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TESTIMONY OF ANDY JOSEPH
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BEFORE THE U.S. SENATE COMMITTEE ON VETERANS' AFFAIRS
HEARING ON VA AND INDIAN HEALTH SERVICE COOPERATION

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Chairman Akaka, Ranking Member Burr and distinguished members of the Committee, I am Andrew Joseph Jr. testifying on the behalf of the National Indian Health Board (NIHB). Also, I serve as a Tribal Council Member of the Confederated Tribes of the Colville Reservation and as the Chairman of the Northwest Portland Area Indian Health Board.
Thank you for inviting the NIHB to testify today regarding the cooperation and coordination between the Veteran Affairs and the Indian Health Service (IHS) in providing care to our American Indian/Alaska Natives (AI/AN) Veterans. Since 1972, the NIHB serves all federally recognized Tribes by advocating for the improvement of health care delivery to AI/AN. It is the belief of the NIHB that the federal government must uphold its trust responsibility to AI/AN populations in the provision and facilitation of quality health care to our people. The results that we all wish to achieve are the enhancement of the level and quality of health care and the adequacy of funding for health services that are operated by Tribal governments, the Indian Health Service and other federal programs. As health care is the top priority of Tribes across the nation, and delivery of health care is unique and individual to each Tribal nation and their tribal members in the United States, it is fitting that the NIHB provides testimony regarding the health care provided to our Native Veterans. Thank you for inviting us to do so.

Health Care Available for Our AI/AN Veterans
AI/AN who have served in the US Armed Forces are a special segment in our communities as they are both Tribal members and honored veterans. They are fellow members, relatives and friends of the 564 federally recognized tribal communities in United States. As well as, the long history of AI/AN serving in the United States Armed Forces should never be forgotten. AI/AN have volunteered to serve the United States at a higher percentage in all of America's wars and conflicts than any other ethnic group on a per capita basis. In addition, 25% of AI/AN population serve in military, which is higher than any other in the U.S. Based on the association with both the AI/AN and Veteran communities, AI/AN Veterans are entitled to health care both as a right as a tribal member and as a benefit for their military service.

Indian Health Service
As a member of federally recognized Tribe, AI/AN Veterans are entitled to health care. The provision of health services to AI/AN is the direct result of treaties and executive orders that were made between the United States and Indian Tribes. This federal trust responsibility forms

the basis of providing health care to AI/AN people and reaffirmed by judicial decisions, executive orders, and congressional law.

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

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

Veteran Health Administration

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

Memorandum of Understanding between HHS and the Veterans' Health Administration

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

communications between IHS and VHA and to create opportunities to develop strategies for sharing information, services, and information technology.

The MOU has served as an impetus for improving the coordination of care between IHS and VHA. In some areas, this coordination between IHS and VHA has improved but while in other areas, such coordination necessitates improvement. A recent study examined the AI/AN veteran's utilization of the IHS and VHA health services. Based the study's survey, 25% of AI/AN Veterans receive care through both IHS and VHA, while over 25% of AI/AN Veterans accessed care through VHA only and nearly 50% of AI/AN Veterans accessed care through IHS only. Of the dual use AI/AN Veterans, these individuals were more likely to receive primary care from IHS and to receive diagnostic and behavioral healthcare from VHA. Although such AI/AN Veterans are eligible to receive health care from the VHA and IHS, AI/AN Veterans report a high rate of unmet health care needs and exhibit high rates of disease risk factors for Post Traumatic Stress Disorder (PTSD).

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

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

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

Recommendations

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

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

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