S. HRG. 112–703

VA'S COLLABORATION WITH INDIAN HEALTH SERVICE: IMPROVING ACCESS TO CARE FOR NATIVE AMERICAN VETERANS BY MAXIMIZING THE EFFECTIVE USE OF FEDERAL FUNDS AND SERVICES

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

SPECIAL HEARING

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VA'S COLLABORATION WITH INDIAN HEALTH SERVICE: IMPROVING ACCESS TO CARE FOR NATIVE AMERICAN VETERANS BY MAXIMIZING THE EFFECTIVE USE OF FEDERAL FUNDS AND SERVICES

TUESDAY, AUGUST 30, 2011

U.S. SENATE,
SUBCOMMITTEE ON MILITARY CONSTRUCTION AND VETERANS AFFAIRS, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Rapid City, SD.

The subcommittee met at 10 a.m., at the Journey Museum, 222 New York Street, Rapid City, South Dakota, Hon. Tim Johnson (chairman) presiding.

Present: Senator Johnson.

OPENING STATEMENT OF SENATOR TIM JOHNSON

Senator JOHNSON. Good morning. This hearing will come to order.

I welcome everyone to Rapid City today to discuss collaboration between the Department of Veterans Affairs (VA) and the Indian Health Service (IHS).

Present today are councilmen from Crow Creek Tribe, Oglala Tribe, and the chairman of the Rosebud Tribe.

Our first panel today will be Dr. Robert Jesse, Principal Deputy Under Secretary for Health, Veterans Health Administration (VHA); Randy Grinnell, Deputy Director of the IHS; and Stephanie Elaine Birdwell, Director of the Office of Tribal Government Relations (OTGR) at the VA.

Welcome, and I look forward to your testimony today.

IHS and the VA have very unique responsibilities, but often overlap in their roles of providing care to Native American vets. Today's hearing is aimed at determining how the two departments plan to work together to deliver services in a more efficient manner.

The budget climate we face today means that the Federal Government is going to be asked to do more with less. The VA and IHS will need to be more innovative and collaborative than ever in order to provide services in a very demanding environment. In particular, the VA and IHS need to be more proactive in their efforts to ensure that Native American vets receive the care that they have earned through their service in the Armed Forces.

Native American vets face unique challenges in receiving VA benefits due to a number of factors, including a lack of access on tribal lands and an often confusing maze of bureaucratic hurdles leaving vets unsure of whether they should be receiving care through the IHS or the VA.

I am hopeful that today's hearing will provide a better understanding of how both departments plan to address these problems. I am especially interested in how the VA and the IHS plan to leverage technology to bring services closer to where these vets live.

With that said, again I welcome you to South Dakota. Thank you for coming, and I look forward to your testimony.

Dr. Jesse, please proceed.

STATEMENT OF ROBERT L. JESSE, M.D., Ph.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Dr. JESSE. Thank you, Senator.

Good morning, Mr. Chairman. First, thank you for inviting me and Ms. Birdwell, the Director of the OTGR, to discuss the collaboration between the VHA and the IHS on improving access to care for Native American veterans by maximizing the use of Federal funds and services.

I am accompanied today also by Mary Beth Skupien, who is the Director of the VHA Office of Rural Health, and Janet Murphy, who is the Director of the VA Midwest Healthcare Network, which is Network 23, providing services in South Dakota, North Dakota, Iowa, and Minnesota, Nebraska, and portions of Illinois, Kansas, Missouri, Wisconsin, and Wyoming.

Increasing access for veterans is one of Secretary Shinseki's top priorities and has several components immediately relevant to the Native American and rural veterans. On a national level, VA is investing more than $270 million to improve access and quality care services to rural and highly rural veterans, including $43 million in telehealth.

As of August 1, 2011, we are now operating 16 active telehealth programs for Native American, Alaska Native, and Pacific Island veterans. We continue to look for more opportunities to extend our reach in delivering quality healthcare so that Native American veterans in remote areas can have the same access to healthcare from national experts as their urban counterparts.

In October 2010, the VA and IHS signed a new memorandum of understanding (MOU). Its principal goals are for VA and the IHS to provide patient-centered collaborations in consultation with tribes at regional and local levels. These efforts are already paying dividends.

For example, last October, we initiated a pilot program here in Rapid City, South Dakota, to promote the safety and cost effectiveness of providing prescription refills by mail for veterans and other IHS patients. This program will enhance prescription delivery to federally recognized tribes and about 2 million Native Americans.

Similarly, VA collaborates with IHS and tribal governments to expand home-based primary care, including a number of local initiatives to improve access and outreach for Native Americans in South Dakota. The VA Black Hills Healthcare System, to name one example, maintains a robust noninstitutional purchased care pro-

gram that offers eligible veterans in-home care when travel for healthcare is not possible or would be made difficult.

In addition, the Wagner, Watertown, Spirit Lake, Sioux City, and Aberdeen clinics are planning information fairs and open houses to inform veterans of available services and benefits, to enroll eligible veterans so that they may access these hard-earned benefits.

The Sioux Falls VA Healthcare System holds monthly phone conferences with the IHS Aberdeen area office so IHS can determine the potential areas of resource sharing, including services for radiology, audiology, laboratory, physical therapy, and patient transportation.

Through local agreements, VA and IHS share technical training, informatics, and electronic health records (EHRs). VA's contract clinics at Mission, Winner, Eagle Butte, Faith, Pierre, and Isabel now serve veterans from Lakota, Nakota, and Dakota tribes in South and North Dakota. VA provides transportation support to the South Dakota tribes at Rosebud, Standing Rock, Cheyenne River, and Pine Ridge Reservations. And VA provides pharmacy mail order services for tribes in South Dakota.

In April 2010, VA opened the Wagner community-based outreach clinic (CBOC), the first CBOC built on tribal land for a variety of primary and mental healthcare. The Wagner CBOC also hosts a home-based primary care team, which helps Native Americans remain in their homes and avoid frequent rehospitalizations or emergency room visits for chronic conditions.

Our Readjustment Counseling Service Mobile Vet Center Program provides early access to returning combat veterans via outreach at a variety of military and community events, and today we want just to acknowledge and thank them for showing up here. And they are parked outside the museum so that veterans can access our services.

And Mr. Chairman, we understand the unique difficulties Native Americans face when accessing care. We are committed to working to improve that access in partnership with IHS. We are introducing VA providers to traditional healing practices so that they can work to integrate these practices as adjuncts to Western medicine.

PREPARED STATEMENT

And finally, I just really want to thank you personally for your support and that of the subcommittee and the Congress for securing VA resources that we need to deliver better, more accessible care to Native Americans. As you know, there has been a book written about the VA called "The Best Care Anywhere". It is in its second edition. And we think we strongly believe that the title of that next book should be "The Best Care Everywhere", and VA is committed to providing that.

So thank you again, and I am prepared to answer any questions.

[The statement follows:]

PREPARED STATEMENT OF ROBERT L. JESSE

Good Morning, Mr. Chairman. Thank you for inviting me to discuss the collaboration between the Department of Veterans Affairs (VA) and the Indian Health Service (IHS) on improving access to care for Native American veterans by maximizing the use of Federal funds and services. I am accompanied today by Mary Beth Skupien, Director, Veterans Health Administration's (VHA's) Office of Rural Health,

and Ms. Janet Murphy, Director of the VA Midwest Health Care Network (Veterans Integrated Service Network (VISN) 23), which provides services to veterans in South Dakota, North Dakota, Iowa, Minnesota, Nebraska, and portions of Illinois, Kansas, Missouri, Wisconsin, and Wyoming.

Native American veterans face many of the same challenges as veterans living in rural and highly rural areas, such as geographic distance from healthcare facilities and a shortage of skilled community providers. Native American veterans also face unique challenges of their own, such as higher morbidity for certain conditions and the need for culturally appropriate care. Earlier this year, VA established an Office of Tribal Government Relations, which is working in close cooperation with VHA's Office of Rural Health (ORH), specifically to serve as an advocate within the Department for Native American veterans and help VA improve healthcare access and services for Native American veterans. Increasing access for veterans is one of the Secretary's top priorities for the Department and has several components immediately relevant to Native American and rural veterans—it means bringing care closer to home, sometimes even into the veteran's home; increasing the quality of the care we deliver; and providing veteran-centered care in a time and manner that is convenient to our veterans.

My testimony will begin by reviewing VA's plans in fiscal years 2011 and 2012 for continued support of ORH projects and other rural health initiatives. I will then focus on VA's memorandum of understanding (MOU) with IHS and our continually evolving partnership. My statement will conclude with a discussion of VA's efforts in South Dakota to ensure veterans, particularly Native American veterans, receive the care and benefits they have earned.

FUNDING FOR RURAL AND NATIVE AMERICAN VETERANS

With the funding provided by the Congress in fiscal year 2011, VA will invest more than $270 million to improve the access and quality of healthcare services to rural and highly rural veterans, including $43 million in telehealth programs. Telehealth involves the use of information technology to deliver services when the patient and healthcare provider are separated by geographic distance. We have seen a 20-percent increase in the use of telehealth services by veterans living in rural and highly rural areas between fiscal year 2008 and fiscal year 2010. VA-supported telehealth programs offer specialty services, including mental health, dermatology, amputee care, pharmacy, polytrauma, radiology, and others. As of August 1, 2011, VA operates 16 active telehealth programs for Native American, Alaska Native, and Pacific Island veterans. Telehealth can reduce the need for travel by patients and providers, but it does not replace the need for face-to-face care delivery. We continue to look for more opportunities to extend our reach in delivering quality healthcare. We are exploring the use of wireless technologies, mobile resources, and more accessible facilities so that Native American and rural veterans in remote areas can have the same access to healthcare from national experts as their urban counterparts.

Other ORH-managed programs include Project Access Received Closer to Home, a pilot program authorizing the use of contractual agreements with non-VA providers to deliver care closer to home and three veterans rural health resource centers, which function as field-based clinical laboratories and serve as rural health experts for all VISNs. ORH also supports continuing projects and initiatives, including:

—More than $70 million to support 52 rural community-based outpatient clinics (CBOC);

—Almost $26 million in home-based primary care at 21 sites;

—$1.5 million to support treatment for substance use disorders;

—Nearly $5 million to end homelessness among rural veterans including funds to promote outreach, prevent homelessness among at-risk veterans, distribute emergency housing vouchers, and support grant and per diem programs. ORH-funded programs in Sioux Falls and nationally are demonstrating improved collaboration within the community to address homelessness in rural areas and have a demonstrable impact on preventing homelessness. These efforts also improve the quality of life and functioning for veterans served and reduce the frequency of visits by veterans within the primary care setting.

—More than $3 million to enhance transportation options for veterans in rural and highly rural areas; and

—$91.2 million to sustain 76 additional rural health projects, such as mobile health clinics, case management and mental health services, geriatric care, non-institutional care, and other specialty services.

VA is addressing mental healthcare needs of rural veterans through ORH's support of the Mental Health Intensive Case Management program. This allows VA to

hire staff to provide case management services to veterans with severe mental illness. This program has demonstrated its success in preventing homelessness and helping patients to set goals to improve their quality of life and reintegrate into the community.

VA operates a fleet of 50 mobile vet centers that provide early access to returning combat veterans via outreach to a variety of military and community events including demobilization activities. The vehicles are also extending vet center outreach to more rural communities that are isolated from existing VA services. The vehicles consistently provide services to Native American reservations and are staffed with veterans who understand firsthand the needs of these communities.

The VA Black Hills Health Care System (Hot Springs campus) is serving almost 300 veterans in 13 counties within a 60-mile radius of the facility, including much of the Pine Ridge Reservation, through a full home-based primary care (HBPC) team. Further enhancements are planned for fiscal year 2012 to provide HBPC and in-home skilled care for veterans in the southwestern portion of South Dakota, including previously unreached parts of the Pine Ridge Reservation. A second program is VA's Medical Foster Home, which matches veterans who are unable to remain in their homes with people in the community who are willing to care for them. This is a new program that is currently being marketed to veterans and the community, and we anticipate we will begin admitting veterans to the program later this year.

In fiscal year 2012, VA will continue to support many of the same projects as in fiscal year 2011, and we look forward to initiating further measures to increase access to care for rural, highly rural, and Native American veterans. In fiscal year 2012, ORH will again support increased access to care by funding telehealth service projects, such as tele-mental health, tele-retinal care, tele-pharmacy, tele-radiology, tele-rehabilitation, tele-dermatology, and other innovative telehealth services. We will conduct outreach and marketing efforts to encourage veterans who need these services to access them. We will also support greater community collaboration and access to specialty services, and we will promote education programs, including healthcare provider training to teach providers how to care for the unique needs of rural and highly rural veterans, as we enhance our recruitment and retention efforts for providers in rural areas.

INDIAN HEALTH SERVICE PARTNERSHIP

Complementing our national efforts, VA and IHS signed a new MOU on October 1, 2010. In contrast to a February 2003 MOU, this current agreement includes more areas of focus and is more specific concerning the obligations of each party to coordinate the delivery of care for Native American veterans. The memorandum's principal goals are for VA and IHS to promote patient-centered collaborations in consultation with tribes at the regional and local levels. Although national in scope, the MOU provides the necessary flexibility to tailor programs through local implementation. We believe that by bringing together the strengths and resources of each organization, we will improve the health status of American Indian and Alaska Native veterans.

We also recognize that interagency agreements are critical to our joint efforts. VA and IHS continue to work through payment and reimbursement policies and practices, including working to resolve legal questions resulting from new provisions in Public Law 111–148, the Patient Protection and Affordable Care Act.

Another primary goal of the MOU is to promote the health of our veterans through disease prevention and community-based wellness programs. Through cultural awareness and culturally competent care, sharing staff and training programs, and collaborating on issues such as care for post-traumatic stress disorder (PTSD), suicide prevention, pharmacy management, and long-term care, we can deliver the care Native American veterans need.

VA and IHS have established 14 workgroups to develop specific recommendations and action items related to the MOU. The workgroups are focused on areas such as services and benefits, coordination of care, health information technology, implementation of new technologies, payment and reimbursement, sharing of services, cultural competency and awareness, training and recruitment, and others. We have made significant progress in many of these areas, and will continue to monitor progress through weekly meetings and quarterly updates to leadership on the remaining items.

The efforts of VA and IHS are already paying dividends. For example, last October, we initiated a pilot program in Rapid City, South Dakota, to improve the safety and cost effectiveness of providing prescription refills by mail for veterans and other IHS patients. This program will enhance prescription delivery to federally recognized tribes and about 1.9 million Native Americans. Based on initial reports, both

veterans and staff are very pleased with the arrangement, which has reduced the amount of time it takes to transfer medication from VA to veterans and improved the ability of veterans to adhere to their treatment regimens.

Similarly, VA has several collaborative projects with IHS and tribal governments to expand home-based primary care to Native American and rural veterans. In fiscal year 2011, VA supported these programs in 11 States, including two locations in South Dakota (Rosebud and Pine Ridge). Hospice and Palliative Care has also received support from VA's ORH to partner with IHS so that all veterans will have reliable access to these services from a knowledgeable and skilled workforce.

SOUTH DAKOTA PROJECTS AND INITIATIVES

In addition to these collaborative efforts between VA and IHS, the Department is also supporting a number of local initiatives to improve access and outreach for Native American veterans in South Dakota. To this end, VA obligated approximately $4 million in fiscal year 2011 to expand telehealth, audiology, home-based primary care, mental healthcare, and medical foster homes. When we are unable to deliver care ourselves, VA Black Hills Health Care System maintains a robust non-institutional purchased care program. This service offers eligible veterans in-home care when travel for healthcare is not possible or would create a significant hardship. VA Black Hills Health Care System purchases home hospice, skilled nursing, skilled services, homemaker/home health aide, and adult home day care services for more than 1,000 rural veterans.

For mental healthcare, two sites offer Compensated Work Therapy in the State of South Dakota—the Cheyenee River Miniconjou Lakota Reservation and the Pine Ridge Oglala Lakota Reservation. VA's Compensated Work Therapy programs provide paid vocational rehabilitation models designed to return veterans with mental health conditions to the highest level of functioning, living, and working in their communities. VHA program staff work collaboratively and cooperatively with tribal government leadership for reservation-based programming. VA also has established mental health specialty clinics for Native veterans. For example, the Rosebud clinic offers tele-psychiatry, and the Standing Rock facility offers tele-psychiatry and live clinics for mental health conditions. Cultural outreach and other services include a residential alcohol and PTSD program with a VA sweat lodge at the Hot Springs clinic of the VA Black Hills Health Care System. Native Americans use the sweat lodge as a spiritual place for healing to be able to send prayers and thoughts to the Creator and grandfathers through the use of meditation, song, and prayers. A sweat lodge is a dome-shaped structure made of 28 willow branches, which represent the 28 ribs of the sacred buffalo, covered by canvas or other materials to hold in the heat and uses the heat and steam from the heated rocks for spiritual cleansing.

Several additional efforts are underway to increase Native Americans' access to care in South Dakota. For example, the Wagner, Watertown, Spirit Lake, Sioux City, and Aberdeen clinics are planning information fairs and open houses to inform veterans of services and benefits they may be eligible for and to enroll them if needed. The Sioux Falls VA Health Care System holds monthly phone conferences with the IHS Aberdeen area office so the IHS can determine potential areas of resource sharing, including services for radiology, audiology, laboratory, physical therapy, dietetics, telehealth, outreach, and patient transportation. We are also developing plans to use video-teleconferencing to provide tele-mental health services to veterans in the Sisseton area through an agreement between VA and IHS.

VA provides office space and serves as a regional information technical support center for the Aberdeen Area Office of IHS. VA and IHS share technical training, informatics, and electronic health records through local agreements. VA Hot Springs provides IHS' Pine Ridge Hospital with information resource management consultation and other services such as use of a General Services Administration vehicle, phone line costs, and parts exchange-purchase. VA's contract clinic at Mission serves veterans from Lower Brule and Sioux tribes, and the Winner VA CBOC located on the Rosebud Reservation serves veterans from Lower Brule, Rosebud, and Yankton Sioux tribes, Eagle Butte, Faith, and Winner. VA provides transportation support to the South Dakota tribes at Rosebud, Standing Rock, Cheyenne River, and Pine Ridge Reservations, and VA provides pharmacy mail order services for tribes in South Dakota.

In April 2010, VA opened the Wagner CBOC which is located on tribal land provided through an agreement with the Yankton Sioux Tribe and Aberdeen area IHS and is the first CBOC built on tribal land for the sole purpose of providing VA primary and mental healthcare. The Wagner CBOC hosts an HBPC team, which helps veterans remain in their homes and avoid frequent re-hospitalization or emergency

room visits for chronic conditions. Similarly, care coordination/home telehealth services are also provided at this facility.

CONCLUSION

Mr. Chairman, we understand the unique difficulties faced by Native American and rural veterans in accessing care, and we are committed to working to improve access to care. We are introducing VA providers to traditional healing practices and the unique practices of local tribes to help them understand how these practices may be integrated as adjuncts to traditional care. We greatly appreciate your support, and the Congress' support, in securing the resources VA needs to deliver better, more accessible care to all of America's veterans. This concludes my prepared statement. I am prepared to answer your questions at this time.

Senator JOHNSON. Thank you, Dr. Jesse.

Mr. Grinnell, please proceed.

STATEMENT OF RANDY GRINNELL, M.P.H., DEPUTY DIRECTOR, INDIAN HEALTH SERVICE

Mr. GRINNELL. Good morning, Senator Johnson.

I am Randy Grinnell, Deputy Director of IHS. I am accompanied today by Rick Sorenson from the Aberdeen area office. Pleased to have this opportunity to testify on the IHS/VA collaboration.

IHS has a unique role in the Department of Health and Human Services because it is a healthcare system established to meet the Federal trust responsibility to provide healthcare to American Indians and Alaska Natives. Our mission is to raise the physical, mental, social, and spiritual health of American Indian and Alaska Natives to the highest level.

IHS provides comprehensive healthcare services to approximately 1.9 million American Indian and Alaska Natives through a network of hospitals, health centers, and clinics located in 35 States, many of them in rural and remote areas where access is a challenge. We also provide care through the private sector, through Contract Health Service (CHS), for those types of services that are not available directly.

In 2006, a joint VA/IHS study was initiated to review dual use of the two systems. The findings of the study indicated that veterans using the VHA are similar to other veterans with similar medical conditions, such as post-traumatic stress disorder (PTSD), hypertension, and diabetes. The review also found that dual users are more likely to receive primary care from IHS and general medical diagnostics and medical healthcare from the VHA, and they are likely to receive complex healthcare services from both systems.

Many of the American Indian and Alaska Native veterans are eligible for healthcare services from both IHS and VHA. We estimate within our patient registration system that we have got approximately 45,000 who are identified as veterans in our system. Many of them live in rural areas as well and have trouble accessing direct facilities, and therefore, they are dependent upon our urban Indian health programs where they are located in 34 cities.

IHS also pays for referred care outside the system for veterans if they meet the CHS program rules and regulations. The VHA is considered an alternate resource, along with Medicare, Medicaid, and private insurance in accordance with our CHS regulations.

The MOU that Dr. Jesse talked about was recently signed in 2010. He identified the five mutual goals of that, which I will talk about briefly. It was to improve access to care and services; im-

prove communication between the VA, tribes, and IHS; encourage partnerships and sharing agreements between the three entities; also to ensure appropriate support for programs that serve American Indian and Alaska Native veterans; and also to improve access to health promotion and disease prevention services.

The principal focus of both of these agreements is to provide optimal healthcare to American Indian and Alaska Native veterans. Examples include allowing VHA staff to utilize IHS and tribal facilities to provide services, opportunities that IHS providers take advantage of through the VA for clinical skills training and education.

Dr. Jesse also talked about the traditional healing, where we have been working with the VHA to bring that approach into their delivery system. Dr. Jesse also talked about the VHA home-based primary care project. Right now, there are 13 collaborative projects in States in New York, North Carolina, Oklahoma, Oregon, New Mexico, California, Mississippi, and Minnesota, as well as the Rosebud and Pine Ridge Reservations here in South Dakota.

One of the other examples includes increasing mental health services by locating VHA social workers in healthcare facilities on both the Navajo and the Hopi reservations in the Southwest.

Dr. Jesse also talked about the Wagner service unit, where the VA has opened a community-based outpatient clinic. Services are being shared there, include audiology, include lab, include dietary and radiology.

On the Navajo reservation, an agreement is currently in place with the Prescott VA that allows IHS office space for VA PTSD counselors. Also there is work underway with Prescott to increase services by allowing more space so that they can provide services directly to Navajo veterans.

In Montana, there are currently telepsychiatry mental health services provided at each of the service units throughout the Montana area. It is an example of success and a way of reaching those remote locations and providing needed services.

Another example is in Alaska. Since 1995, there has been the Alaska Federal Healthcare Partnership, which brought Federal and tribal entities together to increase access of services both in the rural areas and the remote areas of Alaska, but also to bring the technology advancements that the VA has brought to healthcare and take advantage of it.

There are more than 100 telemedicine equipment carts that are now in rural locations throughout Alaska, and they also have deployed digital imaging radiology services to more than 51 Federal and tribal facilities across Alaska.

I would like to also point out that the IHS and the VHA have a long history of partnering for many decades, especially in the health information technology arena. The IHS Resource and Patient Management System (RPMS) is actually a system that was built and designed by the VA. IHS uses that in place. Many of the tribes also take advantage of that.

And Dr. Jesse mentioned about the VistA, the VistA system that they function with as well. The EHR that IHS currently has is one that came out of the RPMS system. It is in place now. The RPMS EHR is in place in more than 300 IHS tribal and urban facilities.

There are other projects underway with the VA that will increase our utilization of their technology, and one of the results of that is that the IHS EHR has been certified for meaningful use, which is one of the new requirements under the Affordable Care Act.

Dr. Jesse also talked about the Consolidated Mail Outpatient Pharmacy (CMOP) project. IHS is working with them. One of the pilots is right here in Rapid City. To date, we have had more than 20,000 prescriptions that have been filled through that project. It has allowed two of our pharmacists at our IHS facility to focus on providing direct patient care, which we feel is a tremendous outcome.

Also both staff and patients have been extremely satisfied with this new service. So IHS and VA are pursuing utilizing the CMOP throughout the entire system.

So we are committed. IHS is very committed to working with the VHA to improve access to services for American Indian and Alaska Native veterans.

PREPARED STATEMENT

That concludes my remarks today, Senator, and I am happy to answer any questions.

[The statement follows:]

PREPARED STATEMENT OF RANDY GRINNELL

Mr. Chairman and members of the subcommittee: Good morning. I am Randy Grinnell, the Deputy Director of the Indian Health Service (IHS). I am pleased to have the opportunity to testify on the IHS/Department of Veterans Affairs (VA) collaboration.

The IHS plays a unique role in the Department of Health and Human Services (HHS) because it is a healthcare system that was established to meet the Federal trust responsibility to provide healthcare to American Indians and Alaska Natives (AIs/ANs). The mission of the IHS is to raise the physical, mental, social, and spiritual health of AIs/ANs to the highest level. The IHS provides comprehensive health service delivery to approximately 1.9 million AIs/ANs through hospitals, health centers, and clinics located in 35 States, often representing the only source of healthcare for many AI/AN individuals, especially for those who live in the most remote and poverty-stricken areas of the United States. The purchase of healthcare from private providers through the Contract Health Services (CHS) 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 healthcare programs. IHS accomplishes a wide array of clinical, preventive, and public health objectives within a single system for AIs/ANs.

AMERICAN INDIAN/ALASKA NATIVE VETERANS DUAL USE OF INDIAN HEALTH SERVICE AND VETERANS HEALTH ADMINISTRATION

In 2006, a joint Veterans Health Administration (VHA)-IHS study was initiated to review dual use of the two systems by AI/AN veterans. The findings of this study indicate that AI/AN veterans using the VHA are demographically similar to other VHA users with similar medical conditions, such as post-traumatic stress disorder (PTSD), hypertension, and diabetes. The review found that dual users are more likely to receive primary care from IHS, and general medical diagnostic services and mental healthcare from the VHA. They are likely to be receiving complex care from both VHA and IHS.

Many AI/AN veterans are eligible for healthcare services from both IHS and VHA. IHS has an estimated 45,000 Indian beneficiaries registered as veterans in the agency's patient registration system. Some AI/AN 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 Health Programs (UIHP) where they are available. In some of these locations the UIHPs provide limited direct care and assist these patients in accessing VHA and other services in the local

area. AI/AN veterans residing on reservations in some cases are not easily able to access VHA health facilities and services.

IHS recognizes that the complexity of IHS-CHS program and VHA eligibility requirements can make it difficult for AI/AN veterans to access care. IHS pays for the care referred outside of IHS for AIs/ANs including veterans if all the CHS program rules and regulations are met. For the AI/AN veteran, the VHA is an alternate resource along with Medicare, Medicaid, and private insurance in accordance with the CHS regulations.

DEPARTMENT OF HEALTH AND HUMAN SERVICES/INDIAN HEALTH SERVICE–DEPARTMENT OF VETERANS AFFAIRS/VETERANS HEALTH ADMINISTRATION MEMORANDA OF UNDERSTANDING

A memorandum of understanding (MOU) between the HHS/IHS and the VA/VHA was signed in 2003 to encourage cooperation and resource-sharing between the two Departments. The 2003 MOU outlined joint goals and objectives for ongoing collaboration between VA and HHS to be implemented primarily by IHS and VHA. The MOU advanced our common goal of delivering quality healthcare services to and improving the health of the 383,000 veterans who identified as AIs/ANs within the VHA system, a portion of which are served by IHS. The HHS/IHS and the VA entered into this MOU to further their respective missions, to serve AI/AN veterans who comprise a segment of the larger beneficiary population for which they are individually responsible.

Tribes stressed the need to improve collaboration and coordination of services for veterans eligible for both the VA and IHS services. The IHS Director met with VA Secretary Shinseki in May 2010, and they agreed to update the 2003 VA–IHS MOU to improve collaboration and coordination of services for AI/AN veterans. The updated MOU was signed in October 2010 and a consultation on implementation of the MOU was initiated with tribes in November, 2010. Tribal leaders identified priorities for implementation and the VA and IHS are working on improvements to better coordinate care, services and benefits, State-level agreements, implementation of new technologies, payment and reimbursement, health information technology, training, and cultural competency. IHS area directors are already working locally in some areas with the VHA and tribes to make improvements specific to the unique needs of veterans in the IHS area and local levels.

The MOU identifies five mutual goals to:

—Improve beneficiary access to healthcare and services;
—Improve communication among the VA, AI/AN veterans and tribal governments with IHS assistance;
—Encourage partnerships and sharing agreements among VHA, IHS, and tribal governments in support of AI/AN veterans;
—Ensure the availability of appropriate support for programs serving AI/AN veterans; and
—Improve access to health promotion and disease prevention services for AI/AN veterans.

INDIAN HEALTH SERVICE–VETERANS HEALTH ADMINISTRATION COLLABORATIONS

The principal focus of the interagency communication and cooperation is to provide optimal healthcare for the AI/AN 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 healthcare to AI/AN 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 AI/AN veterans.

AREA DIRECTOR MEETINGS WITH VETERANS INTEGRATED SERVICE NETWORK

Other collaborations that meet the goals of the MOU range from expansion of access to VHA home-based primary care for AI/AN veterans through the collaboration with IHS and tribal health facilities to the improvement of interagency partnership on health information and the use of tele-health modalities. The home-based primary care program expansion will increase availability of services for AI/AN veterans with complex chronic disease and disability through 13 collaborative projects located in States including New York, North Carolina, Oklahoma, Oregon, New Mexico, California, Mississippi, and Minnesota and two locations in South Dakota (Rosebud and Pine Ridge). In 2010, this collaboration resulted in a five-fold (11 to 55 veterans) increase in the number of AI/AN veterans served by home-based pri-

mary care. In Arizona, the IHS and the VHA are working together to increase mental health services by locating VHA social workers in IHS health facilities on the Navajo and Hopi reservations.

SHARING FACILITIES

The Wagner IHS facility recently opened a VA community-based outpatient clinic (CBOC). IHS has an audiology booth in the facility and the VA has an audiologist they can send to the facility to see both VA and service unit patients. Both agencies are also sharing lab services, the service unit provides onsite lower level lab services to the VA while the VA provides some higher level lab services at an alternate location. The service unit is developing the capacity to provide radiology services to the CBOC. The service unit also provides onsite dietary services to the CBOC patients.

The Navajo Area IHS (NAIHS) is currently working on an approval for the Prescott VA providers to be allowed space in an IHS facility to increase access to VA services for veterans on the Navajo Nation. The NAIHS already has an agreement with Prescott VA that allows office space for a PTSD counselor in an IHS facility to provide counseling and increase access to services. The NAIHS is also working with Veterans Integrated Service Network (VISN) 18 to develop an IHS–VA task force to address specific issues to these organizations.

TELEMEDICINE

In Montana, the Billings Area IHS and the VHA Montana Healthcare System (VHAMHCS) have ongoing collaborative efforts such as tele-psychiatry established at each service unit to facilitate VHA mental health services for AI/AN veterans. Because of the geographic remoteness and difficulty in accessing transportation to a VHA facility, this service greatly benefits the AI/AN veterans. The Billings Area IHS and VHAMHCS have formalized a PTSD protocol that is utilized by the service units and Fort Harrison. Among the protocol elements, the VHA 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 telepsychiatry clinics. Each service unit has a designated VHA liaison to help the AI/AN veterans needing medical services as well as working with the TOW and local tribal veteran representative (TVR). As the primary IHS contact, they can provide information, assistance, and guidance on VHA services and health benefits to AI/AN veterans. To distinguish the different roles and responsibilities, the TVRs function as an arm of the VA program with the IHS providing and coordinating the medical care for the AI/AN veteran. These collaborative efforts are reviewed on an ongoing basis in efforts to address patient-related issues, improve services, outreach, and rural initiatives, and to assist AI/AN veterans to utilize both the IHS and VHA systems.

OUTREACH (TRIBAL VETERAN REPRESENTATIVES)

VA's development and use of the TVR program has been and is critical to addressing issues related to communicating about and reducing barriers to VHA services and to the IHS-CHS program for AI/AN veterans through coordinated training on benefits and eligibility issues for each of the two programs.

HEALTH INFORMATION TECHNOLOGY

The IHS and VHA have a long history of working jointly on health information technology that dates back to the early 1980s. The Resource and Patient Management System (RPMS) is the IHS' comprehensive health information system that is derived from and evolved alongside the VHA's acclaimed VistA system. IHS/tribal/UIHP (I/T/U) facilities use many components of VistA along with IHS-developed components that address the population and public health mission of IHS.

The model for the RPMS electronic health record (EHR) is the Computerized Patient Record System, the EHR component of VistA. Since its release in 2005, the RPMS EHR has been deployed to more than 300 I/T/U healthcare facilities nationwide. IHS continues to leverage VHA healthcare software development by adapting it for our use where possible.

VISTA IMAGING

Another important example of IT sharing between VHA and IHS is VistA Imaging (VI), the VHA's Food and Drug Administration-certified system for capture, storage and viewing of diagnostic images and scanned documents. VI provides the multimedia component of both agencies' EHR systems, and has now been deployed to more than 90 I/T/U facilities across the country. This deployment would not have

been possible without interagency agreements that have allowed VHA staff and contractors to provide implementation support and help desk services to our facilities. The VHA's VI program is critical to IHS.

BAR CODE MEDICATION ADMINISTRATION

Like VI, the VHA Bar Code Medication Administration (BCMA) system is an integral component of modern hospital practice. BCMA ensures that the right patients are receiving the right doses of the right medications in the inpatient setting. The IHS, in cooperation with the VHA Bar Code Resource Office, is just beginning a joint effort to deploy BCMA in IHS and interested tribal hospitals. This effort will be modeled after the successful VI collaboration previously described.

MEANINGFUL USE

The Meaningful Use Initiative authorized by the HITECH Act of 2009 has given the IHS an opportunity to materially assist the VHA with an important effort. In April 2011, the IHS became the first Government agency to have its health information system certified according to the requirements for Meaningful Use. The VHA is seeking to certify the VistA system in 2012, and has reached out to IHS staff for consultation on how we addressed the various certification criteria. Our staff is more than willing to do so, as IHS has greatly benefited from so many VHA innovations in health information technology for more than two decades.

ALASKA AREA INDIAN HEALTH SERVICE–VETERANS HEALTH ADMINISTRATION HEALTH INFORMATION TECHNOLOGY COLLABORATIONS

The Alaska Area IHS has partnered with the VHA since 1995 via the Alaska Federal Health Care Partnership (AFHCP) which includes IHS/tribal, VHA, Army, Air Force, and Coast Guard partners. The AFHCP 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 IHS 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 the Alaska Federal Health Care Access Network (AFHCAN) which deployed network capability (backbone) along with hundreds of telemedicine equipment carts, the Teleradiology Project, deploying digital imaging radiology services to 51 federally and tribally managed IHS-funded facilities, video teleconferencing equipment to promote administrative and clinical consults, as well as an IT partnership bridge ("Raven Bridge"), allowing Federal and tribal partners to connect to each other.

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.

CONSOLIDATED MAIL OUTPATIENT PHARMACY

The Consolidated Mail Outpatient Pharmacy (CMOP) is a VHA program that consolidates and automates the mailing of prescriptions and refills to veterans across the country, relieving workload from pharmacy staff at VHA facilities. The VHA has permitted IHS to use the CMOP facility at Leavenworth, Kansas to provide prescription mail-out services for IHS beneficiaries. The pilot has been going on for more than a year, right here in Rapid City. More than 21,000 prescriptions have been processed through the IHS CMOP to date, allowing two full-time pharmacists to move from the pharmacy into the clinic where they can provide direct patient care services, (i.e., anti-coagulant clinic) and improve access to care. The program

has improved patient safety by reducing medication errors, and has improved both patient and staff satisfaction. IHS use of the CMOP facilities will centralize routine prescription filling and increase pharmacy collections, and will greatly reduce travel time for patients. In addition, it will enable pharmacy staff to focus on patient counseling, adverse drug event prevention, and primary care.

FUTURE OPPORTUNITIES OF PARTNERSHIP

Local IHS–VHA efforts to improve access and develop formal partnerships have increased since 2003. IHS will continue joint efforts on issues related to access to healthcare for AI/AN veterans. We are committed to working on these issues, within the IHS, as well as with the VA and the VHA. AI/AN Native communities have always honored their 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 HHS through the IHS and the VA through the VHA. I will be happy to answer any questions that you may have. Thank you.

Senator JOHNSON. Thank you, Mr. Grinnell.

Ms. Birdwell.

STATEMENT OF STEPHANIE ELAINE BIRDWELL, DIRECTOR, OFFICE OF TRIBAL GOVERNMENT RELATIONS, DEPARTMENT OF VETERANS AFFAIRS

Ms. BIRDWELL. Good morning, Chairman Johnson. Thank you for inviting me to discuss VA outreach to tribal governments.

On November 5, 2009, President Obama signed the Memorandum on Tribal Consultation, pronouncing tribal consultations a critical ingredient of a sound and productive Federal/tribal partnership. As part of the strategy to realize the President's vision of regular and meaningful consultation and collaboration with tribal officials, VA created the OTGR, and I was appointed as Director of this office earlier this year.

Guided by the tribal consultation policy signed by Secretary Shinseki in February 2011, the office was created to develop partnerships with American Indian and Alaska Native tribal governments for the purpose of enhancing access to services and benefits for Native veterans.

We must maintain lasting bonds with tribal leaders and Native veterans. Meaningful consultation is absolutely vital if we are to effectively address the unique needs of this population.

VA's OTGR serves as an entry point for American Indian and Alaska Native tribal government concerns. With an estimated 383,000 Native American veterans and 565 federally recognized tribes, there is much work to be done.

VA is embarking on a robust outreach and consultation effort that will focus on listening, aiding, and advocating. We believe the best way to create lasting bonds of trust is to meet with tribal leaders and their communities. VA has held listening sessions in Bethel, Alaska; Billings, Montana; and Bismarck, North Dakota. I am excited to hear from local tribal leaders and veterans right here in Rapid City and Kyle, South Dakota.

The office is very grateful for the vast cooperation each of these tribes has provided. Without this support, it would be difficult for OTGR to understand the challenges Native American veterans are facing.

While we are in the communities, we are aiding and training Native American veterans. For example, VA staff have trained tribal

veteran representatives (TVRs) in Montana and Alaska and provided technical assistance to Native American veterans seeking home loans during a recent gathering of Northwest tribal leaders and veterans in Spokane, Washington.

We can leverage these opportunities to increase Native American enrollment in VA's healthcare system, educate veterans about benefits for which they may be eligible, and connect them with online resources, such as eBenefits and My HealtheVet.

VA's goal of creating a bond of trust with American Indian and Alaska Native tribal governments is not an end, in and of itself. This bond should lead to improved access to benefits and services, as well as economic sustainability for veterans in Indian Country.

My office is working with the VHA to enhance access to healthcare in several ways. We are facilitating technical assistance and the sharing of best practices with the IHS as part of our effort to implement the MOU between the VA and IHS. Our role is to ensure tribal concerns are heard and considered.

To this end, we will hold annual listening sessions, in addition to formal consultation, to obtain recommendations, hear local priorities, and advocate the tribes' perspectives on practices that will improve access to care.

After OTGR was created, we worked with various stakeholders within VA to draft a vision statement. We see a future where we consistently demonstrate our commitment to Native American veterans by being culturally competent, respecting the unique sovereign status of tribes, and reaching out to veterans in their communities.

As an enrolled member of the Cherokee Nation of Oklahoma with more than 15 years experience in Indian affairs, I know it will take time, but I believe it is a goal we can achieve. Serving both Indian Country and our Nation's heroes is both a professional and deeply personal calling.

PREPARED STATEMENT

Thank you for the opportunity to discuss the work VA is doing to reach out to Native American veterans and tribal leaders. I look forward to answering any questions you may have.

[The statement follows:]

PREPARED STATEMENT OF STEPHANIE ELAINE BIRDWELL

INTRODUCTION

Good Morning, Chairman Johnson and members of the subcommittee: Thank you for inviting me to discuss Department of Veterans Affairs (VA) outreach to tribal governments.

On November 5, 2009, President Obama signed the Memorandum on Tribal Consultation pronouncing tribal consultations "a critical ingredient of a sound and productive Federal-tribal relationship." As part of the strategy to realize the President's vision of "regular and meaningful consultation and collaboration with tribal officials," VA created the Office of Tribal Government Relations (OTGR). I was hired as the Director of this office earlier this year. The fiscal year 2012 budget request includes $800,000 to support the establishment of this new office.

Guided by the Tribal Consultation Policy signed by Secretary Shinseki in February 2011, OTGR has been charged to develop partnerships with American Indian and Alaska Native tribal governments for the purpose of enhancing access to services and benefits for Native veterans. We must maintain lasting bonds with tribal leaders and Native American veterans. Meaningful consultation is absolutely vital if we are to effectively address the unique needs of this population.

Trust is the single most important aspect in our relationship with the tribes and Native American veterans. VA is working to earn the trust of tribal leaders and Native American veterans through consistent outreach and an open door policy. As an enrolled member of the Cherokee Nation of Oklahoma with more than 15 years experience in Indian Affairs, I know it will take time, but I believe it is a goal we can achieve. Serving both Indian Country and our Nation's heroes is both a professional and deeply personal calling.

OUTREACH AND CONSULTATION

VA's OTGR serves as an entry point for American Indian and Alaskan Native tribal government concerns. With an estimated 383,000 Native American veterans and 565 federally recognized tribal entities, there is much work to be done. VA is embarking on a robust outreach and consultation effort that consists of three pillars: listening, aiding, and advocating.

Listening certainly includes receiving communications from tribal leaders through email, phone, and social media tools, but we believe the best way to create lasting bonds of trust is to meet with tribal leaders in their communities. VA has held listening sessions in Bethel, Alaska; Billings, Montana; and Bismarck, North Dakota. I am excited to hear from local tribal leaders and veterans right here in Rapid City, South Dakota. OTGR has participated in conferences in Arizona, Montana, Idaho, Texas, Wisconsin, Oklahoma, and Washington. We have also conducted site visits to key locations that deliver services to Native American veterans, including the Consolidated Mail Outpatient Pharmacy in Leavenworth, Kansas, and tribal courts in Navajo Nation, Hopi and Laguna Pueblo Tribes. OTGR is very grateful for the vast cooperation each of these tribes has provided. Without this support, it would be difficult for OTGR to understand the challenges Native American veterans are facing. We will maintain an aggressive outreach schedule to increase the number of American Indian and Alaska Native tribal governments with which we are building relationships.

While we are in the communities, we are aiding and training Native American veterans. For example, VA staff have trained tribal veteran representatives in Montana and Alaska and provided technical assistance to Native American veterans seeking home loans during a recent gathering of Northwest tribal leaders and veterans in Spokane, Washington. Our outreach provides a unique opportunity to deliver technical information to Native American veterans. We can leverage these opportunities to increase Native American veteran enrollment in VA's healthcare system, educate veterans about benefits for which they may be eligible, and connect them with online resources such as eBenefits and My HealtheVet. Every encounter with tribal leaders and veterans in Indian Country is an opportunity to make a difference in a veteran's life.

OTGR is also advocating for tribal governments. The Secretary of Veterans Affairs is committed to conducting meaningful consultation with tribes; this means transforming words into action. We plan to facilitate five tribal consultation sessions in 2012 at different locations across the country. Tribal leaders will have an opportunity to voice their concerns on issues that affect the well-being of veterans and their families. With a direct link to the tribes through OTGR, we will be able to address their concerns before new policies and procedures are implemented. OTGR is already serving as a vital intergovernmental link for VA's health, benefits, and memorial programs.

INCREASE ACCESS TO HEALTHCARE AND SUSTAINABLE ECONOMIC OPPORTUNITIES

OTGR's goal of creating a bond of trust with American Indian and Alaska Native tribal governments is not an end in itself. This bond should lead to improved access to benefits and services as well as economic sustainability for veterans in Indian Country.

OTGR is working with the Veterans Health Administration (VHA) to enhance access to healthcare in several ways. First, OTGR is facilitating technical assistance and the sharing of best practices with the Indian Health Service (IHS) as part of our effort to implement the memorandum of understanding (MOU) between VHA and IHS. VHA's Office of Rural Health has made great strides in supporting the delivery of care to rural veterans across the country. OTGR's role is to ensure tribal concerns are heard and considered. To this end, OTGR will hold annual listening sessions in addition to formal consultation to obtain recommendations, hear local priorities, and advocate the tribes' perspectives on practices that will improve access to care. In addition, OTGR is working with VHA to realize opportunities to integrate new media and other communication tools to promote innovative technologies that bring care to rural communities.

Mental healthcare is a critical component of overall healthcare, and Native American veterans often face unique challenges in accessing appropriate mental healthcare. To promote better mental healthcare in this population, VA has undertaken several initiatives. In Alaska, we are exploring a partnership with the South East Alaska Regional Health Consortium to provide mental health compensation and pension examinations. OTGR has worked closely with VHA to identify similar best practices and to explore options for exporting them. Currently, as part of the implementation of the VA/IHS MOU on enhancing services to Native American veterans, several new initiatives are being implemented. Guidance on outreach and education to tribes about VA/IHS post-traumatic stress disorder (PTSD) services will involve further disseminating training materials created by VA, designed to make initial connections with and provide information to tribal governments about VA services.

The training has been used extensively in the Western States (e.g., Montana, Idaho), and a current project will focus on Eastern areas, including those in Veterans Integrated Service Network (VISN) 6, with tribes such as the Lumpee, and in VISN 1. VA staff and tribal groups will expand the original training materials with information that describes local VISN 6 facility services. Information also will be associated with significant symbols of the local tribes. There will also be another satellite broadcast/DVD to support this planned outreach effort. In addition, the National Center for PTSD Web site, (www.ncptsd.va.gov) has the video: "Wounded Spirits, Ailing Hearts: PTSD in Native American Veterans," created in 2000 with versions for clinicians and general audiences (http://www.ptsd.va.gov/public/videos/wounded-spirits-ailing-hearts-vets.asp).

To address substance abuse and mental health issues among veterans, VA has worked with veterans treatment courts across the country. These courts identify treatment options for many of our veterans with substance use disorders or mental health conditions. OTGR is working with VHA to create a veterans treatment court "how to" guide to help identify and link Native American veterans involved with the criminal justice system with VA resources and other providers as an alternative to incarceration. Our goal is to provide tribal governments the resources they need to incorporate, at their discretion, elements of the veterans treatment court model that may promote healing in their communities. This model may not work for every tribal justice system, but these practices generally are consistent with the holistic approach to criminal justice practiced by many tribal justice systems and may be a valuable tool at their disposal. Local circumstances will help define our ability to implement many of these best practices, but we must learn from our experiences and leverage our successes.

In addition to working with VHA to increase access to care, we are also working with the Veterans Benefits Administration to address systemic economic issues within tribal communities. We can and will do more to increase access to and utilization of established benefits such as compensation and pension, vocational rehabilitation and employment services, and Post-9/11 GI Bill and other education benefits. Recent changes to the Post-9/11 GI Bill program illustrate the need for a direct link to Indian Country. We are using every avenue available to us to ensure that veterans know how changes to that program will directly affect them, and OTGR will be a vital resource for tribal leaders and a conduit for feedback.

One area that we believe deserves special attention is the Native American Direct Loan Program (NADL), a vital tool in VA's efforts to provide permanent housing options for Native American veterans. NADL is available for Native American veterans and their spouses to purchase, construct, or improve a home on trust land or to refinance an existing NADL at a lower interest rate. OTGR is increasing VA's efforts in Indian Country and Alaska to educate eligible veterans about this important program. Our goal to make sure every eligible veteran understands the value the NADL benefit as a long-term housing solution.

OTGR will also work with tribal leaders to address memorial issues. VA's first grant to establish a veterans cemetery on tribal trust land, as authorized in Public Law 109–461, was approved by the Secretary of Veterans Affairs on August 15, 2011. The amount of the grant, $6,948,365, is for the Rosebud Sioux Tribe, and the cemetery will be located in White River, South Dakota. This grant will fund the construction of a main entrance, an administration building, a maintenance facility, roads, an assembly area, a committal shelter, preplaced crypts, cremains burial areas, memorial areas, columbaria, landscaping, a memorial walkway, and supporting infrastructure. The project will provide services to approximately 4,036 unserved Rosebud Sioux Tribe veterans and their families. The project will develop approximately 14.40 acres. The construction will include 600 pre-placed crypts, 544 cremains gravesites, and 32 columbarium niches. The cemetery will provide improved service for veterans and their families of the Rosebud Sioux Tribe. The near-

est VA national cemetery is Hot Springs National which is closed and 169 miles away in Hot Springs, South Dakota. The proposed cemetery will be near Mission, South Dakota on the Rosebud Indian Reservation.

We must measure our progress and hold ourselves to a high standard of achievement if we are to accomplish our goals. This starts with compiling recommendations from tribal leaders and tracking these action items to the point of completion. We do not promise that every recommendation we receive will be adopted, but we do commit to ensuring tribal leaders' and veterans' voices are heard and considered. Our success will be not only be measured by the frequency of our contact with federally recognized tribes, but also by utilization rates for benefits and programs and healthcare enrollment by eligible Native American veterans. A stronger relationship between the tribes and VA will lead to better results and outcomes for Native American veterans.

CONCLUSION

After OTGR was created, we worked with the various stakeholders within VA to draft a vision statement. We see a future where American Indian and Alaska Native tribal governments view VA as an organization of integrity that advocates on behalf of Native American veterans for their needs. We see a future where VA demonstrates its commitment to Native American veterans by being culturally competent, respecting the unique sovereign status of tribes, and reaching out to veterans in their communities. We are committed to building a relationship with tribal leaders built on a culture of trust and respect. We see a bright future, but there is still much to be done.

Thank you again for the opportunity to discuss work VA is doing to reach out to Native American veterans and tribal leaders. I look forward to answering any questions you may have.

Senator JOHNSON. Thank you, Ms. Birdwell.

Too often I hear stories from Native American vets that they show up at IHS facilities only to be told that they should be going to the VA and that there is no patient coordination occurring. The new MOU is supposed to address this issue and break down these barriers.

Mr. Grinnell, can you describe in detail how this MOU will increase patient coordination between the IHS and VA? Specifically, if a vet shows up at an IHS facility with a service-connected disability, will they be treated at IHS or be told to go to the VA?

Mr. GRINNELL. Thank you for your question, Senator.

That is probably one of the most challenging aspects of what we are trying to improve on. A good example is that when I mentioned in my opening comments that the VHA is considered an alternate resource for IHS, per our CHS regulations. So any time that a veteran does access our system and they have to be referred out for care, then we have to exhaust all other opportunities before it qualifies for CHS.

To begin to address that, one of the things that the IHS and the VHA are doing is training both the IHS staff, as well as the VHA staff in terms of what services are available and also understanding the eight categories that the veterans have to be eligible for for consideration. Trainings have already taken place in a number of the service units where our staff is being trained so that they fully understand. And our goal at the end is so that the veteran itself is not being shuffled back and forth between the two systems, but there is good coordination of care.

Further things that we are talking about is how we can hopefully do case management of that individual patient between both systems so that they don't feel like that they are being passed off from one system to the other.

INDIAN HEALTH SERVICE AND DEPARTMENT OF VETERANS AFFAIRS COORDINATION

Senator JOHNSON. Dr. Jesse, the VA has a good track record of coordination with DOD health facilities. But it seems that coordination with the IHS has been difficult. From the VA's perspective, how do you believe the MOU will give Native American vets better access to VA services and break down these bureaucratic barriers?

Dr. JESSE. Thank you, Senator.

I think there are several aspects to answering that question. First is the simple matter of coordinating the information related to healthcare. So that what a given patient's issues are, are then visible to both the VA and the IHS. With a shared electronic record, that is increasingly easier to do.

Second is that both the IHS and the VA are actively implementing, I guess as a common collective term, new models of care, moving from a single-provider model into a team-based model of care, with a heavy emphasis on care coordination. This, I think, will allow for that level of coordination which occurs in any one of those services to be much more visible to the other in times when that is needed because it is not dependent on a single provider.

Another piece I think is the great commitment that VA has made and is sharing, I guess is the best way to say that, in terms of telehealth with IHS. By combining these resources, IHS has been extremely accommodating in providing outlets for telehealth on the reservations so that we can get a lot of the care that would normally require people to go somewhere for high-level care. This includes, very importantly, mental healthcare, but also much of the subspecialty care, for instance, in cardiology or any number of the other subspecialties that can be managed through telehealth. It very much minimizes the need to have people travel long distances for what would be simple appointments.

We can't do procedures by telehealth but certainly can determine when procedures are needed and where the best place for people to go when they are needed without having to have multiple visits prior to that. I think there is already, at the early stage of the deployment of telehealth, modalities through American healthcare with VA collaborating with IHS. We are very much moving this whole initiative forward.

There are some challenges, to be sure. The technology is rapidly evolving. Teaching providers how to use it is at times challenging. Although, interestingly, our fear was that patients would be less accepting and have to get used to it, and my sense is that is not the case. You can correct me if I am wrong, but the patients love it. It allows them to speak to the people they need to speak to without having long delays for appointments and long travel times to do this.

The whole notion of how healthcare is going to be delivered through team-based care and the use of telehealth and these other modalities is very important.

One other thing I will just mention is that to my mind, one of my personal interests is, how do we get patients, veterans, and patients in the IHS, invested in their own health in ways that they can take greater control in managing it? Part of that is by having

them be able to interact with their personal health records, so that the health record is not a mystery that lives in the provider's office, but something they can engage with on a relatively routine basis.

VA has started this with My HealtheVet. There has been a lot of press recently about an innovation that we have been rolling out called the Blue Button, which allows patients who use My HealtheVet to actually download substantive parts of their records. Probably, I am guessing, within the year, it will be the entire medical record that can live in their possession, and they can have it with them.

There will never be a question about what has been done, what prior lab results, what prior tests were done. And with all of these things, VA is rolling these out in collaboration with IHS and distributing this into the rural and highly rural populations.

PAYMENT AND REIMBURSEMENT

Senator JOHNSON. Dr. Jesse, in your testimony, you mentioned that the VA and IHS are still working through payment and reimbursement policies. When do you believe these will be worked out?

Dr. JESSE. I think that is actually a pretty simple question to answer because our respective Secretaries have made it very plain to staff that they expect this to be worked out by the end of the calendar year. We have been given marching orders from the Secretaries to get this resolved, to do it quickly, and get it right.

Their timeline is end of the calendar year.

Senator JOHNSON. Mr. Grinnell, how do you see the work with other private hospitals proceeding, and is it true that the Native American saying that "you better get sick through June or it is all over with" still holds true?

Mr. GRINNELL. The statement about "don't get sick after June" referred to—within the CHS program, there is one aspect that is referred to as the Catastrophic Health Emergency Fund account, and that account is centrally managed, and it is a reimbursement program to a local hospital or CHS program whenever they have a high-cost case.

And those are first come, first serve. It starts on October 1, and the funding that we receive, it is there until it is exhausted. At this point, we have got $48 million that we have in that particular account.

In the past, before we had the increases which have—and over the last 5 years, that account has more than doubled. And so, we are able to go beyond May. This year, it looks like we are going to get into September before that account is exhausted, which is tremendous progress from prior years.

We had a real nice increase in 2010. We had a $100 million program increase in CHS that every CHS program benefited from across the country, including an increase in the CHEF account. We see great progress. We have been in contact with pretty much all the CHS programs across the system. They have more resources this year and are able to provide more referrals than they have in the past, but we still feel like that the need is more than we have funding for at this point.

Based on our estimates so far, we estimate that we receive almost $800 million a year in CHS overall. We estimate, based on

the information from our locations and from some tribes, that the need is an additional $860 million more than the $800 million.

So we still have a long ways to go to where we feel like that we will be fully funded to be able to pay for all of our referred care.

Senator JOHNSON. Mr. Grinnell, was that bump up in the income available as a result of the stimulus?

Mr. GRINNELL. No. It had to do with the President's budget in 2010, and actually, President Obama approved that budget and moved it forward as his first act against our budget. So the stimulus did not provide any CHS funding.

TELEMEDICINE

Senator JOHNSON. Telemedicine offers great promise in closing the gap in services in remote areas and lowering healthcare costs. My biggest concern with telemedicine has been the lack of technology infrastructure in highly rural areas, such as access to broadband.

Dr. Jesse, as you highlighted in your testimony, the VA has been moving more aggressively in its use of telemedicine. Can you please describe a bit more how the VA envisions telemedicine being deployed? For example, are these applications located only at IHS facilities, or is the VA planning to implement home-based solutions as well?

And how does the VA plan to overcome the lack of infrastructure in highly rural areas and on reservations as it deploys new technology?

Dr. JESSE. Our chief information officer, Mr. Roger Baker, says that what keeps him awake at night is bandwidth. So I will put that on the table first, and then I will come back and answer the other issues you brought up.

It is an issue. I think the wisdom of the Federal Government is in understanding the value of the Internet in all we do in this country, not just healthcare, but in education, in banking, in communication, and social networking, all the things that are really changing the fabric of American life.

The commitment to get broadband access into rural and highly rural areas is, I think, an important statement on behalf of the Government that we need this. It is certainly not something the VA can do on its own, but I do think that our commitment to making this an integral part of healthcare certainly drives the imperative to do so, more so than some of the other needs for broadband.

We will push very hard to ensure that we have the ability to leverage our technologies through broadband access and with the understanding that this is a shared commitment on the part of the Federal, State, and local governments as well. It may take some time, but I think this will get done.

In terms of the technologies being used, telehealth is a very broad statement, and there are a number of different categories that we look at. For instance, we can talk about telehealth as a provider in one place and a patient in another place so that, when we have a primary care clinic—which I had the honor and pleasure of visiting in the CBOC in town this morning—we can have an extensive primary care capability in that facility. If there is a question for a cardiologist or a pulmonologist, then having ability to

contact somebody, say, in Minneapolis or anywhere else in the country to provide almost an instant referral, or consultation, is one methodology.

Another is the ability to communicate with patients in their homes. We have a program, which is probably, at this point, the widest deployment of home telehealth, which we call CCHT, Coordinating Care Home Telehealth. This is where we have a telehealth communication box in the patient's home that can do some basic things like hook up to a blood pressure cuff, to a scale, or to a rhythm strip, and which provides vital information for caring for patients with multiple chronic disease, in particular heart failure and hypertension.

Because rather than showing up once a month or once every 3 months for an appointment and checking blood pressure, we can actually see the blood pressure every day. Then if it is going outside of bounds, we have triggers, and we can reach out to the patient to intervene.

I am a cardiologist by training. This is extremely important for heart failure because patients can self-manage heart failure if they have that information and particularly if they have a little help. We have been able to markedly reduce admissions for patients with heart failure by being able to communicate with them in their home.

Now that is interesting because, more and more, we are finding people who don't have land lines in their homes, and these things are dependent on land lines. How do you then begin to move a lot of this to a much more ubiquitous platform like the smartphone?

I think that capability is moving forward very quickly. Even things like the PTSD Coach, which is an iPhone app, have been a great demonstration that you can leverage the simple telecommunications platforms that people have to improve their health in many novel ways, most of which we probably haven't even thought of yet.

We do a lot of things that require ongoing monitoring, and I will use an example of that which is teleretinal imaging in diabetic patients. It is really important that we monitor the consequences of that disease, and looking at the retina is a view to the inside of the body in many respects. It speaks to the microvascular state, but also to the catastrophic consequences of diabetes, which is blindness.

You can't have an ophthalmologist or an optometrist everywhere. But we can take those images, store them in the local record, and forward them off where they can be read, and that way the results come back locally so we can monitor for vision changes over time.

We have teleradiology. So, for instance, you can have a CAT scanner in a facility without the advanced radiology capability to read them if that image can get forwarded to somewhere where you do have that capability. This is becoming increasingly important in the management of several complex diseases, where we can get a tech in to do the scan, but we can't have the radiologist available.

In fact, VA now has a series of teleradiology reading centers which actually expands the time throughout the day where we can have studies accurately read. Likewise, you can do the same thing with electrocardiograms and any number of other tests.

We all get very nervous about dermatology, and it is often difficult to discern what are bad lesions from what are ones that are okay. But we have teledermatology where in the clinic they can take an image, and it can go across the country to a dermatologist who can look at it and make a determination that this is benign or, no, this is something we need to follow.

There are a lot of different parts of this that are complex. Probably the most interesting is the ability to do consultation in a way that actually increases the education of the primary care provider. There are projects that we are standing up as part of the patient line care team to bring specialty care into that mix through a project called SCAN—Specialty Care Access Now—that gives real-time consultative capability in a way that actually educates the provider.

And when we talk about telehealth—I am sorry, it is a rambling answer—but there are a broad number of modalities. The capabilities of some require a lot of bandwidth, for instance, moving big images around. But frankly, a lot of them don't, including what we to date have investment in, which is home telehealth, where we have the ability to reach in the patient's home on a daily basis to watch their weight, and their blood pressure, with a simple phone line.

Senator JOHNSON. Mr. Grinnell, how do you see telemedicine being deployed and utilized in Native lands? And please comment on the lack of infrastructure in these areas.

Mr. GRINNELL. You mentioned earlier about the questions about the stimulus and the funding that came through the American Recovery and Reinvestment Act. The IHS did receive $85 million that was targeted to help us to make improvements to the RPMS system. It was also to look at how we can expand telemedicine opportunities.

As Dr. Jesse indicated as well, many of our locations in remote areas have issues with bandwidth. And so, our ability to expand telemedicine to some of those locations is going to be challenged until the bandwidth is made more available. IHS is looking at every opportunity and looking specifically with the VA to expand as many telemedicine opportunities as we can.

Dr. Jesse also talked about the diabetic care specific to eye care. We have a very active telemedicine program with teleophthalmology, where we got a number of IHS and travel sites that actually have optometrists or other staff that take images of the eye, and then they are sent via telemedicine to an ophthalmology center where they are actually read. And then they are followed up with the necessary procedure.

So we have lots of challenges. And some of them really get down to the bandwidth and the ability of that local facility to have the capability.

Different than what Dr. Jesse talked about, we have not looked into going to providing home health through telemedicine. But right now, we have got more than 600 facilities that we have still got to get connected and improve access to some of these services that he talked about.

A couple of the other ones that we are looking into as well is teleradiology. We have got some areas now that have area-wide con-

tracts where they don't have a radiologist on staff, but they have got a radiology service that they contracted with. They take the images, store them, and then send them forward, get the readings that come back to our direct providers, and then they do the follow-up care.

So we still have a lot of work to do. We definitely are counting on our partnership with the VA to help us to move that forward.

MENTAL HEALTH TELEHEALTH

Senator JOHNSON. I understand that the Sisseton IHS health center is partnering with the Sioux City CBOC to offer mental health telehealth. One day a month, vets in Sisseton can meet with a psychologist in Sioux City.

Dr. Jesse, can you speak to this partnership? How did this come to be? Is it meeting demand? Are there similar telehealth collaborations in the State and throughout the country?

Dr. JESSE. With your indulgence, I will ask Jan Murphy to speak to that because I think she can give you the detail you need.

Ms. MURPHY. Sure. Thank you for the question.

There are a number of these kinds of collaborations that we are very anxious to do. I am surprised to hear about Sioux City because we hear more about Wagner. But we are able to put a telemedicine unit either in the IHS clinic or we can have one in our clinic, and the two go back and forth.

Sometimes we send the actual practitioners back and forth, too. So, really, with this sharing agreement, this is really very easy to do.

The technology, if you have the bandwidth, is quite simple and quite successful to be able to do that. So that is an easy one, actually.

TRIBAL CONSULTATION SESSIONS

Senator JOHNSON. Ms. Birdwell, in the Senate appropriations bill for fiscal year 2012, we have included $800,000 as requested to support the establishment of your office. In your testimony, you highlighted the critical need to build trust between the VA and the tribes through meaningful consultation.

The VA is funded to conduct five tribal consultation sessions this year. How many of these sessions have been conducted to date, or are these the first of these sessions? Can you briefly describe what these sessions will include and how they will help shape future VA policy?

Ms. BIRDWELL. Yes, Senator, thank you for that question.

The five consultation sessions will be scheduled during fiscal year 2012. There have been currently no formal consultation sessions held, although we did hold three listening sessions in Bethel, Billings, and Bismarck.

The purpose of the consultation sessions are really to engage the voice and the perspective of the tribes with respect to understanding regulations, grants, funding opportunities, and need for services that VA offers that may impact tribal communities and Native American veterans.

The sessions really seek to engage the voice and perspectives of the tribes in informing how VA does business in Indian Country

and delivers services and resources. Something that is important to note is that there have been a number of very dedicated leaders and employees within VA for many years who have worked and reached out to tribes, tribal leaders, and Native veterans.

The cemetery that is coming up, that is online in Rosebud, the national cemetery is the effort of many years of collaborative hard work with the tribal leadership, and that is something that we are excited to see hopefully expand throughout Indian Country.

It is really the goal of our office to put a face with respect to engaging in Government-to-government relations with tribal leaders. As Dr. Jesse mentioned, it is very important that when we are doing business with tribes and we are reaching our vets in rural areas that we get this right. And really, this is an opportunity for VA to formally engage the voice of the tribes in setting policy as we move forward and getting it right and being informed in the work that we do.

We are talking about the possibility for expanding and sharing best practices and increasing sharing agreements. These consultation sessions and engaging the voice and perspectives of the tribes, hopefully, will result in that.

And not just from the perspective of increasing access to healthcare, but also increasing access to benefits, all of the resources that our veterans have earned through their service, we would like to see that result from these sessions.

OUTREACH

Senator JOHNSON. One major concern that I have has been outreach to educate vets on reservations as to what benefits they are entitled. Ms. Birdwell, outside of the consultation sessions and listening sessions, what specific outreach plans are in place to better educate Native American vets of the benefits available to them?

Ms. BIRDWELL. Senator, a particular one that is very much on our front burner is Alaska. Alaska has a rural outreach coordinator that is working very closely with VA. When the rural outreach coordinator or when our tribal government relations specialist will be going out and meeting with tribal leaders or conducting any listening sessions in Indian Country, they will always be teaming up with representatives from across VA through VHA, through the Veterans Benefits Administration (VBA), and even the National Cemetery Administration (NCA).

The approach is to have a coordinated approach in reaching out to Indian Country and really informing, educating, and providing onsite technical assistance with respect to benefits and resources that are available through the VA. We are partners, and our role is to enhance the role of VA with respect to reaching out to Indian Country. It is critical that we have those relationships internal to the organization, as well as with our external stakeholders. It is a combined effort.

I have to say that Alaska is something that we have just recently worked on in a strategic outreach plan to reach rural Native veterans. That plan is going to be implemented, hopefully, this fall and throughout fiscal year 2012.

We have also had contact from veterans in the Northwest and tribal leaders and also veterans in the Southwest and tribal leaders

seeking technical assistance for how to bring about the MOU, and how to see that the MOU in action is as robust as they would like it to be. That involves coordinating technical assistance with our partners at the local level, within the VBA, VHA, and the NCA.

One of the focuses of our office is to promote economic sustainability in Indian Country within veterans. In other words, by veterans are eligible for post 9/11 GI bill, the Native American direct home loan program, compensation and pension benefits.

Our vision is to see that if there is a veteran in Indian Country, that veteran is at least aware of all of the benefits and can access all of the benefits and resources available with VA through their service. That is a goal and part of the mission of our office.

TRIBAL VETERAN REPRESENTATIVE PROGRAM

Senator JOHNSON. The Tribal Veteran Representative Program was mentioned in testimony today. Dr. Jesse and Ms. Birdwell, can you elaborate on this program. Does the VA plan to expand this program in fiscal year 2012?

Ms. BIRDWELL. Senator, I will be happy to respond to that. The Tribal Veteran Representative Program was started as a best practice and has expanded to Alaska. It was started as a best practice in Montana and is now—the TVRs, as they are called, in rural areas, because it is often the case in tribal communities there may be a lack of a local resource or connection with respect to veteran services and resources.

TVRs are brought together by the VA on an annual basis, and they are provided training into all of the resources that are available through VA. There are even State representatives present. Basically, all of the resources that are available to veterans, the TVRs are trained in and made aware of them.

The TVRs then go back home to their local community, and they become a local resource for vets. So, if a vet comes in and asks questions about benefits, the TVR knows where to direct and how to assist that veteran in moving forward with any kind of claims that they may want to or need to pursue. Healthcare, grants, or information that tribal governments may need to know about, that TVR is a resource.

There are definitely plans of expanding that program. What is also important with respect to sharing resources are that there are some tribal locations that may not have a TVR presence, and there are some tribal locations that actually have their own tribal veterans affairs department. Some States actually have tribal veteran service officers.

And it is interesting because those tribal veteran service officers have asked about the TVR training and have said they would really like to see it expanded locally so that they can also avail themselves of that TVR training.

We are very excited to see that as a best practice. There is definitely a strong interest and a need to expand that, and we look forward to doing that in 2012. Strategically, we would probably be doing that in a way that would be consistent with, moving from the Northwest to the Great Plains to the Southwest and on to the Midwest. It is something that we would probably host with regional

trainings and then ideally make it so that they are held at as local a level as we possibly can hold them.

Senator JOHNSON. Dr. Jesse, did you have anything to add?

Dr. JESSE. Yes, sir. I would just like to amplify something Ms. Birdwell said, and that is that healthcare, in and of itself, will flounder—by whatever VHA does or IHS does—without the strong support of the broader social needs of patients. That support includes education, housing, and a host of things.

I think the elegance of the VA is that we have the capability to provide much of those needed services so that the healthcare side of things can truly flourish. It is vital in order for us to do that, in addition to supporting IHS, we need veterans to get enrolled. Because it is not just access to the healthcare system, it is access to this broader base of very needed and very hard-earned support.

It is very much our interest and important to us that the veterans are aware of how to get enrolled and are aware of this. We are strongly supportive of all these initiatives and are working with the IHS in order that we can identify the Native Americans who are eligible for VA benefits and get them enrolled. I think it is important to note that it is their choice of which of those benefits they wish to access, but the first step is the access into the system.

If I may just go back to the first question you asked me about the MOU and the deadline on that? I just want to be very clear that IHS and VA are committed to making this work.

There are some challenges in the law reconciling parts of title 38 legislation with the Affordable Care Act, but it is not either party being recalcitrant or creating a problem. We just have to get this reconciled. We are anxious to make it work and are working hard and diligently to do so.

Senator JOHNSON. Thank you for your testimony. The witnesses may now be excused.

Thank you.

Dr. JESSE. Thank you, sir. Appreciate it.

NONDEPARTMENTAL WITNESSES

Senator JOHNSON. I would now like to welcome our second panel of witnesses. I am honored to have two South Dakotans testify today—Don Loudner and Iva Good Voice Flute.

Mr. Loudner served 32 years in the Army and is a veteran of the Korean war. He is a member of the Dakota Sioux Nation and has been a tireless advocate for Native American vets, particularly in his role as the national commander of the National American Indian Veterans, Inc.

Iva Good Voice Flute is a Air Force vet, having served here in South Dakota at Ellsworth Air Force Base. She is a member of the Oglala Sioux Tribe. Ms. Good Voice Flute is a strong advocate for female vets and in March of this year received designation as the Oglala Sioux Tribe's women's tribal vets representative.

Thank you both for being here today.

Mr. Loudner, would you begin?

STATEMENT OF DON LOUDNER, NATIONAL COMMANDER, NATIONAL AMERICAN INDIAN VETERANS

Mr. LOUDNER. Good morning. Yes, I have with me one of my regional commanders that has North Dakota, South Dakota, Nebraska. His name is Peter Lengkeek. He is a member of the Crow Creek Tribal Council. He is here with me.

And we also have in our audience some of our tribal veteran service officers. I am glad they are here, and I hope that they speak up to ask these questions that were not answered to them. Don't be afraid of these people. I mean, they are human like all of us.

And this is the time to get them straightened out. Because you know, as well as I know, that the services that they are talking about are not being completed for us veterans.

Senator JOHNSON. We need a lot of straightening out.

Mr. LOUDNER. I want to thank you, Senator Johnson, for holding this important hearing. The last hearing that I can remember that was held for American Indian veterans with congressional people was back in the Nixon administration. And it is a hearing that should have been held long before. Hopefully, we can have more.

Holding this important hearing to discuss the degree of cooperation that currently exists between the IHS and the VA to provide quality care to our American Indian veterans and the Alaska Native veterans and ways to improve the agencies' working relationship.

As you can imagine, American Indians, Alaska Native veterans have many problems in common with other veterans. But because of their geographic remoteness, weak tribal economies, and a host of related pathologies, face challenges that are, in many ways, unique. I believe that the members that share with you, Senator Johnson, are aware of the valor and the service of American In-

dian/Alaska Native veterans to this country and that they have served in the highest proportion than any other ethnic group in the United States.

You may also be aware that the lack of healthcare to these veterans upon returning home is nearly to the point of being unacceptable, considering for what they have done protecting our homeland. Especially with the event of the Afghanistan and Iraqi wars, the number of veterans returning with injuries, disabilities—physical and emotional—has increased largely.

And as we have learned from the past wars and conflicts, the need for treatment of these warriors may not be revealed for several years after these men and women have returned home.

The primary healthcare provider to tribal communities, including American Indian/Alaska Native veterans, is the IHS, which has always been woefully underfunded. Many veterans have sought healthcare from VHA hospitals because that is an option and their right.

In an attempt to stretch their healthcare dollars, both IHS and the VA hospitals have denied services to our veterans, insisting that they go to the other agency for treatment. These proud veterans, who in some instances use their last dollars to travel long distances to either facility, deserve better treatment.

I thought the days of transferring responsibility from one agency to the other were over when this MOU, between the IHS and the VA hospitals, was signed. 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.

In my capacity as national commander, I am in constant contact with these men and women in the States of Arizona, California, Colorado, Montana, New Mexico, Oregon, South Dakota, Wisconsin, Washington, and others. In fact, we just returned home within the last 10 days from a strong visit to the Alaska Natives up there, and I will send you a written report of what we just found out up there that needs immediate attention.

Senator JOHNSON. Please do.

Mr. LOUDNER. Since 2004, the National American Indian Veterans has hosted three national conferences, the most recent taking place in March 2009. I know that has been a couple of years ago, but it takes money to hold them, and we are working with our own dollars to do those. It was held at the Morongo Convention Center in California. We had more than 500 American Indian veterans from throughout the West and Southwest and Midwest in attendance.

The National American Indian Veterans has the support of the National Congress of the American Indians, the National Association of State Directors—and I want to just elaborate a little something there. My chief of staff, Joey Strickland, is the only American Indian that serves, in all 50 States, as a Secretary of Veterans Affairs, and now he is in Arizona.

There he serves for all veterans in the State of Arizona. Although his job is to support all of Arizona's 600,000 veterans, Arizona is home to 21 federally recognized Indian tribes, and American Indian veterans regularly attend his commission meetings. As a result of

these meetings, he relays to me the concerns, issues, and needs regarding the lack of proper medical care delivered through the VA and Indian veterans residing on Indian lands.

I just wanted to stress just a little bit about the Navajo Nation. I heard them talk about it. The Navajo Nation reservation is roughly the size of West Virginia. And on that reservation, there are more than 12,000 veterans living today.

To date, the Disabled American Veterans (DAV) has rejected repeated calls to locate a permanent community-based outpatient clinic within that reservation. They are claiming the number of veterans will not support it. The fact is the numbers will not support a CBOC at the Navajo reservation because the reservation is divided into three Veterans Integrated Service Networks (VISNs).

Given this division, the VA 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, just recently, the VA's Office of Intergovernmental Affairs—I say recently, but about 1 year. It has been more than 1 year ago. The director of VISN 18 and others visited the Navajo reservation and witnessed for themselves the urgent need for additional healthcare facilities.

They graciously called on the director of VA from Arizona, who is a Choctaw Indian, for his input, which he, of course, provided. The reality is that I have seen numerous visits over the years throughout Navajo, the Pine Ridge Indian Reservation, and other Indian reservations with little or no follow-up by the Federal officials.

When an American Indian veteran will get to the VA medical center in Prescott, Arizona; or Albuquerque, New Mexico; or Sioux Falls, South Dakota; or Fort Meade, the medical care is excellent. But few, if any, of the veterans cannot overcome the vast distances to use such facilities. The distances are vast, and transportation is not always available.

As a result, many of the American Indian veterans' efforts to obtain care at IHS facilities fail because they are veterans. In this regard, the MOU that was entered in 2003 by the VA and the IHS has been ineffective because the level of cooperation is nowhere near where it needs to be for the benefit of American Indians.

I bring that up because I brought this to the attention of Secretary Shinseki when you brought him out here, and we met with him out at Fort Meade. I told him we needed to revisit that, and we need to make it more effective with the use of American Indian veterans' input.

Today, we have that new MOU signed. No American Indian veterans' input whatsoever in it. So, you know, my personal thought in talking with some of the tribal officials and the American Indian veterans is why—if not, then why do we need a CBOC on an Indian reservation?

Why not use our IHS to provide all these services that they are providing to our Indian veterans today and have the VA reimburse them back for those services—for the doctors, the nurses, the facility, administrative services, pharmacy, and so on, so forth? Those

monies can go to help the IHS hospitals for other services that are needed.

And I turned in my statement to you, Senator, and I said I wasn't going to go through it all. But there are some things that I would like to bring up on that. I would like to conclude on that now, and I would answer any questions on it.

But it has been brought to my attention from some of the veterans here in South Dakota, which you asked me to respond on, that the VA is putting many of our American Indian veterans on the payee system. I don't know if you are aware of that?

But the people that brought that to my attention are very upset about that because the payee is being paid out of his benefits. And he said that now he is getting around one-half of what he was getting from the VA because the other one-half is going to pay the payee for his travels to visit him and condemn him from going back to the reservations to attend the American Indian functions, such as pow-wows and stuff, visiting his relations.

When I first talked with Secretary Shinseki, I told him that most of our American Indian veterans, especially in South Dakota, are very elderly. We have World War II veterans still alive. But with them having to ride or rent a car or take the family car or if they have DAV vans are available to go to Fort Meade or go to Sioux Falls, it is a great distance to travel, and they are unable to make those long distance travels.

You know, you talk about elderly. At one time when I was growing up—you know Vern Ashley like I do. Vern Ashley is World War II Air Corps veteran. He never went to the VA, to my knowledge, for help, although he needs it. Today, he is 96 years old, 97 years old, needs hearing aids, and he is too proud to go ask for them. But he needs them. He told me that he couldn't go there.

But today, you talk about elderly, I served during the Korean war in 1950. My gray hair is here because I am 80 years old, and I am proud to have served my country. There were 12 of us cousins that volunteered and went into the service. They all returned home.

Off-reservation American Indian veterans; that was brought to my attention. When they go back to the IHS facility back on the reservation, because they are working off the reservation—their families are growing up off the reservation, going to public schools—when they go back to IHS facilities, they are being denied services yet today.

I asked one of the veterans from Sisseton to come today, and he couldn't make it. At least I don't see him here anyway, but he said he was going to try. To tell his story on how he was treated when he was having a heart attack at the IHS facility.

Burial flags. That is one of the NCA's—I am on that board, and the next meeting, I am going to bring that out again.

But burial flags are not able to be gotten by a lot of American Indian veterans because they are human like everybody else. They either lost it or delayed it or something, but they can't get that flag from the post offices unless they have that DD–214 or the discharge papers or something to prove that they are a veteran. And when you die, they have got only so many days to be buried, and they need that flag.

I know when I served on the South Dakota Veterans Commission, I served on that for more than 20 years, and we were told that the headstones, some of the headstones were being held hostage by some of the funeral directors because of lack of payment for the burial, when they ordered the stone. We need to change that.

We have our own tribal veteran service officers, and there is no reason in the world why those headstones can't be shipped directly back to that tribe itself, to the tribal veteran service officer.

Senator JOHNSON. Don, will you please wrap it up? And let us go to Ms. Good Voice Flute, and then I will ask you some questions.

Mr. LOUDNER. Okay. Thank you. Thank you.

Senator JOHNSON. Ms. Good Voice Flute.

STATEMENT OF IVA GOOD VOICE FLUTE, AIR FORCE VETERAN, OGLALA SIOUX TRIBE

Ms. GOOD VOICE FLUTE. Good morning, Senator Johnson. Thank you for allowing me this opportunity to be here today.

Good morning, ladies and gentlemen, to the various agencies that are represented here to come together for our Native American veterans.

I would like to recognize our tribal president, John Yellow Bird Steele, who is in the audience. And also our fifth member, Mr. Myron Pourier, is over here on my left.

And thank you to the many Native American veterans who have appeared here today for this hearing.

I would like to begin by sharing two stories from veterans that I have visited with regarding the service that they did not receive from IHS and the VA.

"Iva, I wish I had never let our Indian Health Service know that I am a veteran. They sent me to the VA hospital right away, only to find out that the VA hospital did not have the doctors I needed to address my female medical problems."

To this day, this woman veteran will never visit a VA hospital again. And she finished in the conversation with me, "Iva, I am a Lakota first."

Senator JOHNSON. Could you pull the microphone up closer to you?

Ms. GOOD VOICE FLUTE. Okay. And the other story I have is from a Marine Corps veteran. He traveled to the IHS, and he was told that he needed to update his contact information. He came there for a dislocated shoulder.

And IHS told him that they could not provide services for him because he is a veteran and that he had to utilize other resources that he may qualify for. So he traveled to a VA hospital, and then the hospital tells him that his income is too high to qualify for their services. But if he writes "zero" for an income, the VA can take his vital readings. And if he returns for medical treatment, he will have to pay for it.

He never returned to the VA after that initial visit. He thought he deserved those VA services because he is a veteran.

These tribal-enrolled, honorably discharged veterans fulfilled their commitment in serving our country, but experienced the cruelest of ironies when two agencies, the VA and IHS, tell them we

cannot help you, although based on the facts that you are members of a tribe with whom the Federal Government has treaties with, and you did serve in our country's military.

Why was this MOU created between the VA and IHS when it only hurts our veterans when it is supposed to help them? And these two agencies have proven that they did not collaboratively, effectively work toward the common goal of meeting our veterans' healthcare needs.

I have never agreed to this MOU, and once again, my personal thoughts on this are that I feel that it is a situation with the intentions of one agency to be profit-making in nature and the other agency to become cost efficient by not providing services to one particular group of people.

I believe that our Federal Government has a fiduciary responsibility in obligating funds to our Native American veterans' healthcare, to bring everyone together to troubleshoot the problems of this MOU, and resolve the problems that have existed since its inception in 2003.

And in closing, we deserve quality healthcare, and we must all work together to make this happen for the generation of veterans now and our younger generation of veterans, who need to be encouraged to utilize the services meant for us.

Senator JOHNSON. Thank you.

Ms. Good Voice Flute and Mr. Loudner, I will pose this question to both of you. In what specific areas do you see a need for improved collaboration between VA and IHS? In your opinion, going forward, where do the VA and IHS need to be focusing their efforts to ensure Native American vets receive appropriate healthcare?

Ms. GOOD VOICE FLUTE. First of all, I would like to comment on the services that the VA provides, that there be more medical care for our women veterans. And not just Native American women veterans, but all women veterans, and then to make these services more visibly available to where we are aware.

And my question is whose responsibility will that be on behalf of the VA to make us aware that there are doctors for our unique special needs?

Mr. LOUDNER. Thank you, Senator Johnson.

I think what needs to be done is we need to try to work together. There are a lot of us out there trying to do the same thing, but we are going in different ways. But our American Indian veterans deserve to be given the opportunity to decide, because of their age and stuff, where they want to have their treatment done.

If an elderly American Indian veteran knows that IHS facilities has the capability of helping him, he should be allowed to go there. And if IHS doesn't have the capabilities, there should be a way to get him to the VA facilities, whether it be Fort Meade or Sioux Falls.

Right now, some of them are saying that they have to beg, borrow, and steal to try to get someone to take them there. A lot of them don't have a VA vehicle. I am proud to say that with a lot of arguing and everything, we finally got a new van back in Crow Creek delivered back there last Friday. So they have the capability.

But those are some of the things that they are bringing to our attention.

Senator JOHNSON. It is important that the VA communicate with the tribes, and I appreciate the creation of the OTGR. As Ms. Birdwell highlighted in her testimony, the office is focused on meaningful outreach with tribal officials.

How do you think the VA can improve communication and outreach to Native American vets, Mr. Loudner and Ms. Good Voice Flute?

Mr. LOUDNER. Let me start on that. Thanks for the question, Senator.

I personally went and met with Stephanie Birdwell in her office and volunteered to work with her in any way that she has seen possible for me to work with in providing input that is coming back to me as the national commander from all over the United States. To this day, she has never returned any calls or even asked me to talk to her.

So I think what she needs to do is see the importance of our national organization, which is called upon by you people, Senator Johnson, in Washington to testify on behalf of the American Indian veterans. There can be only one veteran organization to do that, and that is our organization.

So I feel that they need to start working with us, both VA and IHS, so that we can get that brought to your attention in the Congress.

Senator JOHNSON. Ms. Good Voice Flute.

Ms. GOOD VOICE FLUTE. Yes, Senator Johnson.

I believe that the VA can improve communication with the tribes by being more of a visible presence. I keep going back to that. And I also must add that there be a healthy balance of being more culturally sensitive and not so much as a clinical approach to our problems.

Have a liaison within the tribe to work with the VA to where we can bring both worlds together to benefit the needs of the veterans. So that is how I believe that there can be more communication is for the VA to have a more visible presence on the reservations.

Senator JOHNSON. Speaking of female vets, the VA is having to undergo a culture change from a department designed to treat male vets to one that has a growing female vet population.

Ms. Good Voice Flute, in your opinion, what steps do you think the VA needs to take to better meet the unique needs of female vets?

Ms. GOOD VOICE FLUTE. What I think, first of all, the VA needs to do in the hospitals is have more doctors available for our medical needs, and second is make us aware that there will be these medical needs that will be met for the medical needs that we have.

I think the VA overall and IHS need to work together to meet the needs of the women veterans because, since my separation from the military and being home on the reservation, women veterans are very reluctant to come forward and tell the service providers what they need. And a lot of it, I believe, is trust issues.

Senator JOHNSON. Are there enough OB/GYNs to go around?

Ms. GOOD VOICE FLUTE. No, I don't think there are. I do not think so, Senator.

Senator JOHNSON. Yes. I want to thank everyone for attending today's hearing, especially those who have traveled from out of

town to be here. I believe it is important for both the VA and IHS to appear together routinely to update everyone on how a more collaborative partnership will enhance services for Native American vets.

As a reminder, Ms. Birdwell will be conducting a listening session today at 3 p.m. at the Pejuta Haka College Center in Kyle, South Dakota, on the Pine Ridge Indian Reservation.

CONCLUSION OF HEARING

Senator JOHNSON. Again, thank you to everyone, and I look forward to continuing this dialogue as the VA and IHS move forward, creating a meaningful partnership.

This hearing is concluded. Thank you.

[Whereupon, at 11 a.m., Tuesday, August 30, the subcommittee was recessed, to reconvene subject to the call of the Chair.]

MATERIAL SUBMITTED SUBSEQUENT TO THE HEARING

[CLERK'S NOTE.—The following testimony was received subsequent to the hearing for inclusion in the record.]

PREPARED STATEMENT OF THE CHEYENNE RIVER SIOUX TRIBE

EXECUTIVE RESOLUTION NO. E–360–2011–CR

WHEREAS, the Cheyenne River Sioux Tribe of South Dakota is an unincorporated tribe of Indians, having accepted the provision of the act of June 18, 1934, (48 Stat. 984); and

WHEREAS, the Tribe [1] in order to establish its tribal organizations, to conserve its tribal property, to develop its common resources, and to promote the general welfare of its people, has ordained and established a Constitution and By-Laws; and

WHEREAS, the Tribal Council has authority pursuant to article IV, Section 1(a) of the Tribal Constitution "[t]o enter into negotiations with the Federal, State, and local Governments on behalf of the tribe." Id.; and

WHEREAS, the Cheyenne River Sioux Tribe is the successor in interest to four of the historic bands of the Great Sioux Nation (Titonwan Lakota Oceti Sakowin/Seven Council Fires of the Teton or Prairie-dwelling Nation of Friends or Allies), i.e., Mnicoujou (Plants-by-the-Water), Itazipco (Without Bows), Siha Sapa (Blackfoot) and Oohenumpa (Two Kettles or Boilings) signatory to the Fort Laramie Treaties of 1851 (11 Stat. 749) and 1868 (15 Stat. 635); and

WHEREAS, as a stipulation of the Fort Laramie Treaty of 1868 health care is right provided to enrolled members of the Cheyenne River Sioux Tribe (15 Stat. 635); and

WHEREAS, American Indian Servicemen and women have the highest record of service per capita of all the ethnic groups in America; and

WHEREAS, American Indian people have participated with distinction in United States military actions for more than 200 years, their courage, determination, and fighting spirit were recognized by American military leaders as early as the 18th century; and

WHEREAS, American Indian people have served in all our nation's wars despite the fact that we were not granted citizenship until 1924; and

WHEREAS, American Indian veterans face unique challenges when it comes to equal access to care and navigating the VA and IHS systems; and

WHEREAS, the Memorandum of Understanding (MOU) Between the Department of Veterans Affairs and Indian Health Service is difficult to understand and makes no provision for payments made on behalf of American Indians between the said two Federal governmental agencies; and

WHEREAS, upon their service to the United States military the Department of Veterans Affairs became the payer of first resort; and

WHEREAS, American Indian people have access to the healthcare via the Department of Health and Human Service office of Indian Health Service (IHS), IHS becomes the payer of last resort, as their service to the U.S. Armed Services supersedes the initial obligation of IHS to enrolled members of Federally Recognized Tribes; and

WHEREAS, the Cheyenne River Service Unit, Indian Health Service, Contract Health in Eagle Butte, SD, acted in good faith in preparing and issuing payment vouchers for 15 veterans of the Cheyenne River Sioux Tribe to the Department of Veterans Affairs, Black Hills Health Care System (BHHCS); and

[1] Cheyenne River Sioux Tribe, Cheyenne River Reservation, Act of March 2, 1889, Section 4, 25 Stat. 888 (reservation boundaries).

WHEREAS, the BHHCS have denied the payments citing no "Sharing Agreement" between the Department of Veterans Affairs and the Indian Health Service; and

WHEREAS, the Cheyenne River Sioux Tribe hereby recommends and fully endorses a Sharing Agreement between the Cheyenne River Service Unit, Indian Health Service, Contract Health in Eagle Butte, SD; now

THEREFORE BE IT RESOLVED, that the Cheyenne River Sioux Tribal Council hereby calls upon South Dakota Senator Tim Johnson, Chairman, Subcommittee on Military Construction and Veterans Affairs Appropriations Subcommittee, support a Sharing Agreement; and

BE IT FURTHER RESOLVED, that this resolution be transmitted to the South Dakota Congressional delegation;[2] and

BE IT FURTHER RESOLVED, that the Cheyenne River Sioux Tribal Chairman is authorized to take all necessary and appropriate actions for the implementation of this Resolution; and

BE IT FINALLY RESOLVED, that nothing in this Resolution diminishes, divests, alters, or otherwise affects any inherent, treaty, statutory, or other rights of the Cheyenne River Sioux Tribe over the property or activities described herein. The Cheyenne River Sioux Tribe expressly retains all rights and authority over the property and activities described herein, including but not limited to legislative, regulatory, adjudicatory, and taxing powers.

CERTIFICATION

This is to certify that the foregoing Executive Resolution has been reviewed and approved by the Executive Committee, acting under the Executive Authority and in the best interest of the Cheyenne River Sioux Tribe this 29th day of August, 2011 in Eagle Butte, South Dakota.

KEVIN C. KECKLER,
Chairman, Tribal Chairman.
EV ANN WHITE FEATHER,
Tribal Secretary.
BENITA CLARK,
Tribal Treasurer.

PREPARED STATEMENT OF GERI OPSAL, TRIBAL VETERANS SERVICE OFFICER FOR THE SISSETON WAHPETON OYATE, LAKE TRAVERSE RESERVATION

Chairman Johnson and members of the Subcommittee on Military Construction and Veterans Affairs, and Related Agencies: Good morning, I am Geri Opsal, tribal veterans service officer (TVSO) for the Sisseton Wahpeton Oyate located on the Lake Traverse Reservation.

I want to thank you for inviting us to attend this very important meeting, and since our schedules conflicted due to the annual certification school of the TVSOs and county veterans service officers, we are unable to attend. We do want to provide some comments regarding this important issue of improving access to care for Native American veterans in maximizing the effective use of Federal funds and services.

The Sisseton Wahpeton Oyate is comprised of more than 12,941 tribal members. Of those tribal members, we have a veteran roster that goes back to the scout to present—we have more than 1,250 tribal members that are veterans. Each year we have of our members going off to serve. We have more than 80-plus tribal member veterans that have served in the Desert Era War from 1990 to present. We have tribal members stationed across the United States and also overseas fighting the fight for our country.

Our Tribal Veterans Service Office has met many times with our Indian Health Service (IHS) regarding our veterans utilizing IHS verses having to travel and use the Department of Veterans Affairs (VA). Although progress has been made in the following areas, there are other areas we have concern about and wish to resolve.

The following areas that we have had success with are:

Pharmacy.—Veterans can bring their prescriptions to the pharmacy and our pharmacist will call directly to the VA and confirm. Our veterans are able to get the prescriptions filled locally at IHS rather than traveling to get refills, etc.

Walk-In Clinic, Optometry, Dental-Pharmacy.—Our veterans are able to utilize IHS for their medical needs. They don't have to travel if they chose not to

[2] [Addressed to U.S. Senator Tim Johnson, U.S. Senator John Thune, and U.S. Representative Kristi Noem.]

but should they need referral to a specialist they are required to then go to the VA and have the referral done through them.

Co-Pays.—IHS will pay for the veterans co-pays they accumulate at the VA, but they do require that either the veteran or myself contact Tami Seiber, contract health specialist, and notify her of the appointment ahead of time. We've had a couple of veterans that had their income tax refund withheld due to nonpayment. One went and appealed this and had about 90 percent of it returned to him. The co-pays that aren't covered by IHS are the prescription co-pays and this they say is due to the fact the prescription can be filled by IHS. A prescription has two meds—one is covered; one is not. One you can get through the VA and one through IHS, a simple Rx that takes days to fill as someone has to run back and forth determining the least cost-effective way to get this filled. Why isn't their brochure geared for the Native American veteran notifying them to of what extent their services are covered through the VA and IHS. We have found out by trial and error as each case comes up why are we pieced out the information as we seek it?

The following areas of concern for us that we would like help to resolve are:

Electronic Records.—If possible to have IHS doctors as well as VA doctor's access electronically each others records/labs/notes on the veteran. This will help eliminate duplicate care and often times our veterans after going to the VA for their appointment or even after discharge from a hospitalization will go to the IHS and ask the doctor to explain the procedure or any questions. They sometimes are so happy to get discharged and get home they don't ask questions until they get back to the reservation and they have all the follow-up questions.

Co-pays being returned or not paid in a timely manner, the veteran getting sent to collections, or either getting their income tax taken. How are we able to correct any negative credit rating they may get as a result? And is their any way to flag the tribal member veteran's record so the VA automatically bills the IHS first rather than sending it to the patient's address and expecting them to take or forward to IHS. Co-pays for prescriptions should be covered as well. How is the veteran to know that they only get co-pays for appointments?

Solution.—We have a memorandum of understanding (MOU). This says the VA and the IHS are working together for the benefit of the veteran. Have the MOU give the VA authority (a new policy) that when a Native American veteran utilizes the VA, the VA is given authority to document under the financial part that the veteran is IHS-eligible; no co-pays. This will eliminate co-pays for office visits, medications, or referrals to specialty doctors. Right now, our biggest problem for our veterans is navigating the VA and IHS issue. The sharing of electronic records would come in handy with this process as well. Who's going to pay; hurry-up-and-wait game for referrals and getting bills because they didn't know they could take their Rx to IHS if they carry the meds; if they don't carry them they will order them and still no co-pay for the patient.

We feel as a tribal member, first, and veteran, second, that we are protected under treaty rights. We are considered "dual eligible". Theoretically, being dual-eligible has caused more trouble for us due to trying to navigate the system which we have difficulty understanding. The Snyder Act of 1921 (25 U.S.C. 13) and the Indian Health Care Improvement Act (25 U.S.C. 1601) of 1976 provide specific legislative authority for the Congress to appropriate funds specifically for the healthcare of Indian people. In addition, we also have treaty rights to Federal healthcare services through the Department of Health and Human Services. The Federal trust to uphold the treaty responsibility for healthcare is first, and being a veteran is secondary to our healthcare process—moreso, when the tribal member is also a veteran, as they took the oath to fight for our freedom. We as veterans have heard the term from IHS that they are the "payor of last resort", and, as such, the use of alternative resources is required when such resources are available and accessible to the individual. We are required to go to the VA for any referrals; otherwise, IHS will not cover it. Dual eligibility which has us going between the IHS and the VA, and we try and keep our records straight.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss the unique challenges when it comes to access to care and navigating the VA and IHS. We will be happy to answer any questions and consult on this process and perhaps if you have another meeting in the future we can attend along with our tribal secretary of the Sisseton Wahpeton Oyate; Ms. Winfield Rondell who is a Marine Corps veteran as well as one of our tribal executives.

LETTER FROM THE STANDING ROCK SIOUX TRIBE [1]

AUGUST 26, 2011.

Hon. TIM JOHNSON,
Chairman, Subcommittee on Military Construction and Veterans Affairs, and Related Agencies, Committee on Appropriations,
Washington, DC.

MOST HONORABLE SENATOR TIM JOHNSON: We are in receipt of your letter and are most honored to be invited to the hearing to be held in Rapid City, SD on August 30, 2011.

We are grateful for the opportunity to express our concerns regarding the collaboration with the Indian Health Services and the Department of Veterans Affairs. The following are our primary concerns for the Standing Rock Sioux Tribal veterans.

I. Standing Rock veterans would like to have x-rays, labs, pharmacy, referrals, and all primary care provided at the local level.

II. Standing Rock veterans would like to have a day set aside for their care. One day scheduled for veterans to come in and see a doctor. These visits would then be put into their charts at the Veterans Hospital that they have been assigned to.

III. Technological access to the Department of Veterans Affairs medical records would allow for all medical and pharmaceutical visits to be viewed by the veteran's primary care physician. This would also eliminate the duplication of services and medications given to the veteran.

IV. Veterans would like the Indian Health Services and the Department of Veterans Affairs to have better communications so the veterans get the best care available. Such as getting veterans stabilized at the Indian Health Services and then transported to the VA for care.

V. Veterans on the Standing Rock Reservation travel 300+ miles to get to their primary care provider. Services here would eliminate the travel time for our veterans.

Thank you for your interest in our veterans on the Standing Rock Sioux Tribal reservation.

CHARLES W. MURPHY,
Chairman and Vietnam Veteran.
WENELLE F. CLOWN,
Tribal Veterans Service Office.

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[1] Charles W. Murphy, Chairman; Mike Faith, Vice Chairman; and Adele M. White, Secretary:
Tribal Council (At Large).—Jesse "Jay" Taken Alive; Ronald C. Brownotter; Avis Little Eagle; Dave Archambault II; Joseph McNeil Jr.; and Jesse McLaughlin.
Tribal Council (Districts).—Sharon Two Bears, Cannonball District; Henry Harrison, Long Soldier District; Duane Claymore, Wakpala District; Kerby St. John, Kenel District; Errol D. Cross Ghost, Bear Soldier District; Milton Brown Otter, Rock Creek District; Frank Jamerson Jr., Running Antelope District; and Samuel B. Harrison, Porcupine District.