficulty recruiting experienced nurses for its operating room, patient acute care unit, and intensive care unit specialties. Numerous VHA facilities provide these types of complex services and can provide a rich didactic and clinical experience for nurses who have minimal or no previous experience in these specialties. While several IHS and VHA sites were identified for further planning, a changeover in nursing leadership at those sites occurred and planning was delayed. Discussion however has resumed on this activity between the IHS and VHA in Oklahoma and Phoenix.
	Establish opportunities for IHS staff to receive clinical nursing training and experience in VHA facilities (continued)		The VHA is implementing and testing a nationally standardized staffing methodology for nursing personnel. The VHA system is automated, driven by data on nursing workforce, patient need, and nurse skill mix. It ultimately will reflect nurse staffing impact on patient outcomes. The IHS is in the process of updating its Inpatient Nursing Resource Requirement Methodology (RRM) which defines the nurse staffing required to staff a new facility as well as the Inpatient Patient Acuity Package which identifies the hours of nursing care required in a 24 hour period for patients. In light of these activities, IHS nursing leadership met with VHA nursing leadership at the Jack C. Montgomery VA Medical Center in Muskogee, OK to further explore what each organization was doing and as a result VHA has offered to work with IHS in further exploring the relationship between nurse staffing, nursing practice, and patient outcomes; an endeavor that will result in consistency of nurse staffing practices throughout the country.

Project/Initiative	Goal	Date of Update	Status of Project and next steps on deliverables
Educational Sharing	Share educational materials between organizations	10/19/2009	FY 09 Accomplishments: In FY 09 VHA has delivered 131 training programs to IHS staff and the tribal community of which 34 were made available using satellite technology, four using video technology, and 93 using web-based technology. The direct cost avoidance generated by the satellite programs is $617,000. The cost avoidance generated by the video programs was $6,460, and the cost avoidance generated by the sharing of web-based training is $3,470,000 for an aggregate cost avoidance of $4,094,122. In FY 09 there was a decrease in the number of training programs shared from VHA to IHS of 8% from the number shared in FY 08 and the cost avoidance decreased by 1%. This decline is due to architectural barriers in the vetting and deployment of web-based training in IHS and the decline in the number of satellite programs shared in FY 09. Next steps include: 1. Increase the satellite training programs shared with IHS in the 1st quarter of FY 10 2. Implement a plan for enhancing the shared training architecture between IHS and VHA to support increased web-based training for IHS 3. Share additional web-based healthcare management training courses with IHS in the 1st quarter FY10.
Tribal Veteran Representative (TVR)	On-going program to recruit and train tribal volunteers to become knowledgeable about VA benefits and programs (i.e., VBA, VHA, and NCA)	10/27/2009	10/27/09: Several informal trainings were held over the summer for the TVRs and the TOWs (Tribal Outreach Workers) of the Telepsychiatry program. There have also been outreach efforts at 10 pow wows (events sponsored by Native American organizations) in an effort to enroll new Veterans and also help Veterans and their families begin new claims or work on existing claims. During August Buck Richardson was asked to go to CS&K College at Pablo, MT, and tape a show for "Good Medicine" which is aired on the public broadcast network of the college station of the Tribal network in the community about the TVR program, telepsychiatry program, and VA outreach in Native communities. In September Mr. Richardson traveled to South Dakota with 11 of the TVRs for the " Gathering of tthe Healers" which is held in the Black Hills by VISN 23. These TVRs are asked to help with the training for VA employees and the veiwpoint of Native Veterans using VA services and returning from service in the military. During October Mr. Richardson and TVRs attended the Flathead Warrior Society to the Montana Crime Stoppers Convention for a presentation about the TVR program and outreach efforts.

Project/Initiative	Goal	Date of Update	Status of Project and next steps on deliverables
Traditional Practices		10/19/2009	10/19/09: A survey of field facilities identified traditional practices being used throughout VHA was initiated in Fall 2008. The report was published in November 2008. Since then, the Palo Alto Healthcare System (PAHCS) has closed their sweat lodge due to safety concerns. The Director, National VA Chaplain Center has been in dialogue with the Director, VAPAHCS, expressing concerns about the closure of the sweat lodge and its potential impact on the right of free exercise of religion for American Indian veterans. 10/19/09: Currently VHA has eight authorized Traditional Practitioners.
Care Coordination (Transfer and Payment Policy)		10/23/2009	10/23/09: Projects funded through the Office of Rural Health may provide best practices and models that could be replicated elsewhere. The VA/IHS workgroup indicated at its call on 10/27/09 that this should be a priority for its work in 2010. VHA is developing a current status document for the next call.
Employment Initiatives		10/23/2009	10/23/09 Work continues to enhance materials and recruiting among Native Americans. Currently, a link is established between the IHS website and the VHA website re employment. VA/IHS workgroup has indicated to be a priority for its work in 2010.
Telehealth collaboration		10/23/2009	10/23/09. VHA continues to provide input into Ryan Haight Act (Internet Prescribing Legislation). This Act has implications for telehealth and particularly telemental health. The Indian Health Service has also been providing input and has voiced concerns similar to VHA with respect to this legislation. Update on telehealth implementations into tribal communities. Seven are operational. In VISN 19 these are with Northern Arapahoe/Eastern Shoshone, Northern Cheyenne, Crow, Gros Ventres/Assiniboines and Chippewa Creek. In VISN 20 operational programs are the home telehealth program from Anchorage and links into the Alaska Federal Health Care Partnership. Programs in deployment include in VISN 19: Sioux/Assiniboine, Shoshone Bannock, Confederated Saleesh (Flathead), Blackfeet, Ute, Navajo. In VISN 20 programs in deployment include ones to Yakama, Nez Perce and Umatilla.
Consolidated Mail Out Pharmacy (CMOP) demonstration project	Explore opportunities for IHS to use VA-CMOP	10/19/2009	10/19/09: The CMOP Pilot initiative is nearing implementation. The catchment areas for pilot have changed to South Dakota and Phoenix for participating IHS clinics. The coordinating CMOP is the CMOP-Leavenworth facility. The Information Security Agreement is in place, connectivity and testing have been accomplished. The Inter-Agency Agreement (IAA) has been drafted and pending approvals. The pilot will commence as soon as IAA is in place.
Joint Map of VHA and IHS medical facilities	Design map showing VHA and IHS medical facilities	10/23/2009	A map was developed for planning for the Home-Based Primary Care (HBPC) project. Expansion of the project will be done as needed.

Project/Initiative	Goal	Date of Update	Status of Project and next steps on deliverables
Collaboration re elder care including Indian Health Service re providing home-based primary care (HBPC)	Expansion of HBPC via collaborations with IHS and tribal hospitals and clinics; fourteen projects funded.	10/19/2009	Fourteen VA medical centers have been funded for this initiative. HBPC teams will be co-located at tribal and IHS clinics and hospitals. The goal is to improve access to primary care services and enhance mentoring between VA staff with geriatric expertise and IHS/tribal staff. First Veterans were served in September 2009 at two sites. The VHA Office of Geriatric and Extended Care also received funding to convene a Rural Health and Indian Health Conference in the summer of 2010.
Urban Indian Programs	Identify how VA and IHS can collaborate in projects involving the IHS Urban Indian Program.	6/30/2009	6/30/09 Buck Richardson reported that the TVR program is discussing how to work the TVR program in more urban areas. VHA is also waiting to hear from IHS staff regarding needs of the urban program.
VHA Performance Monitors	Monitor status of projects implementing MOU joint objectives and goals.	10/23/2009	10/23/09: The Deputy Under Secretary for Health for Operations and Management VHA/IHS monitor template has been revised for FY 09 and is being used by the field to report VHA/IHS activities. The summary report of VA initiatives for FY 09 is being compiled.
VHA Office for Rural Health		10/23/2009	10/23/09 update in process. See separate section

[Additional information about this topic can be found under response to Question 3 from Hon. Daniel K. Akaka to Mr. James R. Floyd, which appears previously.]

Senator BEGICH. Both of you? I don't know who is the right person. Mine is a dual-eligible question, so——

Mr. GRINNELL. Yes. It is maintained through this National Committee that——

Senator BEGICH. OK. So you can provide that to us to give us a sense?

In implementing that, is one of the pieces of the puzzle funding? It doesn't matter if it is VA or Indian Health Service, but on both sides, are any of the implementations of those just a funding issue versus a desire or a combination? Does that make sense, the question? In other words, do you get to an item and say, we want to do it, but there is just no money for it? And just to make sure you know, my second question will be, if the answer is yes to that, then I would ask, are you asking for that? Is it OMB and their magical black box that kind of strips at the pieces and then you end up having to take what you get? How is that for putting you on the spot? I wanted to warn you of the second part of the question.

Mr. FLOYD. The way the funds are allocated, having been in the Indian Health Service and now in the VA, I know how money is allocated in both. Within the Veterans Health Administration, it is a capitated system. The money follows the workload. So, the generation of the workload is going to retrospectively provide the resources to sustain that service for those individuals. So, there is through that system that we have within the VA a way to reimburse us for going out and getting that workload.

Senator BEGICH. Quickly—I know my time is over——

Mr. GRINNELL. As far as the funding, I think that everybody is aware of the funding of the Indian Health Service and the programs that are administered by us and the Tribes. The 2010 budget is definitely an increase. We have 13 percent that is now in place. The increases are very targeted and we are going to see some advances in Contract Health Service, which will have an impact on veterans that access that part of the system, as well.

The other part is within Health Information Technology. We are seeing some increases in our budget there that will be targeted to move us into more of these telemedicine partnerships that we have with the VHA to expand our services to those veterans in those remote locations.

Senator BEGICH. Thank you very much. I will ask one question, and it is a yes or no. Does Indian Health Service believe they should be on a 2-year budgeting cycle like the VA?

Mr. GRINNELL. I would have to——

Senator BEGICH. It is a yes or no. It is very simple.

Mr. GRINNELL. I would have to defer on that question to the Department. I am sorry.

Senator BEGICH. OK. No problem. Thank you.

Senator TESTER. Thank you, Senator Begich.

A couple more questions, and the first one is for Mr. Richardson. Buck, you are the guy who actually executes the goals of the MOU on the ground. You go out to reservations. You deal with the veterans, the IHS, and Indian Tribal Health. How do you and other

folks in the VA know what the challenges are out there and how do you share your ideas among your counterparts? How do you let them know what you are doing outside your region to influence folks?

Mr. RICHARDSON. We do a combination of things, Senator. It is either through conference calls, and reports I do through the VISN Director or actually taking other VA employees out. Then Dr. Shore and I do a report monthly that shows what we are actually doing at each one of the reservations, that shows the activity that we are doing, and how many veterans we are seeing through the different clinics. And then I have got a Web site for the TVRs that shows what is going on with each reservation and what is going on for the TVR, or the Tribal Veterans Representative Program, so that they can see what is going on in each one of the reservations.

Then in VISN 19 or the Rocky Mountain Health Care Network, I have got 23 Sovereign Nations that I work with, so I keep that up to date as to what is going on. So, I try to keep as much information flowing, and when I run across employees that are actually interested in trying to find out more about the Sovereign Nations, I take them out to the Nation with me.

Senator TESTER. Thank you.

Mr. Floyd and Mr. Grinnell, from your perspective, do you co-manage patients at this point in time?

Mr. FLOYD. Well, from my experience, yes, sir, we do.

Mr. GRINNELL. Yes.

Senator TESTER. OK. So, how do you effectively co-manage patients when you don't have an interoperable recordkeeping system and no one in either agency is really tracking how you are doing, implementing these strategies?

Mr. FLOYD. Well, my own experience, if I can answer that——

Senator TESTER. Sure.

Mr. FLOYD [continuing]. And maybe Buck can follow up, is it is as simple as a phone call. Each VA facility has a Transfer Coordinator. A lot of times, calls are made into the Transfer Coordination Office or to some of us individually of the specific case. At that point, we get the Transfer Coordinator to work with the individual at the local site. They coordinate the care to get the patient where they need to go.

Senator TESTER. Mr. Richardson, did you want to further respond?

Mr. RICHARDSON. There will be occasions where maybe an OEF/OIF Coordinator, either Iraq or Afghanistan, they will get phone calls trying to find individual veterans, and they will call me too. And what I will do is call the TVRs. The TVRs will actually go out into the field and find the veteran.

Senator TESTER. OK.

Mr. RICHARDSON. And once they find that veteran, a lot of times, there is a language barrier, so they have to get through the language issue through the family of that veteran. Once they get over the problem of the language and they get the veteran found, whichever reservation it might be, then they will get the veteran back in touch with me and then I will get the veteran in touch with the appropriate employee so that they can get them into whatever facility they might need to go to.

Senator TESTER. How about you, Mr. Grinnell?

Mr. GRINNELL. I would like Dr. Cullen to answer that, if she could.

Senator TESTER. Sure.

Dr. CULLEN. If the patient is cared for primarily in our system and identified as a veteran, they may be referred to the VA. If they are referred—because we do have a similar Electronic Health Record to the VA, especially in terms of patient registration, we will have captured their veteran status, we ask the nine questions the VA asks. In addition, we can drill down and tick off war and other things like that. If they are referred, we have a contract health and a referred care software application that allows us to track the referral out.

The question will be, can we get the records back in. At the current time, we have locations that have what we call read-only access into the VA systems, where the providers have been credentialed appropriately and they can dial into, with appropriate security, the VA VISTA system and get a read-only access to that patient's chart.

Senator TESTER. Let me restate what you just said. You are telling me that health care professionals in Indian Health Service can access those medical records in the VA?

Dr. CULLEN. At certain locations where there have been local sharing agreements developed and the provider has been appropriately credentialed, yes.

Senator TESTER. OK. Can the VA do the same thing, Dr. Shore? Can the VA do the same thing with the Indian Health Service records?

Dr. SHORE. I can only speak for the series of clinics where I work in Montana, Wyoming, and South Dakota. I run a series of telehealth clinics for the VA mental health clinics. So in those, with those specific sites, we do not have read-only capacity. It depends on the medical record, although often, our clinics are colocated in the actual IHS facility. So, we do a lot of phone calling back and forth with the providers.

Senator TESTER. All right. Thank you.

Senator Begich, did you have any other questions?

Senator BEGICH. I want to fall back in. Dr. Cullen, that is interesting, how you crafted that answer. I just want to make sure I am following you correctly here. If it is locally done, it has credentials done locally, then it is a read-only into the system, correct?

Dr. CULLEN. Appropriate credentials and security, yes.

Senator BEGICH. Security. If I can ask you a question, how many of your facilities have that, in percentage of total?

Dr. CULLEN. We are only aware of five at the current time.

Senator BEGICH. What about the percentage? What would that be—very small?

Dr. CULLEN. Very small percentage.

Senator BEGICH. And is it successful?

Dr. CULLEN. Yes.

Senator BEGICH. Why do we not model that nationally and do it? If you want to kick it back to Mr. Grinnell, that is fine. But if it is successful, why not just do it?

Mr. GRINNELL. Resources.

Senator BEGICH. Is that the issue? Have you requested that in the 2010 or 2011——

Mr. GRINNELL. That has been part of the request that we have made in the health IT line, is to begin to improve the ability to increase our telemedicine capabilities.

Senator BEGICH. OK. Do you have a plan of action if you get the resources? How long would it take you to convert, or not convert, but to ensure that this occurs in this manner?

Mr. GRINNELL. This——

Senator BEGICH. And to give you the pre-warning, if you say yes, I will ask you for that document. [Laughter.]

In all fairness.

Mr. GRINNELL. I think that at this point, the talk that is going on nationally about the Health Information Network, I think has been taking precedence over anything that we are doing right now.

Senator BEGICH. It just seems that it is working, and I think your request, Mr. Chairman, was really good. If it is working, sometimes the stuff that is working, we kind of forget about and we move on. But it seems like this is such a good one, and this is such a need, to make sure the records are back and forth. So I will follow that up at another time.

One last question, if I can, Mr. Chairman, and that is it was asked earlier on the first panel on the ability to bill the VA. Indian Health Service can bill Medicare and Medicaid but they can't bill the VA to get reimbursed, I guess. Is that correct? If you remember the earlier testimony, there was some discussion about that.

Mr. GRINNELL. Yes, that is correct.

Senator BEGICH. Is there a reason why we should not allow that to occur? Why not? Again, you can kind of flip it to Mr. Floyd if you would like, but whoever would like to answer that. Or no answer.

[Laughter.]

Mr. FLOYD. In all due respect, I am not quite sure that I know the exact——

Senator BEGICH. That is fair.

Mr. FLOYD. I could respond to that as a follow-up for this hearing——

Senator BEGICH. I would appreciate that.

Mr. FLOYD [continuing]. Question of the authority.

Senator BEGICH. Yes, if you could just answer that question. It is more so that I understand it better and to consider if there is something that we need to be thinking about here in the process of how to improve that.

Mr. Chairman, thank you very much.

[The additional information requested during the hearing follows:]

RESPONSE TO QUESTIONS ARISING DURING THE HEARING BY HON. MARK BEGICH TO JAMES R. FLOYD, FACHE, NETWORK DIRECTOR, VA HEARTLAND NETWORK (VISN 15), VETERANS HEALTH ADMINISTRATION

Question: Senator Mark Begich (D-AK) requested information about a statute that prohibits VA from reimbursing IHS for the cost of medical care provided to Veterans.

Response. No statute prohibits VA from reimbursing IHS for the cost of medical care provided to Veterans and VA does reimburse IHS for services provided to Veterans in certain situations. VA currently reimburses eligible Veterans for health

care provided by non-VA providers only in limited circumstances whereby the care that VA has deemed necessary is otherwise not offered by VA Healthcare facilities. VA seeks to control and monitor all care that eligible Veterans receive.

Current law provides sufficient direction and authority for the appropriate apportionment of costs for the care of Indian Veterans between IHS and VA. In the event that VA determines that a Veteran needs care at a non-VA facility, VA has the authority to enter into an agreement with IHS under which VA would pay for that care.

Senator TESTER. Yes, thank you, Senator Begich, and I want to thank the panelists.

Let me give a quick overview. We had in the first panel some folks that represent health care in Indian Country on the ground. My sense is—and it is not just a sense but I think it is reality—there is a level of frustration there that we could be doing more work and getting it to the ground to really serve the Native American veterans in a better way.

This panel we had here, and you are all great folks, I sense much less attention on what is going on the ground. All I would say is that the question asked by grading where you were at—I mean, you are right, Mr. Floyd, we can always do better. But I think we need to really, really work at doing better. These are really tough issues, and sometimes it just comes down to who is paying the bill. But more than that, I think it comes down to working together and finding ways which we can service, in this case, Native American veterans in a way that they deserve.

As Senator Murray said, these folks worked for the benefits. They served this country, in many cases, put their lives on the line. Promises were made. We need to make sure that those promises are kept.

I want to thank each and every one of the panelists today for their service in their individual capacities and I want to thank you for taking time out of your busy schedule to come here and visit with us. Thank you very much.

This meeting is adjourned.

[Whereupon, at 12:07 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. ROLAND W. BURRIS, U.S. SENATOR FROM ILLINOIS

Thank you Mr. Chairman, I would like to begin by extending a "Warm Welcome" to our distinguished guests, as well as fellow colleagues from the Committee. Moreover, I would like to thank you and Senator Tester for creating this opportunity to further discuss the ongoing efforts in the Veterans Health Administration (VHA) to provide safe, effective, efficient and compassionate health care to American Indian and Alaska Natives (AI/AN) veterans residing in rural areas.

It is of course my desire to see that this hearing focus on the progress between the VA and the Indian Health Service (IHS) in delivering quality health care to (AI/AN) veterans. In particular, it is my hope that we will examine the challenge of making health care in rural and urban areas more accessible, as well as the VA's needs to overcome cultural barriers to serve veterans in Indian Country.

Mr. Chairman, as you know, in February 2003 the Departments of Health and Human Services-Indian Health Service and VA signed a memorandum of understanding (MOU) to promote cooperation and sharing between the Veterans Health Administration and the IHS to further each Department's respective mission.

It is my understanding that over the past six and a half years there has been limited progress made toward the goals of this MOU. That said, it is also my understanding that overall the networks have made some progress in developing closer relationships with IHS and the Tribes and in considering means to improve services and access for AI/AN veterans. This is a good start but I would like to see further strides established toward the original intent of the MOU.

Furthermore Mr. Chairman, for a contributing ethnic group of the U.S. population (who retains dual citizenship) that has a higher percentage of people serving "per capita" in the Armed Forces than that of the general US population (24% compared to 19%) I think it only appropriate that these measures be carried out in an expedient manner.

With this in mind I want to bring to this Committee's attention a few interesting points that I think are relevant to this discussion and need to be factored in. To begin, studies and testimony from AI/AN veterans indicate that travel distance and a lack of coordination between the two agencies are key factors that inhibit AI/AN veterans' access to health care at VHA.

Another barrier AI/AN veterans are dealing with is the perception that VHA staff do not understand or accommodate the needs and unique perspectives of Indian veterans and that VHA care is not culturally or linguistically sensitive.

In addition, AI/AN veterans have indicated that the eligibility requirements and application process for receiving care from VHA can be very confusing. AI/AN veterans find the process particularly baffling as many of them may have been receiving health care from the Federal Government, IHS, all their lives under a different system of eligibility and rules for access.

Mr. Chairman, I close simply with this: it is my belief—as I know it is yours—that providing safe, effective, efficient and compassionate health care to our (AI/AN) veterans, regardless of where they live, should be the primary goal of the VHA and IHS.

PREPARED STATEMENT OF JEFFERSON KEEL, PRESIDENT,
NATIONAL CONGRESS OF AMERICAN INDIANS

Thank you for the opportunity for the National Congress of American Indians to provide testimony regarding American Indian and Alaska Native veterans and health care services provided by the Department of Veterans Affairs and the Indian Health Service.

In addition to thanking Chairman Akaka and Ranking Member Burr for the opportunity to present testimony, I want to acknowledge and thank Senator Tester for requesting today's hearing and for his leadership on the Rural Veterans Health Care Improvement Act, which includes provisions for Native American veterans' health care, through this Committee.

I believe that the Members of this Committee are aware of the valor and service of American Indian, Alaska Native and Native Hawaiian veterans to this country and that they have served in higher proportion than any other ethnic group. You also may be aware that the lack of health care to these veterans upon returning home is appalling, considering what they have done in protecting our homelands.

With the advent of the Afghanistan and Iraq wars, the number of veterans returning with injuries and disabilities, physically and emotionally, has significantly increased. And as we have learned from past wars and conflicts, the need for treatment of these warriors may not be revealed for several years after these courageous men and women return home.

The primary health care provider to tribal communities, including American Indian and Alaska Native veterans, is the Indian Health Service, which has always been woefully underfunded. Many veterans have sought health care from Veterans Health Administration hospitals because that is an option and a right. In an attempt to stretch their health care dollars, both IHS and VA hospitals have denied services to veterans, insisting they had to go to the other agency for treatment. These proud veterans, who in some instances used their last dollars to travel long distances to either facility, deserve better treatment.

As a tribal leader and veteran, I thought the days of transferring responsibility from one agency to the other were over when a Memoranda of Understanding between the IHS and Veterans Health Administration was signed in 2003. It is my understanding that the issue is still with us and it is my hope that this hearing will be a step forward in finally resolving this situation to prevent more veterans from additional suffering or worse.

There are far too many reports of inconsistency in delivery of health care to American Indian and Alaska Native veterans. NCAI staff members have been informed of concerns about delays in scheduling appointments as well as the cancellation of appointments without notice by both the Indian Health Service and Veterans Administration hospitals. We have been made aware of the backlog of delivery of basic services including dispensing eyeglasses and hearing aids. Many veterans also have shared their complaints that they believe their health problems have not been addressed because they met with medical staff who rushed them through medical exams and sent them away quickly without diagnosing problems or providing proper treatment including medication.

There are some things that are under the purview of this Committee that might help to alleviate the problems. The Veterans Health Administration has authority to create Tribal Veterans Service Offices in tribal communities, which would provide a resource for local veterans to be informed of their best options for health, housing, and other benefits and what additional resources are available for specific assistance.

I am hoping that there will be additional resources available that veterans will be able to draw from, including the reauthorization of the Indian Health Care Improvement Act that is before Congress. But any money appropriated for services authorized under the Indian Health Care Improvement Act is desperately needed for the overall population of tribal communities, and even though veterans may benefit, there still is a need for increased VA health care funding.

Remoteness of IHS and VA health facilities will always be a problem. Native veterans are likely to have scarce financial resources to expend on travel to IHS or VA hospitals. The VA, perhaps in cooperation with the Department of Transportation, should be able to work with tribal governments to facilitate transportation from tribal community hubs to Veterans Health Administration hospitals, which can, in some instances, be over 200 miles roundtrip, and for Alaska Native veterans, much, much further.

In providing services to Native American veterans, it is a basic requirement that the two agencies' systems for data exchange and communication are compatible. One of the agreements in the 2003 VA-IHS MOU was to "[d]evelop national sharing agreements, as appropriate, in healthcare information technology to include electronic medical records systems, provider order entry of prescriptions, bar code medication, telemedicine, and other medical technologies . . ."

We are aware that the IHS received $85 million under the American Recovery and Reinvestment Act for Health Information Technology. We would hope that a portion of this funding—to be used for electronic health record development and deployment, personal health record development, telehealth and network infrastruc-

ture, and other purposes—would benefit Native veterans through improved data exchange and patient tracking. We would also like the Committee to consider requesting that the IHS make some Recovery Act health IT dollars available to tribally-administered health programs, perhaps including Tribal Veterans Service Offices, in addition to internal IHS records management and infrastructure development.

Members of the Committee can also assist American Indian and Alaska Native veterans by supporting current legislation. The Indian Veterans Housing Opportunity Act of 2009 (H.R. 3553) has been introduced by Representative Ann Kirkpatrick (D-AZ), which will help disabled Native American veterans and their survivors by providing eligibility for housing assistance to which they are currently denied because they are receiving veterans disability and survivor benefits. I ask that you support this critical legislation.

The National Congress of American Indians (NCAI) passed a resolution (SD–02–079) in 2002 at their Annual Convention, calling for the development of a report on the health status of American Indian and Alaska Native veterans. Today's hearing is a significant step in pointing out that both the VA and IHS have roles and responsibilities in the treatment and care of Native veterans. We all know that Native peoples are subject to more studies than anyone in the country, but perhaps a report of the nature called for in the NCAI resolution would not be an infringement or intrusion on privacy when weighed with the potential outcome and value of such a survey. I am offering the assistance of the NCAI in supporting this effort and am sure that the NCAI Veterans Committee would lend its assistance.

Because of the government to government relationship, nearly all agencies have instituted an Indian affairs desk tasked with outreach and communication to tribal governments and organizations. The NCAI has always supported implementation of tribal affairs offices because they enhance and advance program delivery and implement policies that better serve tribal governments and communities. The Veterans Administration currently has a Native American who serves as a tribal contact in the Office of Minority Affairs. We strongly urge the VA to expand this position and move it out from the Office of Minority Affairs and establish an Office of Tribal Affairs staffed by American Indian and Alaska Native personnel who report directly to the VA Secretary. The creation of an Office of Tribal Affairs with VA also complies with the Memorandum of November 5, 2009 on Tribal Consultation issued by President Obama.

Thank you again on behalf of the National Congress of American Indians for taking the time to conduct this hearing and to provide this opportunity to hear from our organization, veterans and other supporters in calling for comprehensive delivery of the best health care available for the honorable men and women who deserve no less than the best.

Prepared Statement of Don Loudner, National Commander, National American Indian Veterans, Inc.

INTRODUCTION

Good morning Chairman Akaka, Ranking Member Burr, and Members of the Committee on Veterans Affairs. I am Don Loudner, the national commander of the National American Indian Veterans, Inc. ("NAIV"), a national not-for-profit organization dedicated to the welfare of American Indian veterans who have proudly served this country for generations. I am an enrolled member in the Crow Creek Sioux Tribe, SD, and am a veteran of the Korean War.

I want to thank the Chairman for holding this important hearing on the degree of cooperation that currently exists between the Indian Health Service ("IHS") and the Department of Veterans Affairs ("DVA") when it comes to providing the best quality health care to our Native veterans. As you can imagine, Native veterans have many of the same problems other veterans do, but also face unique challenges of unemployment and poverty as well as living in geographically-remote areas of the country.

HEALTH CARE AND AMERICAN INDIAN VETERANS

I would like to provide the Committee with information pertaining to the challenges faced by American Indian veterans regarding DVA benefits and health care, as well as DVA memorial services (e.g. Indian veteran's cemeteries). While I have worked my entire adult life to improve the standard of care and living of these men and women, in my capacity as national commander of the NAIV, I am in constant contact with American Indian veterans in the States of Arizona, California, Colo-

rado, Montana, New Mexico, Oregon, South Dakota, Wisconsin, Washington, and others.

Since 2004, the NAIV has hosted three National Conferences, the last taking place in March 2009 at the Morongo Convention Center in Cabazon, CA, with more than 500 American Indian veterans from throughout the West and Southwest in attendance. The NAIV has the support of the National Congress of American Indians, the National Association of State Directors of Veterans Affairs, the National Disabled American Veterans, and the National American GI Forum.

The chief of staff for the NAIV is the only American Indian to serve as the Director of Veterans Affairs—serving the veterans of the State of Arizona. He and I travel to the many Indian reservations constantly. Although his job is to support all of Arizona's 600,000 plus veterans, Arizona is home to 22 federally-recognized Indian tribes and American Indian veterans regularly attend his commission meetings. As a result of these meetings, he relays to me concerns regarding the lack of proper medical care delivered through the DVA to reservation-dwelling Indian veterans.

On the Navajo Reservation, for example, there are more than 12,000 veterans, but DVA has rebuffed calls to locate a permanent Community-based Outpatient Clinic ("CBOC") there claiming the number of veterans will not justify it. The fact is, the numbers will not support a CBOC at Navajo because the reservation is divided into 3 Veteran Integrated Service Network ("VISN") and, given this division, the DVA cannot count the number of veterans to justify the clinic. It is precisely this type of bureaucratic red tape which results in inaction and, ultimately, inferior or a complete lack of medical care to American Indian veterans.

Recently the DVA's Office of Intergovernmental Affairs and the Director of VISN 18 and others visited the Navajo Nation and witnessed for themselves the urgent need for additional health care facilities. They graciously called the Director of Veterans Affairs in Arizona for his input which he, of course, provided. The reality is that I have seen numerous visits over the years throughout Navajo, Pine Ridge and other Indian reservations, with little follow-up action.

When a Navajo veteran can get to a Veterans Administration Medical Center in Prescott, Arizona or Albuquerque, New Mexico, or Sioux Falls, SD, the medical care is excellent, but few if any veterans can overcome the vast distances to use such facilities. The distances are vast and transportation is not always available. As a result, many American Indian veterans try to obtain care at IHS facilities but do not receive treatment because they are veterans.

In this regard, the Memorandum of Understanding ("MOU") that was entered in 2003 by the DVA and the IHS has been ineffective because the level of cooperation is nowhere near where it needs to be for the benefit of American Indian veterans.

The idea behind the MOU was that the American Indian veteran could receive the treatment she needs at an IHS facility and the DVA would reimburse IHS for those services. The reality is that the veteran is usually the last to be seen at an IHS facility. The MOU can be strengthened and this in itself would alleviate some of the need for Community Based Outpatient Clinics on Indian reservations.

COMMENTS ON THE CAREGIVER AND VETERANS OMNIBUS HEALTH SERVICES ACT (S. 1963)

Mr. Chairman, I want to thank you for sponsoring the Caregiver and Veterans Omnibus Health Services Act (S. 1963), which was introduced last week and is already pending on the Senate Calendar. While we are carefully studying S. 1963 in its entirety, there are many excellent elements included in it that I would like to highlight.

The bill creates a much-needed Demonstration Project to examine the feasibility and advisability of expanding care for veterans in rural areas, including expanding coordination between the DVA and the IHS for health care for American Indian veterans. The bill would also assign an Indian Veterans Health Care Coordinator to each of the 10 Department Medical Centers that serve communities with the greatest number of American Indian veterans per capita, as well as an official or employee of the Department to act as the coordinator of health care for Indian veterans at the Medical Centers.

In an effort to bring the benefits of information technology to the medical records of American Indian veterans, S. 1963 would bring real advances in two key areas: (1) It would establish a Memorandum of Understanding to ensure that the health records of Indian veterans can be transferred electronically between facilities of the IHS and the DVA; and (2) It would transfer and install surplus DVA medical and information technology equipment to the IHS.

Perhaps most importantly, S. 1963 requires the Secretary of the DVA and the Secretary of the Department of Health and Human Services to jointly submit to

Congress a report on the feasibility and advisability of the joint establishment and operation by the Veterans Health Administration and the Indian Health Service of health clinics on Indian reservations to serve the populations of such reservations, including Indian veterans.

NAIV AND ITS PURSUIT OF A FEDERAL CHARTER

In 2005, then-Senator Tom Daschle introduced legislation to award a Federal Charter to NAIV. The legislation passed unanimously in the Senate but languished in the House Committee on the Judiciary. At the time, there were two bills seeking to award Federal charters to veteran's organizations, one for NAIV and one for the Korean War Veterans Association. In 2008, Congress passed legislation awarding a charter to the Korean War Veterans Association, but failed to consider the NAIV bill.

One question that NAIV faces constantly is why does NAIV need a Federal charter? Indian veterans have come together to form their own professional veterans service organization which was created out of the necessity to support ourselves and not have to rely on other service organizations like the American Legion, the VFW, or others to support and advocate for them. With our own Federal charter, NAIV would be officially sanctioned and as national commander I would be able to testify before Congress on Native veteran's issues, just as the American Legion, VFW, AmVets, and other organizations do each winter.

Chairman Akaka, American Indian veterans have earned the right to have their own Federal charter and to be recognized by Congress. No other group of Americans serves in our Nation's Armed Forces in proportion to their numbers as do Native Americans. With a Federal charter, NAIV could train and certify the required veterans benefits counselors and certify them to work on Indian reservations. This would alleviate some of the obstacles such as language barriers and access which is one of the major complaints American Indian veterans now have. Thousands of Indian veterans are going without claims being process for them because of cultural barriers. Indian veterans are dying without ever having filed a claim, leaving their widows destitute, and dependent on their respective tribe.

AMERICAN INDIAN VETERANS CEMETERIES

Currently, there are no American Indian veterans cemeteries on Indian reservations and many Indian veterans are being buried in tribal cemeteries. The sad fact is that these tribal cemeteries are often in a horrible physical condition. For example, the cemetery at Fort Defiance, AZ is so decrepit and horrible that it brought me to tears and should be closed immediately but the tribe does not have the funds to close or rehabilitate it. Visitors from the VA's office of Intergovernmental Affairs toured this cemetery and can vouch for this accuracy of my statement.

AMERICAN INDIAN VETERAN REPRESENTATION AT THE VA

Finally, there is great unhappiness among veterans in Indian country at the lack of representation of Indian veterans at the VA headquarters. All other veterans groups are represented in the ranks of the Senior Executive Service—with the exception of Indian veterans. There is only one Indian official working in the Center for Minority Veterans and that person is a GS–13. The Center for Minority Veterans in Washington, DC, has little to no credibility with American Indian veterans, and for good reason: They seldom visit the reservations. I conclude this report by stating sadly that as the situation now stands, the American Indian veteran is the least-served veteran in the United States by the VA and currently has no voice at the VA.

Unless Secretary Shinseki, who is highly respected by American Indian veterans, pays special attention to this situation and directs that the VA study the plight of Indian veterans, or Congress changes the makeup of the Center for Minority veterans to make it more accessible, nothing will change and the American Indian veterans will continue to receive poor health and other services.

This concludes my prepared statement Mr. Chairman.

PREPARED STATEMENT OF CAROL WILD SCOTT, CHAIR, VETERANS LAW SECTION, FEDERAL BAR ASSOCIATION

The National Congress of the American Indian estimates that 22% of the Native American/Hawaiian and Alaskan Native population are either members or the Armed Services or veterans. This represents the highest level of participation of any identifiable group in our population in the defense of this country. The service ren-

dered to this Nation is freely given by sovereign peoples among us chiefly out of patriotism and the warrior tradition.

All veterans, including Native American veterans are entitled to a wide range of benefits and services as a result of their military service. Native American/Hawaiian and Alaskan Native veterans have less access to and thus receive far fewer, VA benefits and services than does the veteran population as a whole. Native American veterans who live west of the Mississippi and in Alaska live in great part on reservations. They do not have access to VA health care or meaningful access to the Veterans Benefits system though which they may seek the health care to which they are entitled. Accordingly, there are far fewer appeals taken from denial of pension and compensation.

The estimates of the incidence of PTSD in the population of Vietnam and Southwest Asia veterans as a whole range around 50%. For many reasons grounded in cultural and economic circumstances, this may be a low estimate in Native American veterans. Neither VA nor IHS provides effective treatment modalities for these veterans. With very few exceptions, there is no culturally compliant therapy available to Native American veterans and their families, particularly in dealing with the secondary effects of PTSD presenting as self-medication, domestic violence and suicide. Native American women veterans particularly receive nowhere near the mental health care they need for Military Sexual Trauma (MST). Nor do they receive the other medical care they need for service related trauma and illnesses from either VA or IHS. Despite the existence of the MOU of 2003 between DVA and IHS there is insufficient effective interface between IHS and VA health care systems.

Traditionally, Vet Centers, in urban and suburban settings have provided counseling and treatment for PTSD and other mental health issues. There is currently legislation pending to expand the number of these centers. The creation of "Traditional Tribal Vet Centers" (Centers) on the reservations, conjoined and complementing existing IHS facilities, would address a wider range of issues for the Native American veterans than those in urban and suburban settings.

These Centers would be a cooperative enterprise between DVA, IHS and the Tribal governments, fully implementing the MOU of 2003 between IHS and DVA. Through the Centers Native American veterans would receive mental health services from Western and Traditional Healing practitioners. The availability and presence of both modalities would provide documentation for benefits purposes. In addition to the mental health services, the VA/IHS cooperation would provide readily available attention for medical issues arising from such matters as TBI, wound care, damaged prostheses as well as medication. Such issues, once identified would then be referred into the clinic/VAMC system. Native American women veterans would particularly benefit from the availability of mental health and medical care in this setting. Family counseling and training for family care givers for severely wounded veterans should also be available through these Centers.

The availability of adequate medical care is dependent on the grant of service connection for injuries, illness and diseases incurred in or the result of military service. Not only must the grant of compensation be appropriate, but the rating must be adequate. The presence of trained representatives designated as such by the Tribal Councils, and most importantly, accredited and certified to the Agency on the same footing as state and county employees is critical to the adequate utilization of the Centers. This status is not provided for in the current regulatory scheme, and would require modification of 38 CFR Sect. 629.14(2), which currently provides only for state and county employees, thus by definition excluding Tribal Veterans Representatives (TVRs) as designees or employees of a sovereign entity.

The innovative concept of "TVRs" was designed and implemented by James R. Floyd, currently Network Director of VISN 15 in Kansas City, MO. This was an effort to provide Native American veterans with a trustworthy emissary to assist in seeking benefits and dealing with the VA benefits and health care bureaucracy. The drawback is that the TVRs lack accreditation and all training is done by VA, which gives rise to inherent conflict of interest issues as well as a wholly unintended contribution to the inadequacy of representation because the TVRs function largely as intermediaries rather than accredited representatives. Provided with a training program independent of VA, culminating in accreditation to the Agency, the TVRs would make a tremendous contribution to the meaningful availability of compensation and benefits to Native American/Hawaiian and Alaskan Native Veterans.

An important issue relating to the needs of Native American veterans is trust, or lack of it. There is a profound reluctance to discuss matters related to combat with anyone; including members of the same tribe. A long history of racism, distrust of governmental entities, and an unwillingness to approach representatives of governmental entities exacerbate the situation. Intergovernmental cooperation in establishing Traditional Tribal Native American Vet Centers would provide at least some

solutions. The establishment of an Office of Native American Affairs within the Department of Veterans Affairs would further considerably the development of programs and services for Native American/Hawaiian and Alaskan Native veterans.

The Veterans Law Section of the Federal Bar Association urges your recognition of the profound needs of these veterans, and consideration and adoption of the measures discussed herein. The views and proposals discussed herein are those of the Veterans Law Section and not necessarily those of the Federal Bar Association as a whole.

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Testimony for the Record
Northwest Portland Area Indian Health Board

before the

Senate Committee on Veterans' Affairs
Veteran's Affairs and Indian Health Service Cooperation

Chairman Akaka, Vice-Chair Burr, Senator Murray of Washington, and members of the Committee, thank you for this opportunity to include our statement into the record concerning the Veterans Administration and Indian Health Services cooperation.

Established in 1972, the NPAHB is a P.L. 93-638 tribal organization that represents forty-three federally recognized Tribes in the states of Idaho, Oregon, and Washington on health care issues. The Board facilitates consultation between Northwest Tribes with federal and state agencies, conducts policy and budget analysis, and operates a number of health promotion and disease prevention programs. NPAIHB is dedicated to improving the health status and quality of life of Indian people and is recognized as a national leader on Indian health issues.

This hearing has been long awaited by Indian Country. The entire federal health system is obligated to step up and work in collaboration to meet the needs of the most worthy of health care in our nation--our Veterans. American Indian and Alaska Natives (AI/AN) have volunteered to serve in the United States military in greater numbers on a per capita basis than any other race in this country. Most compelling is that even when AI/AN Warriors were not considered U.S. citizens, they volunteered to serve in this Country's military. AI/AN veterans have served with honor and valor in every war fought by this nation.

Many AI/AN veterans returned from war to face barriers in accessing health care for medical conditions that were received defending this Country. Many Indian communities are isolated in the rural areas which require veterans to travel hours to a VA hospital, and this is often a barrier to receiving care. AI/AN veterans are often not able to navigate the cumbersome process of applying for benefits they are entitled to, nor may they know what benefits they are eligible for. A number of AI/AN veterans have returned with Post Traumatic Stress Disorder (PTSD); a mental illness that has just recently been deemed as a qualifying condition for VA benefits. Most frustrating to AI/AN veterans, is the lack of culturally competent services or treatment offered. This results in AI/AN veterans not seeking treatment for PTSD or other health conditions, because the VA does not provide culturally competent health services. Often, there is no help offered to the spouses and children of veterans who have suffered trauma associated with worrying about the well-being of their loved one or that they may never return from war. Domestic violence issues have risen greatly in this current war with Iraq and Afghanistan, yet culturally competent services are not provided to returning AI/AN Veterans.

The Indian Health Services

The federal government has a duty- acknowledged in treaties, statutes, court decisions, and Executive Orders – to provide for the health and welfare of Indian Tribes and their members. In order to fulfill this legal obligation to Tribes, it has long been the policy of the United States to provide health care to AI/AN people through a network made up of Indian Health Service (IHS) programs, tribal health programs, and urban clinics. The IHS directly and through tribal health programs carrying out IHS programs under the Indian Self-Determination and Education Assistance Act, P.L. 93-638 as amended (ISDEAA), provides health services to more that 1.9 million AI/AN people. These services are provided to members of 562 federally recognized tribes in the United States, located in 35 different states.

However, Congress has never fully funded the IHS budget; at best this budget has been funded at 50% of need. This puts most Indian Health Service clinics and hospitals under a priority one status every year; which mean only patients in danger of losing" life or limb" are seen by a provider This means only extreme medical conditions are treated, leaving thousands untreated and this includes native veterans. Due to these funding constraints the IHS and VA must do a better job of collaborating to provide AI/AN veterans health care services.

The Veterans' Administration

The Veterans Health Administration's six strategic goals are; quality first until we are first in quality; provide easy access to medical knowledge, expertise and care; enhance, preserve, and restore patient function; exceed patient's expectations; maximize resource use to benefit veterans; and build healthy communities. The VA has been charged by Congress under Title 38, USC to provide compensation and health benefits to qualifying veterans.

MOU Between Veterans Health Administration and Indian Health Services

On February 25, 2003, Leo S. MacKay Jr., Deputy Secretary of Veterans Affairs and Claude A. Allen, Deputy Secretary of Health and Human services, signed a Memorandum of Understanding between the VA/Veterans Administration and HHS/Indian Health Services.

"The purpose of this Memorandum of Understanding (MOU) is to encourage cooperation and resource sharing between the Veterans Health Administration and Indian Health Services (IHS). The goal of the MOU is to use the strengths and expertise of our organizations to deliver quality health care services and enhance the health of AI/AN veterans. This MOU establishes joint goals and objectives for ongoing collaboration between VHA and IHS in support of their respective missions." The MOU set forth five mutual goals:

1. Improves beneficiary's access to quality healthcare and services
2. Improves communications among the VA, AI/AN veterans and Tribal governments with assistance from the HIS
3. Encourage partnerships and sharing agreements among VHA headquarters and facilities, IHS headquarters and facilities, and Tribal governments in support of AI/AN veterans.
4. Ensure that appropriate resources are available to support programs for AI/AN veterans.

5. Improve health-promotion and disease prevention services to AI/AN veterans.

Another criterion of this MOU is to create an interagency work group to oversee proposed national initiatives. This work group was established with personnel from IHS headquarters and VHA headquarters. There were no Tribal leaders on this workgroup to address the needs of native veterans.

Recommendations related to the VA/IHS MOU:

1. The VHA-HHS MOU needs to be re-invigorated on the national level by placing benchmarks, and timelines on the MOU workgroup; requiring tribal representation on this workgroup; and finally, identifying key personnel to fulfill the work of this group. If a meaningful template could be developed it could be used across the IHS system and tribal governments, evaluated, and then become a culturally competent evidenced based vehicle and be modeled nationally.

   AI/AN veterans should be allowed to receive services at their local IHS/tribal facility to ensure that they receive the highest quality and culturally competent health care they are entitled to from either, or both, agencies. This allows the veteran to receive care at their "medical home" from providers they are acquainted with and who understand their health conditions. This also saves the AI/AN veteran from having to endure a lengthy journey to a VHA facility. The IHS facility in turn should be reimbursed by VHA for this service to a qualifying veteran. Many Tribes rely on Contract Health Services funding to acquire specialty care services for their AI/AN veterans. These are veterans who do meet the criteria for care at a VHA facility by VA standards. These veterans should be allowed to receive specialty care at a VHA facility and be reimbursed by the tribe through their CHS funding. Both systems are federal providers of health care, and when one can save the other money, should be allowed to provide services. An alternative to this situation would be to outstation VHA specialty care providers at IHS facilities.

2. Compensation Examination: IHS physicians should be allowed to perform these examinations for AI/AN veterans. This not only saves travel costs by the veteran and VA, it also allows the native veteran to be seen in their "medical home" by providers that are familiar with the veteran's health issues. Currently, the VA contracts with a "gatekeeper" (QTC Medical Services, Inc.) who in turn contracts with approved providers to do compensation-examinations and assessments. IHS would be able to more effectively complete related diagnosis for compensation examinations due to established relationships with the veteran's medical providers.

3. Mental Illness Conditions – This is the most sensitive issue for a native warrior to face, this deals with AIAN veterans most sacred being—his spirit. When an AI/AN veteran's spirit is wounded it cannot be cured by traditional Western medicine. Tribes have spiritual medicine people that provide this service not only to their own tribal members, but also to other tribal members. Suicide rates have long been a problem among native veterans; again this is a mental illness that requires culturally competent evidenced based treatment. This may also be accomplished by the VHA by out-stationing mental health personnel to IHS facilities.

Tribal Veterans Representative Program (TVR)

The VA should establish under the joint MOU a TVR Program at IHS Headquarters and in each of the twelve IHS Area Offices. These personnel should be trained by the existing TVR program to serve AI/AN veterans within each area; they would also facilitate quality health care that best meets the needs of the native veterans within their area. Also "Area" TVRs could assist Tribes to negotiate sharing agreements with the local VA Regions.

Three local native veterans from Washington State started a collaboration to help native veterans navigate the VA system, which has grown into a program that is now chartered in Washington State as non-profit organization. At last count there are seventeen TVRs in Washington, four of these are paid positions and the rest are volunteers. This group provides cultural competency training to VA/VHA personnel and technical assistance to tribes to develop a TVR program for themselves. This group has provided a service that is invaluable to native veterans and a large financial savings to tribal programs. They assist veterans in obtaining their compensation benefits, education benefits, dependent benefits, housing benefits, and a whole host of other services. They are the strongest advocates for native veterans and do a lot of their work on their own time and on their own resources. This is something that these people do culturally and naturally, this is the way Indian people help each other. They do not limit themselves to just the veteran, they work with the community as a whole. The community is the family; everyone knows what these veterans are suffering. It is common that native veterans are hesitant to approach a government agency for help. They turn to these TVR people to help them through a very cumbersome system, a person that will advocate for them specifically, one who won't back down until the veteran has receive the benefits they are richly entitled to. These programs must be supported by IHS and the VA.

Conclusions

The challenges in providing care to AI/AN veterans are unlike any other. They are the poorest, sickest, and most remote populations in the United States. It is because of these barriers that the joint MOU between VA and HIS was brought into being. Unfortunately like a lot of great ideas this one never really got off the ground. A few sharing agreements were established however had little long term viability—especially at the grassroots level—for tribal veterans. It is our position that establishing a TVR program with IHS will effectively facilitate implementation of MOUs with local tribal governments and that AI/AN veterans will receive the compensation benefits they are entitled to. We as a nation should never forget the sacrifices our veterans have made for all of us throughout the history of this great nation. They should not be forgotten or denied services they deserve and are entitled to. Please do not let them not be forsaken.

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